Table of Contents

State/Territory Name: Idaho

State Plan Amendment (SPA) #: 16-0004

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
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

April 29, 2016

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

RE: Idaho State Plan Amendment (SPA) Transmittal Number 16-0004

Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number 16-0004. This SPA amends Idaho's Basic and Enhanced Alternative Benefit Plans (ABPs) to specify that the Prenatal and Postnatal care benefits provided in these respective ABPs does not meet the requirements for Minimal Essential Coverage (MEC) as designated by the Internal Revenue Service (IRS) regulations.

The enclosed SPA was approved on April 27, 2016 with an effective date of January 1, 2016.

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

Sincerely,

Digitally signed by David L. Meacham -S

[redacted]

Date: 2016.04.29 08:11:51 -07'00'

David L. Meacham
Associate Regional Administrator

Enclosure

cc:
Lisa Hettinger, Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **16-0004**

2. STATE **IDAHO**

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE **01 January 2016**

5. TYPE OF PLAN MATERIAL *(Check One)*:
☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
IRS Code of Regulations Section 500A(f)(1)(A)(ii)

7. FEDERAL BUDGET IMPACT:
Total ($) Federal Funds
FFY 2016 – $0
FFY 2017 – $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-C Basic
Attachment 3.1-C Enhanced

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-C Basic
Attachment 3.1-C Enhanced

10. SUBJECT OF AMENDMENT:
The proposed changes are in response to CMS's letter of February 12, 2016 to clarify that coverage for pregnant women with income between $365 per month and 133 percent of the federal poverty level is not equivalent to MEC as defined in the IRS Code of Regulations.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ **GOVERNOR'S OFFICE REPORTED NO COMMENT**
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
LISA HETTINGER

14. TITLE:
Administrator

15. DATE SUBMITTED:
3/22/16

16. RETURN TO:
Lisa Hettinger, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0009

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **3/22/16**

18. DATE APPROVED: **04/27/16**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01/01/16

20. SIGNATURE [redacted]
Digitally signed by David L. Meacham -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=People, 0.9.2342.19200300.100.1.1=2000041858, cn=David L. Meacham -S
Date: 2016.04.29 08:33:52 -07'00'

21. TYPED NAME:
David L. Meacham

22. TITLE:
Associate Regional Administrator

23. REMARKS:

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Idaho**

Transmittal Number:

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

ID-16-0004

Proposed Effective Date

01/01/2016 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

IRS Code of Regulations Section 500A(f)(1)(A)(ii)

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 827225.00
Second Year	2017	$ 3308900.00

Subject of Amendment

The proposed changes are in response to CMS's letter of February 12, 2016 to clarify that coverage for pregnant women with income between $365 per month and 133 percent of the federal poverty level is not equivalent to MEC as defined in the IRS Code of Regulations.

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: **Mar 22, 2016**

Submit Date: **Mar 22, 2016**

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- B

OMB Expiration date: 10/31/2014

Benefits Description ABP5

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

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

Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table

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

An attachment is submitted.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

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

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

"Secretary-Approved"

Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services — Collapse All

Benefit Provided: Primary Care Visit to Treat an Injury or Illness
Source: Base Benchmark Small Group
Remove

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

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

Benefit Provided: Specialist Visit
Source: Base Benchmark Small Group
Remove

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

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

Benefit Provided: Other Practitioner Office Visit
Source: Base Benchmark Small Group

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

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 PA.

Remove

Benefit Provided: Outpatient Facility Fee (e.g., ASC)

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Ambulatory Surgery Center (ASC);

Selected services require prior authorization.

Benefit Provided: Outpatient Surgery Physician/ Surgical Services

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Selected services require prior authorization.

Benefit Provided: Urgent Care Centers or Facilities

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Remove

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

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:

6 Visits

Duration Limit:

None

Scope Limit:

None

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

The Department will 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

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: None

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

Benefit Provided: Respiratory Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Enterostomal Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Home IV Therapy

Source: Base Benchmark Small Group

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Hospice

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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

Medicaid covers hospice services beyond the $10,000 lifetime limit covered by the Base Benchmark.

Add

Alternative Benefit Plan

Essential Health Benefit 2: Emergency services

Collapse All

Benefit Provided: Emergency Room Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Emergency Transportation/Ambulance

Source: Base Benchmark Small Group

Remove

Authorization: Retroactive Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization — Collapse All

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

Authorization: Authorization required in excess of limitation
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

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 a PA.

Benefit Provided: Inpatient Physician and Surgical Services
Source: Base Benchmark Small Group
Remove

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

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

Selected services require prior authorization.

Benefit Provided: Radiation Therapy: Inpatient
Source: Base Benchmark Small Group

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

Remove

Add

Alternative Benefit Plan

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

Benefit Provided: Prenatal and Postnatal care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

See "Other 1937 Benefits" for additional provider types covered beyond the Base Benchmark: Other Licensed Practitioner, Licensed Midwife;
Beneficiaries in the optional pregnant women group may receive EHB and other 1937 services that are pregnancy related as described below:
Idaho covers services that are necessary for the health of the pregnant woman and fetus, or that have become necessary because of the woman having been pregnant and services for other conditions that might complicate the pregnancy. Coverage includes prenatal care, delivery, postpartum care, and family planning services. This coverage includes services for the mother or fetus for other conditions that might complicate the pregnancy include those for diagnoses, illnesses, or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus. Pregnancy related services are covered for a postpartum period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.
Idaho does not cover services for pregnant women that are medically contraindicated during pregnancy or elective procedures for conditions that do not threaten the health of the pregnant woman, the carrying of the fetus to full term, or the safe delivery of the fetus.

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

Benefit Provided: Delivery and All Inpatient Services-Maternity Care

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

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

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

Remove

Add

Alternative Benefit Plan

Collapse All ☐

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

Benefit Provided: Substance Abuse Disorder Outpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Qualified Providers:
1) Licensed physician,
2) Advanced Practice Professional Nurse,
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Marriage and Family Therapist
7) Providers who hold at least a Bachelor degree, 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 Licensing)
9) Registered Nurse

Services rendered by a physician are subject to the program integrity controls.

Benefit Provided: MH/BH Inpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Mental Health/Behavioral Health Inpatient Services.

Services are not provided in an IMD.

Alternative Benefit Plan

Benefit Provided:
Substance Abuse Disorder Inpatient 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:

The Department covers Substance Abuse 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

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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

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

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

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

- Services may be provided by one of the following contracted professionals when provided within the scope of their practice:
  1) Licensed physician,
  2) Advanced Practice Professional Nurse,
  3) Physician Assistant
  4) Licensed Social Worker
  5) Licensed Counselor
  6) Licensed Marriage and Family Therapist
  7) Providers who hold at least a Bachelor degree, are Licensed or certified in their field (i.e. Adult or Children's Certificate in Psychosocial Rehabilitation), and who meet requirements of Idaho Department of Health and Welfare or its Contractor
  8) Licensed Psychologist, Psychologist Extender-(Registered with the Idaho Bureau of Occupational Licensing)
  9) Registered Nurse

Remove

Benefit Provided: Partial Care

Source: Secretary-Approved Other

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

- Services are prior authorized, and there is no limitation is amount, duration nor 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 when provided within the scope of their practice:

1) Licensed physician,
2) Advanced Practice Professional Nurse,
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Marriage and Family Therapist
7) Providers who hold at least a Bachelor degree and are Licensed Social Workers
8) Licensed Psychologist, Psychologist Extender-(Registered with the Idaho Bureau of Occupational Licensing)
9) Registered Nurse

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

Remove

Benefit Provided: MH/BH Outpatient Services: Group therapy

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: MH/BH Outpatient: Family and Individual Therapy

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:

Alternative Benefit Plan

Benefit Provided: MH/BH Outpatient: ECT Therapy

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: MH/BH Outpatient Services:Med Management

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

Alternative Benefit Plan

☒ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

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

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

Coverage that exceeds the minimum requirements or other:

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

Prior Authorization criteria is 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 is 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

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

Benefit Provided: Home Health Care Services

Source: Base Benchmark Small Group

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: 100 visits per year

Duration Limit: None

Scope Limit: Skilled Nursing, Home Health Aide, Occupational Therapy (OT), Physical Therapy (PT), and Speech Language Pathology (SLP) services when 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:

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

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: None

Duration Limit: None

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

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

The Base Benchmark limit is up to 20 visits for all occupational therapy (OT), speech-language pathology services (SLP) & physical therapy (PT) combined & includes both rehabilitation and habilitation.

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

Benefit Provided: Habilitation Services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

PT, OT, ST 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.

Remove

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) & physical therapy (PT) combined & includes both rehabilitation and habilitation.

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 which can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of Accidental Injury, Disease or Illness, and are appropriate for use in the beneficiary's home.

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: None

Duration Limit: None

Scope Limit:

Skilled Nursing Facility services for rehabilitation.

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

Add

Alternative Benefit Plan

Essential Health Benefit 8: Laboratory services

Collapse All

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

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Source: Base Benchmark Small Group

Remove

Authorization: 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

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

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

Benefit Provided: Preventive Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

The 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: Preventive Care/Screening/Immunization

Source: Secretary-Approved Other

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

The Basic Alternative Benefit Plan includes the following:
- Health Risk Assessment which consists of:
  - An initial health questionnaire, and
  - A well child screen, or
  - An adult physical.
- The health questionnaire is designed to assess the general health status and health behaviors of a recipient. This information will be used to provide customized health education. The health questionnaire will be administered at initial program entry and periodic intervals thereafter.

Alternative Benefit Plan

- A well child screen or adult physical conducted at periodic or interperiodic intervals which constitutes a health risk assessment will consist of a comprehensive physical examination and health education.

The Well Child Screen includes periodic medical screens and services completed at intervals recommended by the 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 Basic Alternative Benefit Plan for both children and adults includes an annual preventive health visit and services with "A" and "B" recommendations by the US Prevention Services Task Force.

Remove

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.

Add

Alternative Benefit Plan

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

Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
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 under the age of twenty-one (21).

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: Child

See Other 1937 Benefits for services in excess of the Base Benchmark lifetime limit of up to $1500 or about half the usual cost.

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
Base Benchmark Small Group

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

None

Remove

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

Eyeglasses for children.

Participants under the age of 21 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

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 - Child

Selected services require prior authorization.

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
Base Benchmark Small Group

Alternative Benefit Plan

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Remove

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Major Dental Care - Child

Selected services require prior authorization.

Add

Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

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

Base Benchmark Benefit that was Substituted: Residential Treatment

Source: Base Benchmark

Remove

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

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

This is an IMD.

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 Treatment for Partial Hospitalization (part of the EHB Mental/Behavioral Health Outpatient services).

This is an IMD.

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Non-Emergency Care When Traveling Outside the U.S.

Source:
Base Benchmark

Remove

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

Non-covered in accordance with federal statute.

Add

Alternative Benefit Plan

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

Other 1937 Benefit Provided: Licensed Midwife

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Services include antepartem, 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.

Other 1937 Benefit Provided: Orthodontia: Child

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 and 1905(r)(3)

Services in excess of the Base Benchmark: Orthodontia.

The Department will cover complete, medically necessary orthodontia in excess of the Base Benchmark lifetime dollar limit of $1500.

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

Remove

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. Up to one pair of glasses or contacts is covered post-cataract surgery.

Other 1937 Benefit Provided:
Dental Services: Adults

Source:
Section 1937 Coverage Option Benchmark Benefit Package

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

~ Restorative Dental Services:
- Medically necessary exams
- Fillings are covered once in a 24-month period per tooth/surface
- Simple and surgical extractions

- Endodontic services include therapeutic pulpotomy and pulpa debridement.
- Periodontic service s include scaling and root planning full mouth debridement
- Periodontal maintenance is covered up to 2 visits every 12 months.

~ Dentures:
-Dentures are covered once every 5 years

Limitations may be exceeded if medically necessary.

Non-pregnant adults who are past the month of their twenty-first (21st) birthday:
~ The Department will cover emergency and palliative dental care.

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

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

Remove

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

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Retroactive Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

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

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

Services in excess of the Base Benchmark: Rehabilitation Services;

The Department covers Physical Therapy, Occupational Therapy, and Speech Language Pathology services in excess of the Base Benchmark aggregate 20 visit limit. Claims exceeding $1870 for OT or $1870 for a combination of SLP and PT are subject to prepayment review for medical necessity.

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

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Retroactive Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

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

Remove

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 $1870 for OT or $1870 for a combination of SLP and PT are subject to prepayment review.

Other 1937 Benefit Provided:

Bariatric Surgery

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

nONE

Scope Limit:

None

Other:

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

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

Other 1937 Benefit Provided:

Prescription Drugs

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Prescription Drugs: In excess of Base Benchmark

Non-legend products will be covered when prescribed as follows:

- Permethrin,

- Federal legend medications that change to non-legend status, as well as their therapeutic equivalents, based on Director approval which is determined by 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.

Remove

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

The Department provides coverage for the following Medicare-excluded or otherwise restricted drugs or classes of drugs or their medical uses 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:
  Lipase inhibitors subject to Prior Authorization
- Prescription Cough & Cold symptomatic relief
- Legend Therapeutic Vitamins which include:
  ~ Injectable Vitamin B 12
  ~ Vitamin K and analogues, and
  ~ Legend folic acid
- Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients;
- Legend Vitamin D and analogues and
- Non-legend Products which include:
- Permethrin
- 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 are 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
- Ovulation stimulants and fertility enhancing drugs
- Prescription vitamins except injectable B 12, vitamin K, legend vitamin D, legend pediatric vitamin and fluoride preparations, legend prenatal vitamins for pregnant or lactating women, and legend folic acid.

Other 1937 Benefit Provided:

Prevention and Health Assistance

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

Other:

Program Description: This benefit is one of many preventive benefits that are included in this ABP. This benefit is covered in addition to the prevention and wellness benefits found in EHB9 and is being approved as Secretary-Approved Coverage.

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

The Basic Alternative Benefit Plan includes certain enhanced Prevention and Health Assistance (PHA) benefits for target individuals provided in accordance with applicable Department rules.

Basic 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 Basic Alternative Benefit Plan will be target to 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 material related to the condition.

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

Remove

Other 1937 Benefit Provided:

Home Health Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

100 visits per year

Duration Limit:

None

Scope Limit:

None

Other:

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

Services covered in excess of the Base Benchmark: The Base Benchmark covers up to $5,000 per year or about 50 visits for Home Health Services.

The Department will cover up to 100 visits without PA for any combination of Skilled Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, or Speech-Language Pathology services. More can be authorized when medically necessary.

Other 1937 Benefit Provided:

Durable Medical Equipment

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Program Description: 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.

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

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

Routine foot care is not covered.

Other 1937 Benefit Provided:
Individual and Family Medical Social Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
Two visits

Duration Limit:
Pregnancy and six weeks post-partum

Scope Limit:
None

Other:

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

Other services covered by the Department, but not covered by the Base Benchmark: Services directed at helping a patient to overcome social or behavioral problems which 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 Board of Social Work Examiners. Additional services may be prior authorized.

Remove

Other 1937 Benefit Provided:

Diabetes Education

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:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Services in excess of the Base Benchmark: Diabetes Education

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. Additional services may be prior authorized when medically necessary.

Other 1937 Benefit Provided:

Target Case Management Services: Idaho Behavioral

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

- Other services covered by the Department, but not covered by the Base Benchmark: Target Case Management in the Idaho Behavioral Health Program.

- Services are prior authorized, and there is no limitation is amount, duration nor 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;
  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 Target Case Management services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational and other services. Target case Management includes the following assistance:

- 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 following conditions are met:
    ~ Services are being furnished in accordance with the individual's care plan;
    ~ Services in the care plan are adequate; and

~ If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements with providers.

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

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

~ Waiver of Freedom of Choice of Providers
As permitted and authorized under section 1915 (b)(4) of the Social Security Act, choice of target case management providers is waived. Behavioral Health target 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 interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]

Individuals will not be compelled to receive 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 target case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

~Case Records (42 CFR 441.18(a)(7)):
The State assures that providers maintain case records that document for all individuals receiving case management as follows [42 CFR 441.18(a)(7)]:

- The name of the individual.

- The dates of the case management services.
- The name of the provider agency and the person providing the case the case management service
- The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved.
- Whether the individuals has declined services in the care plan
- The need for, and occurrences of, coordination with other case managers.
- A timeline for obtaining needed services
- A timeline for reevaluation of the plan.

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

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

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

Remove

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 set per five years

Duration Limit:
None

Scope Limit:
None

Other:
Dentures for the purpose of restoring oral form and function due to loss of permanent teeth that would result in significant occlusal dysfunction are only covered for children through the month of their twenty-first (21st) birthday, and pregnant women when medically necessary.

Other 1937 Benefit Provided:
Audiology

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Prior Authorization

Provider Qualifications: Other

Remove

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:

Certain services require PA.

Audiologist services are covered for individuals with hearing disorders when provided by an audiologist who is licensed by the Speech and Hearing Services Board in the Idaho Board of Occupational Licensing.

~ 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

Authorization: Other

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

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 are:
~ Behavioral consultation must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) hours of relevant coursework or training, or both, in principles of child development,

learning theory, positive behavior support techniques, dual diagnosis, or behavior analysis (may be included as part of degree program); and who meets one (1) of the following:

~ An individual with an Exceptional Child Certificate as defined by State law.
~ An individual with an Early Childhood/Early Childhood Special Education Blended Certificate as defined by State law.
~ A Special Education Consulting Teacher as defined by State law.
~ An individual with a Pupil Personnel Certificate as defined by State law, excluding a registered nurse or Audiologist.
~ An occupational therapist who is qualified and registered to practice in Idaho.
~ Therapeutic consultation professional who meets the requirements defined by the Department.

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

Remove

Other 1937 Benefit Provided:

Behavioral Intervention

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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 who 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, are qualified to provide behavioral intervention; and
~ Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities.

- Qualifications for a Behavioral Intervention Paraprofessional are as follows:
~ Must be at least eighteen (18) years of age;
~ 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.

Remove

Add

Alternative Benefit Plan

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

Collapse All ☐

PRA Disclosure Statement

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

V.20130808

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- N

OMB Expiration date: 10/31/2014

Benefits Description ABP5

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

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

Secretary-Approved Benchmark Package: Benefit by Benefit Comparison Table

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

An attachment is submitted.

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

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

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

"Secretary-Approved"

Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services — Collapse All

Benefit Provided: Primary Care Visit to Treat an Injury or Illness
Source: Base Benchmark Small Group
Remove

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

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

Benefit Provided: Specialist Visit
Source: Base Benchmark Small Group
Remove

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

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

Benefit Provided: Other Practitioner Office Visit
Source: Base Benchmark Small Group

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

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 PA.

Remove

Benefit Provided: Outpatient Facility Fee (e.g., ASC)

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Ambulatory Surgery Center (ASC);

Selected services require prior authorization.

Benefit Provided: Outpatient Surgery Physician/ Surgical Services

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Selected services require prior authorization.

Benefit Provided: Urgent Care Centers or Facilities

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Remove

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

Benefit Provided: Chiropractic Care

Source: Base Benchmark Small Group

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: 6 Visits

Duration Limit: None

Scope Limit:

None

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

The Department will 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

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: None

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

Benefit Provided: Respiratory Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Enterostomal Therapy

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Home IV Therapy

Source: Base Benchmark Small Group

Alternative Benefit Plan

Authorization:
None

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided:
Hospice

Source:
Base Benchmark Small Group

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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

Medicaid covers hospice services beyond the $10,000 lifetime limit covered by the Base Benchmark.

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

Add

Alternative Benefit Plan

Essential Health Benefit 2: Emergency services

Collapse All

Benefit Provided: Emergency Room Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Emergency Transportation/Ambulance

Source: Base Benchmark Small Group

Remove

Authorization: Retroactive Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization — Collapse All

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

Authorization: Authorization required in excess of limitation
Provider Qualifications: Selected Public Employee/Commercial Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

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 a PA.

Benefit Provided: Inpatient Physician and Surgical Services
Source: Base Benchmark Small Group
Remove

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

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

Selected services require prior authorization.

Benefit Provided: Radiation Therapy: Inpatient
Source: Base Benchmark Small Group

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

Remove

Add

Alternative Benefit Plan

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

Benefit Provided: Prenatal and Postnatal care

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

See "Other 1937 Benefits" for additional provider types covered beyond the Base Benchmark: Other Licensed Practitioner, Licensed Midwife;
Beneficiaries in the optional pregnant women group may receive EHB and other 1937 services that are pregnancy related as described below:
Idaho covers services that are necessary for the health of the pregnant woman and fetus, or that have become necessary because of the woman having been pregnant and services for other conditions that might complicate the pregnancy. Coverage includes prenatal care, delivery, postpartum care, and family planning services. This coverage includes services for the mother or fetus for other conditions that might complicate the pregnancy include those for diagnoses, illnesses, or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus. Pregnancy related services are covered for a postpartum period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.
Idaho does not cover services for pregnant women that are medically contraindicated during pregnancy or elective procedures for conditions that do not threaten the health of the pregnant woman, the carrying of the fetus to full term, or the safe delivery of the fetus.

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

Benefit Provided: Delivery and All Inpatient Services-Maternity Care

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

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

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

Remove

Add

Alternative Benefit Plan

Collapse All ☐

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

Benefit Provided: Substance Abuse Disorder Outpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Qualified Providers:
1) Licensed physician,
2) Advanced Practice Professional Nurse,
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Marriage and Family Therapist
7) Providers who hold at least a Bachelor degree, 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 Licensing)
9) Registered Nurse

Services rendered by a physician are subject to the program integrity controls.

Benefit Provided: MH/BH Inpatient Services

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Mental Health/Behavioral Health Inpatient Services.

Services are not provided in an IMD.

Alternative Benefit Plan

Benefit Provided: Substance Abuse Disorder Inpatient 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:

The Department covers Substance Abuse 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

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

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

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

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

- Services may be provided by one of the following contracted professionals when provided within the scope of their practice:
  1) Licensed physician,
  2) Advanced Practice Professional Nurse,
  3) Physician Assistant
  4) Licensed Social Worker
  5) Licensed Counselor
  6) Licensed Marriage and Family Therapist
  7) Providers who hold at least a Bachelor degree, are Licensed or certified in their field (i.e. Adult or Children's Certificate in Psychosocial Rehabilitation), and who meet requirements of Idaho Department of Health and Welfare or its Contractor
  8) Licensed Psychologist, Psychologist Extender-(Registered with the Idaho Bureau of Occupational Licensing)
  9) Registered Nurse

Remove

Benefit Provided: Partial Care

Source: Secretary-Approved Other

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

- Services are prior authorized, and there is no limitation is amount, duration nor 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 when provided within the scope of their practice:

1) Licensed physician,
2) Advanced Practice Professional Nurse,
3) Physician Assistant
4) Licensed Social Worker
5) Licensed Counselor
6) Licensed Marriage and Family Therapist
7) Providers who hold at least a Bachelor degree and are Licensed Social Workers
8) Licensed Psychologist, Psychologist Extender-(Registered with the Idaho Bureau of Occupational Licensing)
9) Registered Nurse

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

Remove

Benefit Provided: MH/BH Outpatient Services: Group therapy

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: MH/BH Outpatient: Family and Individual Therapy

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:

Alternative Benefit Plan

Benefit Provided: MH/BH Outpatient: ECT Therapy

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: MH/BH Outpatient Services:Med Management

Source: Base Benchmark Small Group

Remove

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Add

Alternative Benefit Plan

☒ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

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

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

Coverage that exceeds the minimum requirements or other:

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

Prior Authorization criteria is 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 is 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

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

Benefit Provided: Home Health Care Services

Source: Base Benchmark Small Group

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: 100 visits per year

Duration Limit: None

Scope Limit:

Skilled Nursing, Home Health Aide, Occupational Therapy (OT), Physical Therapy (PT), and Speech Language Pathology (SLP) services when 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:

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

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: None

Duration Limit: None

Scope Limit:

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

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

The Base Benchmark limit is up to 20 visits for all occupational therapy (OT), speech-language pathology services (SLP) & physical therapy (PT) combined & includes both rehabilitation and habilitation.

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

Benefit Provided: Habilitation Services

Source: Base Benchmark Small Group

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

PT, OT, ST 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.

Remove

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) & physical therapy (PT) combined & includes both rehabilitation and habilitation.

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 which can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of Accidental Injury, Disease or Illness, and are appropriate for use in the beneficiary's home.

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: None

Duration Limit: None

Scope Limit:

Skilled Nursing Facility services for rehabilitation.

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

See "Other 1937 Benefits" for services in excess of the Base Benchmark limit of $5,000 per year.

Add

Alternative Benefit Plan

Essential Health Benefit 8: Laboratory services

Collapse All

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

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Source: Base Benchmark Small Group

Remove

Authorization: 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

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

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

Benefit Provided: Preventive Services

Source: Base Benchmark Small Group

Remove

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

The 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: Preventive Care/Screening/Immunization

Source: Secretary-Approved Other

Authorization: None

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

The Enhanced Alternative Benefit Plan includes the following:
- Health Risk Assessment which consists of:
  - An initial health questionnaire, and
  - A well child screen, or
  - An adult physical.
- The health questionnaire is designed to assess the general health status and health behaviors of a recipient. This information will be used to provide customized health education. The health questionnaire will be administered at initial program entry and periodic intervals thereafter.

Alternative Benefit Plan

- A well child screen or adult physical conducted at periodic or interperiodic intervals which constitutes a health risk assessment will consist of a comprehensive physical examination and health education.

The Well Child Screen includes periodic medical screens and services completed at intervals recommended by the 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 US Prevention Services Task Force.

Remove

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.

Add

Alternative Benefit Plan

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

Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
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 under the age of twenty-one (21).

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: Child

See Other 1937 Benefits for services in excess of the Base Benchmark lifetime limit of up to $1500 or about half the usual cost.

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
Base Benchmark Small Group

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

None

Remove

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

Eyeglasses for children.

Participants under the age of 21 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

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 - Child

Selected services require prior authorization.

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
Base Benchmark Small Group

Alternative Benefit Plan

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Remove

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Major Dental Care - Child

Selected services require prior authorization.

Add

Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

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

Base Benchmark Benefit that was Substituted: Residential Treatment

Source: Base Benchmark

Remove

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

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

This is an IMD.

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 Treatment for Partial Hospitalization (part of the EHB Mental/Behavioral Health Outpatient services).

This is an IMD.

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Non-Emergency Care When Traveling Outside the U.S.

Source:
Base Benchmark

Remove

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

Non-covered in accordance with federal statute.

Add

Alternative Benefit Plan

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

Other 1937 Benefit Provided: Nursing Facility: Custodial Care

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:

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

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

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

The nursing facility benefits defined in the other 1937 section described as Nursing Facility: Rehabilitative and Nursing Facility: Custodial care along with the Skilled Nursing Facility benefit in the EHB7 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: Hospice

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Prior Authorization

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: NONE

Scope Limit: None

Other:

Program Description: Hospice Care; 1905(a)(18) of the Act.

Services in excess of the Base Benchmark: The Department will cover hospice services beyond the Base Benchmark limit of $10,000 per life time.

Remove

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-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 nursing services. All PDN services are provided under the direction of a physician.

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 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 school.

Other 1937 Benefit Provided:

Licensed Midwife

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Other

Provider Qualifications: Medicaid State Plan

Remove

Amount Limit: None

Duration Limit: None

Scope Limit:

Services include antepartem, 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.

Other 1937 Benefit Provided: Orthodontia: Child

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 and 1905(r)(3)

Services in excess of the Base Benchmark: Orthodontia.

The Department will cover complete, medically necessary orthodontia in excess of the Base Benchmark lifetime dollar limit of $1500.

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

Remove

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. Up to one pair of glasses or contacts is covered post-cataract surgery.

Other 1937 Benefit Provided:

Dental Services: Adults

Source:

Section 1937 Coverage Option Benchmark Benefit Package

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

All adult participants over age 21,receive all medically necessary dental services, including the following preventative and restorative services:
~ Preventive dental services:
- Oral exam every 12 months
- Cleaning every six months
- Fluoride treatment every 12 months
- Dental X-rays every 12 months (Full mouth or Panoramic every 36 months)

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

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

Limitations may be exceeded if medically necessary.

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

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

Remove

Other 1937 Benefit Provided:

Personal Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

16 Hours per week

Duration Limit:

None

Scope Limit:

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

Other:

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

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

PCS include medically-oriented tasks related to a participant's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the participant's home or personal residence. The provider must deliver at least one (1) of the following services for a participant needing that service (as identified by the Department Nurse Reviewer):

a. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care;
b. Assistance with bladder or bowel requirements that may include helping the participant to and from the bathroom or assisting the participant with bedpan routines;
c. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need;
d. The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the participant with developmental disabilities;
e. Assisting the participant with physician-ordered medications that are ordinarily self-administered, when the provider has completed an Idaho State Board of Nursing approved training program and in accordance with Idaho state statute and regulations governing assistance with medications.;
f. Non-nasogastric gastrostomy tube feedings if authorized by RMS prior to implementation and if the following requirements are met:
   i. The task is not complex and can be safely performed in the given participant care situation;
   ii. A Licensed Professional Nurse (RN) has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, individualized for the participant's characteristics and needs;
   iii. Individuals to whom the procedure can be delegated are identified by name. The RN must provide

proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing the procedure, and evaluate the performance of the procedure at least monthly;

iv. Any change in the participant's status or problem related to the procedure must be reported immediately to the RN.

PCS may also include non-medical tasks. In addition to performing at least one (1) of the services listed above, the provider may also perform the following services, if no natural supports are available:

a. Incidental housekeeping services essential to the participant's comfort and health, including changing bed linens, rearranging furniture to enable the participant to move around more easily, laundry, and room cleaning incidental to the participant's treatment. Cleaning and laundry for any other occupant of the participant's residence are excluded.
b. Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment.
c. Shopping for groceries or other household items specifically required for the health and maintenance of the participant.

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

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

PCS are furnished in an educational setting or in the participants place of residence which may include:

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

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

Provider Qualifications: Personal care services are provided by Licensed Professional Nurse (RN), Licensed Practical Nurse (LPN), Certified Nursing Assistant (CNA) (person listed on the CNA Registry who performs selected nursing services under the supervision of a registered professional nurse person who has successfully completed a training program and holds a Certificate of Training meeting Federal eligibility requirements for listing on the Registry), or personal assistant (must be at least age eighteen (18) years of age and receive training to ensure the quality of services). Services may be provided by any qualified individual who is qualified to provide such services and who is not a member of the individual's family (legally responsible relative).

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

Personal care service providers will receive training in the following areas:

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

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

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

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services if determined to be medically necessary and prior authorized by the Department.

Remove

Other 1937 Benefit Provided:

Target CM:Adults with Developmental Disabilities

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Other services covered by the Department, but not covered by the Base Benchmark: Target Case Management (CM) for Adults with Developmental Disabilities

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

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

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

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

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

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

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

Additional hours may be prior authorized if medically necessary.

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

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

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

Target Case management may include:
• Contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

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

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

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

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

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

Access to Services: The State assures that:
- Target Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]
- Individuals will not be compelled to receive target case management services, condition receipt of target case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of target case management services; [section 1902 (a)(19)]
- Providers of target case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

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

Case Records (42 CFR 441.18(a)(7):
The State assures that providers maintain case records that document for all individuals receiving target case management as follows [42 CFR 441.18(a)(7)]:
- The name of the individual.
- The dates of the target case management services.
- The name of the provider agency and the person providing the target case management service.
- The nature, content, units of the target case management services received and whether goals specified in the care plan have been achieved.
- Whether the individual has declined services in the care plan.

• The need for, and occurrences of, coordination with other case managers.
• A timeline for obtaining needed services.
• A timeline for reevaluation of the plan.

Remove

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

Target case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440. 169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

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

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

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

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Retroactive Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Services 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 $1870 for OT or $1870 for a combination of SLP and PT are subject to prepayment review for medical necessity.

Remove

Other 1937 Benefit Provided:

Outpatient Habilitation: OT, PT, and 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 $1870 for OT or $1870 for a combination of SLP and PT are subject to prepayment review.

Other 1937 Benefit Provided:

TCM Service:Children w/ SHCN

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Limited to the target population

Other:

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

Other services covered by the Department, but not covered by the Base Benchmark:
Target Case Management (CM) for SHCN (Services for Children with Special Health Care Needs).

~ Target Group:
Target Case Management for Children with Special Health Needs is target to cover:
- Children under the age of 21 who have special health care 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 case management services provided to individuals in medical institutions: [Olmstead letter #3]

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

~ Areas of State in which services will be provided:
Services will be provided throughout the entire State.

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

~ Definition of services: [42 CFR 440.169]
Target case management services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational and other services. Target case Management includes the following assistance:

• Initial comprehensive assessment and periodic reassessment based on the needs of the individual to determine the need for any medical, educational, social or other services. These assessment activities, conducted at least annually, or more often if necessary, are based on the individual's needs, and include:
  o Taking client history;
  o Identifying the individual's needs and completing related documentation;
  o Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

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

• Referral and related activities:
  o 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:
  o 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. These activities must include at least one face-to-face contact with the participant at least every ninety (90) days, to determine whether 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.

Target Case management may include:

- Contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

~ Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Target case management must only be provided by a service coordination agency enrolled as a Medicaid provider. An agency is a business entity that provides management, supervision, and quality assurance for service coordination and includes at least two (2) individuals, one (1) supervisor and a minimum of one (1) service coordinator.

- Agencies must provide supervision to all case managers and all paraprofessionals.
- Any willing, qualified public or private service coordination agency may be enrolled.

Agency Supervisor - Education and Experience.

- Master's Degree in a human service field from a nationally accredited university or college and twelve (12) months experience with the target population they will be serving; or
- Bachelor's degree in human services field from a nationally accredited university or college or licensed professional nurse (RN) and twenty-four (24) months experience with the target population they will be serving.

Case Manager - Education and Experience.

- Minimum of a Bachelor's Degree in a human services field from a nationally accredited university or college and twelve (12) months experience working with the target population they will be serving; or be a licensed professional nurse (RN) and twelve (12) months experience working with the target population they will be serving. Individuals who meet the education or licensing requirements but do not have the required work experience, may work as a case manager under the supervision of a qualified case manager while they gain this experience.

Paraprofessional - Education and Experience.

- Be at least eighteen (18) years of age, have a minimum of a high school diploma (or equivalency), be able to read and write at a level with the paperwork and forms involved in the provision of the service, and have twelve (12) months experience with the target population they will be serving. Under the supervision of a qualified case manager (service coordinator), a paraprofessional may be used to assist in the implementation of the service plan.

~ Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of target case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

- Eligible recipients will have free choice of the providers of target case management services within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

~ Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures that:

- Target case management services will be provided in a manner consistent with best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]
- Individuals will not be compelled to receive target case management services, condition receipt of target case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of target case management services;[section 1902 (a)(19)]
- Providers of target case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

~ Payment (42 CFR 441.18(a)(4)):

Payment for target case management or target case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Remove

~ Case Records (42 CFR 441.18(a)(7):
The State assures that providers maintain case records that document for all individuals receiving target case management as follows [42 CFR 441.18(a)(7)]:

- The name of the individual.
- The dates of the target case management services.
- The name of the provider agency and the person providing the case management service.
- The nature, content, 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:
Target case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Target case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440. 169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

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

Additional limitations:

- Reimbursement for on-going case management is not reimbursable prior to the completion of the assessment and service plan.
- 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/IID

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Other

Amount Limit:
None

Duration Limit:
None

Scope Limit:

None

Remove

Other:

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

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

Other services covered by the Department, but not covered by the Base Benchmark: ICF/IID - Intermediate Care Facility for the Individual with an Intellectual Disability

Other 1937 Benefit Provided:

Bariatric Surgery

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

nONE

Scope Limit:

None

Other:

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

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

Other 1937 Benefit Provided:

Prescription Drugs

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Prescription Drugs: In excess of Base Benchmark

Non-legend products will be covered when prescribed as follows:

- Permethrin,
- Federal legend medications that change to non-legend status, as well as their therapeutic equivalents,

based on Director approval which is determined by 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.

Remove

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

The Department provides coverage for the following Medicare-excluded or otherwise restricted drugs or classes of drugs or their medical uses 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:
  Lipase inhibitors subject to Prior Authorization
- Prescription Cough & Cold symptomatic relief
- Legend Therapeutic Vitamins which include:
  ~ Injectable Vitamin B 12
  ~ Vitamin K and analogues, and
  ~ Legend folic acid
- Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients;
- Legend Vitamin D and analogues and
- Non-legend Products which include:
- Permethrin
- 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 are 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
- Ovulation stimulants and fertility enhancing drugs
- Prescription vitamins except injectable B 12, vitamin K, legend vitamin D, legend pediatric vitamin and fluoride preparations, legend prenatal vitamins for pregnant or lactating women, and legend folic acid.

Other 1937 Benefit Provided:

Prevention and Health Assistance

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

Other:

Program Description: This benefit is one of many preventive benefits that are included in this ABP. This benefit is covered in addition to the prevention and wellness benefits found in EHB9 and is being approved as Secretary-Approved Coverage.

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

The Enhanced Alternative Benefit Plan includes certain enhanced Prevention and Health Assistance (PHA) benefits for target individuals 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 be target to 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 material related to the condition.

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

Remove

Other 1937 Benefit Provided:

Home Health Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

100 visits per year

Duration Limit:

None

Scope Limit:

None

Other:

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

Services covered in excess of the Base Benchmark: The Base Benchmark covers up to $5,000 per year or about 50 visits for Home Health Services.

The Department will cover up to 100 visits without PA for any combination of Skilled Nursing, Home Health Aide, Physical Therapy, Occupational Therapy, or Speech-Language Pathology services. More can be authorized when medically necessary.

Other 1937 Benefit Provided:

Nursing Facility: Rehabilitative

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Alternative Benefit Plan

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Remove

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Services in excess of the Base Benchmark: Skilled Nursing Facility

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

The nursing facility benefits defined in the other 1937 section described as Nursing Facility: Rehabilitative and Nursing Facility: Custodial care along with the Skilled Nursing Facility benefit in the EHB7 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:
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

Authorization: Prior Authorization

Provider Qualifications: Other

Remove

Amount Limit: None

Duration Limit: None

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

Other:

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

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

Routine foot care is not covered.

Other 1937 Benefit Provided: Individual and Family Medical Social Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: Two visits

Duration Limit: Pregnancy and six weeks post-partum

Scope Limit: None

Other:

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

Other services covered by the Department, but not covered by the Base Benchmark: Services directed at helping a patient to overcome social or behavioral problems which 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 Board of Social Work Examiners. Additional services may be prior authorized.

Other 1937 Benefit Provided: Diabetes Education

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Authorization required in excess of limitation

Provider Qualifications: Selected Public Employee/Commercial Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Remove

Other:

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

Services in excess of the Base Benchmark: Diabetes Education

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. Additional services may be prior authorized when medically necessary.

Other 1937 Benefit Provided:

Target Case Management Services: Idaho Behavioral

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

- Other services covered by the Department, but not covered by the Base Benchmark: Target Case Management in the Idaho Behavioral Health Program.

- Services are prior authorized, and there is no limitation is amount, duration nor 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;
  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 Target Case Management services are services furnished to assist individuals, eligible under the State plan, in gaining access to needed medical, social, educational and other services. Target case Management includes the following assistance:

- 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 following conditions are met:
    - ~ Services are being furnished in accordance with the individual's care plan;
    - ~ Services in the care plan are adequate; and
    - ~ If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements with providers.

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

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

~ Waiver of Freedom of Choice of Providers
As permitted and authorized under section 1915 (b)(4) of the Social Security Act, choice of target case management providers is waived. Behavioral Health target 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 interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]

Individuals will not be compelled to receive 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 target case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

~Case Records (42 CFR 441.18(a)(7)):
The State assures that providers maintain case records that document for all individuals receiving case management as follows [42 CFR 441.18(a)(7)]:

- The name of the individual.
- The dates of the case management services.
- The name of the provider agency and the person providing the case the case management service
- The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved.
- Whether the individuals has declined services in the care plan
- The need for, and occurrences of, coordination with other case managers.
- A timeline for obtaining needed services
- A timeline for reevaluation of the plan.

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

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

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

Remove

Other 1937 Benefit Provided:
Institution for Mental Diseases for Adults over 65

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 individuals with mental disease.

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 include services provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

The 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.

Other 1937 Benefit Provided:
Dentures

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Selected Public Employee/Commercial Plan

Amount Limit:
One set per five years

Duration Limit:
None

Scope Limit:

None

Remove

Other:

Dentures for the purpose of restoring oral form and function due to loss of permanent teeth that would result in significant occlusal dysfunction are only covered for children through the month of their twenty-first (21st) birthday, and pregnant women 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

Other:

Certain services require PA.

Audiologist services are covered for individuals with hearing disorders when provided by an audiologist who is licensed by the Speech and Hearing Services Board in the Idaho Board of Occupational Licensing.

~ 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

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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.

Remove

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 are:
  ~ Behavioral consultation must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or have a related discipline with one thousand five hundred (1500) 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 occupation therapist who is qualified and registered to practice in Idaho.
  ~ Therapeutic consultation professional who meets the requirements defined by the Department.

- Services provided in the schools must be the same in amount, duration and scope as the services provided in the community.
- Individuals delivering services in the schools must adhere to the same provider qualifications as required for individuals delivering services in the community.
- Beneficiaries are able to choose to receive Medicaid services from the pool of qualified Medicaid providers, which include school-based and community providers.
- Individuals under twenty-one (21) years of age 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

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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 who 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, are qualified to provide behavioral intervention; and
~ Must be able to provide documentation of one (1) year's supervised experience working with children with developmental disabilities.

- Qualifications for a Behavioral Intervention Paraprofessional are as follows:
~ Must be at least eighteen (18) years of age;
~ 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.

Remove

Add

Alternative Benefit Plan

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

Collapse All ☐

PRA Disclosure Statement

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

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