



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Alternative Benefit Plan Populations ABP1

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

Alternative Benefit Plan Population Name:

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Parents and Other Caretaker Relatives	Voluntary	X
+	Pregnant Women	Voluntary	X
+	Infants and Children under Age 19	Voluntary	X
+	Former Foster Care Children	Voluntary	X
+	Extended Medicaid due to Spousal Support Collections	Voluntary	X
+	Transitional Medical Assistance	Voluntary	X
+	Deemed Newborns	Voluntary	X
+	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Voluntary	X
+	Aged, Blind and Disabled Individuals in 209(b) States	Voluntary	X
+	SSI Beneficiaries	Voluntary	X
+	Individuals Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Voluntary	X
+	Certain Individuals Needing Treatment for Breast or Cervical Cancer	Voluntary	X

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

Targeting Criteria (select all that apply):

Income Standard.

Income Standard:

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

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

The income standard is as follows:



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- A percentage:
- A specific amount

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Other basis for income standard

Statewide standard

	Household Size	Income Standard	
+	1	233	X
+	2	289	X
+	3	365	X
+	4	439	X
+	5	515	X
+	6	590	X
+	7	666	X
+	8	741	X
+	9	816	X
+	10	892	X

Additional incremental amount?

- Yes
- No

Increment amount \$

Disease/Condition/Diagnosis/Disorder.

Other.

Other Targeting Criteria (Describe):

Individuals with health care needs that cannot be met with the Basic ABP
 Pregnant Women within the income limits above are eligible for full Medicaid
 Pregnant Women with income greater than those listed above, but below 133% FPL are eligible for pregnancy-related services
 Children 0 - 6 in families with income under 142% FPL are eligible for Medicaid
 Children 6 - 18 in families with income under 133% FPL are eligible for Medicaid
 Deemed Newborns - Automatic Eligibility
 Former Foster Care Children - Automatic Eligibility
 Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care - Automatic Eligibility
 Extended Medicaid due to Spousal Support Collections - Continue with previous eligibility



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Geographic Area

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

Yes

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

PRA Disclosure Statement

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

V.20130724



Alternative Benefit Plan

OMB Control Number: 0938-1148

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Attachment 3.1-C- N

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

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

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

- The state/territory must inform the individual they are exempt and the state/territory must comply with all requirements related to voluntary enrollment.
- The state/territory assures it will effectively inform individuals who voluntary enroll of the following:
 - a) Enrollment is voluntary;
 - b) The individual may disenroll from the Alternative Benefit Plan at any time and regain immediate access to full standard state/territory plan coverage;
 - c) What the process is for disenrolling.
- The state/territory assures it will inform the individual of:
 - a) The benefits available under the Alternative Benefit Plan; and
 - b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan differs from the approved Medicaid state/territory plan.

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

- Letter
- Email
- Other:

Describe:

The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that includes informing each eligible individual of the available benefit options. The Department will inform each individual in a covered population that enrollment in the Enhanced Benchmark Benefit Package is voluntary (i.e. participants may opt-in), and that such individuals may opt out of the Enhanced Benchmark Benefit Package at any time and regain immediate eligibility for Medicaid benefits under the State plan.

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

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

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

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

The Participant handbook, "Idaho Health Plan Coverage," tells the participant how they can enroll in another plan. There is also a document entitled Medicaid Comparison Benefits. Both documents are available on line at <http://healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx>, and are also available in hard copy upon request from any Health and Welfare office.



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

An attachment is submitted.

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

The state informs participants of their benefit plan options at the time of enrollment, at redetermination, and upon request.

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

The Department has an "Any Door" policy. The participant can notify their local eligibility office, their regional office, their Healthy Connections provider, or the Medicaid Central Office and obtain information about changing plans.

- The state/territory assures it will document in the exempt individual's eligibility file that the individual:
- a) Was informed in accordance with this section prior to enrollment;
 - b) Was given ample time to arrive at an informed choice; and
 - c) Voluntarily and affirmatively chose to enroll in the Alternative Benefit Plan.

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

- In the eligibility system.
- In the hard copy of the case record.
- Other:

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

- Copy of correspondence sent to the individual.
- Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- Other:

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

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



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V.20130807

TN NO: 14-0003 ABP2b Approval Date: 06/04/2014
Idaho ENH Effective Date: January 1, 2014

Application for Assistance



Food Assistance

The Idaho Food Stamp Program is a supplemental nutrition assistance program that helps families buy food for good health. Eligible families get a debit like card to buy food items. You may be required to participate in work programs, and cooperate with Child Support Services.



Health Coverage Assistance

The Idaho Medicaid Program provides health coverage assistance according to individual needs. Eligible families may qualify for 1) free or low-cost coverage from Medicaid, 2) tax credits to help pay health coverage premiums, or 3) affordable private health insurance plans.



Cash Assistance

The Temporary Assistance for Families in Idaho Program provides cash assistance for: emergency situations, families with children, and the elderly, blind, or disabled. Eligible families receive a one-time or on-going payment, depending on the needs of the household.



Child Care Assistance

The Idaho Child Care Program helps parents and caretakers pay for a part of their child care costs while working, going to school, or participating in approved training activities. Eligible families receive a portion of child care costs paid to the provider.

Who can use this application

Anyone may use this application to:

- Apply for assistance for themselves and their household members
- Apply for just one type of assistance or for multiple types of assistance

What you may need to apply

Sending or bringing proof of the items below will help speed up your application:

- Identity
- Income
- Household expenses
- Resources

Why we ask for this information

We keep all information private and secure, as required by law. We ask for this information for a few reasons:

- To figure out what types of assistance you qualify for
- To figure out how much assistance you qualify for
- To make sure you get the right amount of assistance based on your situation

Equal opportunity for applicants

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, the Idaho Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS at:

- USDA, Director, Office of Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
(800) 795.3272 (voice)
(202)720.6382 (TTY)
- U.S. Department of Health & Human Services
Room 506F, 200 Independence Avenue, SW
Washington, D.C. 20201
ocrcomplain@hhs.gov
(202) 619.0403 (Voice)
(202) 619.3257 (TTY)

What happens next

Send your complete, signed application to the address below. We will tell you if you're eligible or not, or give you further instructions for completing your application.

Self Reliance Programs - Statewide Application Team

PO Box 83720
Boise, ID 83720-0026
Fax: 1-866-434-8278
E-mail: MyBenefits@dhw.idaho.gov

Get help with this application

- **Online:** healthandwelfare.idaho.gov
- **Phone:** 1-877-456-1233
- **E-mail:** MyBenefits@dhw.idaho.gov
- **In person:** Visit our website or call 1-877-456-1233 to find a local office.
- **Language Interpreter:** Call 1-877-456-1233 or TDD 208-332-7205

Tell us about yourself (or another adult in the household who will be the primary contact for this application)

1. First Name	Middle Name	Last Name	Suffix	2. Date of birth	3. Former Names, if any
4. Physical Address	City	State	Zip Code	County	
5. Mailing Address	City	State	Zip code	County	
6. Daytime Phone	7. Phone type (choose one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	8. If none, where can we leave a message? Phone:		9. Email	
10. Preferred language spoken (if not English):			11. Preferred language written/read (if not English):		
12. Do you want an interpreter if you are interviewed? One will be provided at no cost to you. <input type="checkbox"/> No <input type="checkbox"/> Yes ¿Le gustaría un intérprete si a usted le están entrevistando? Uno estará disponible a ningún costo para usted.					
13. Would you like to name someone as your authorized representative? <input type="checkbox"/> No <input type="checkbox"/> Yes. Complete Appendix A. You may give a trusted friend, partner, or third party representative permission as an "authorized representative" to talk to the Department, see your information, and act on your behalf for all matters relating to your case.					
14. Type(s) of assistance requested for this person: <input type="checkbox"/> Food <input type="checkbox"/> Health Coverage <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None					
15. Social Security Number	16. Birth Country	17. Sex <input type="checkbox"/> M <input type="checkbox"/> F	18. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		
19. Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes	a. If yes, due date	b. How many due?	20. Race (Optional) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island		
21. Hispanic or Latino? (Optional) <input type="checkbox"/> No <input type="checkbox"/> Yes		22. U.S. citizen or national? (Skip #22 & 23 if not applying for assistance) <input type="checkbox"/> No <input type="checkbox"/> Yes			
23. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a through d. a. Immigration document type: _____ b. Document ID number: _____ c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes					
24. Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a, b, c. a. Filing jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____ b. Claiming dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____ c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? <input type="checkbox"/> No <input type="checkbox"/> Yes					
25. Do you want telephone assistance for your household? <input type="checkbox"/> No. Go to the next section. <input type="checkbox"/> Yes. Complete the questions below. The Idaho Telecommunications Service Assistance Program (ITSAP) helps pay monthly telephone service costs. a. Name of phone company _____ b. Phone number _____ c. Name on bill _____					
26. If applying for Food Assistance , does your household meet one of the following situations (check any that apply)? <input type="checkbox"/> Your household will have less than \$150 income and less than \$100 liquid resources (cash, checking, savings) this month <input type="checkbox"/> Your household's income and resources are less than your monthly housing and utility costs <input type="checkbox"/> Your household includes a migrant or seasonal farm worker If you qualify, emergency Food Stamp benefits can begin within 7 days of the date on this application. You may start the Food Stamp application process immediately by filling out this page, signing it, and turning it in. You must complete the rest of the application and turn it in as soon as possible.					
Signature of applicant/authorized representative to request Food Stamps				Date	

Tell us who lives in your household

Who you need to include on this application

- Regardless of the types of assistance you are applying for, we need information about **everyone** who lives at the physical address you wrote down in the "Tell Us About Yourself" section above.
- If applying for health coverage for anyone under 65 and not disabled, also tell us about everyone included on your federal tax return (if you file taxes), even if they don't live at the same address. You don't need to file taxes to get health coverage.

Information that is optional or not required

- Social Security Number - optional for people not applying, and for people applying for emergency health coverage or child care assistance
- Race - optional for all types of assistance
- Hispanic or Latino - optional for all types of assistance
- U.S. citizen or national questions - not required for household members who are not applying for assistance

Tell us about everyone else in your household

Tell us about each person who lives with you at the address you wrote down in the "Tell Us About Yourself" section on page 1. If applying for health coverage for anyone under 65 and not disabled, tell us about everyone included on your federal tax return. See page 1 for details.

Copy this page or attach another sheet if you need to provide more information than space allows.

Person 1				1. Type(s) of assistance requested for this person: <input type="checkbox"/> Food <input type="checkbox"/> Health Coverage <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None					
2. First Name		Middle Name		Last Name		Suffix	3. Former Names, if any	4. Relationship to you	
5. Social Security Number		6. Date of birth		7. Birth Country		8. Sex <input type="checkbox"/> M <input type="checkbox"/> F	9. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		
10. Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes		a. If yes, due date	b. How many due?	11. Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island					
12. Hispanic or Latino? (Optional) <input type="checkbox"/> No <input type="checkbox"/> Yes		13. U.S. citizen or national? (Skip #13 & 14 if not applying for assistance) <input type="checkbox"/> No <input type="checkbox"/> Yes							
14. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a through d.									
a. Immigration document type: _____				b. Document ID number: _____					
c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes				d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes					
15. Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a, b, c.									
a. Filing jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____									
b. Claiming dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____									
c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? <input type="checkbox"/> No <input type="checkbox"/> Yes									

Person 2				1. Type(s) of assistance requested for this person: <input type="checkbox"/> Food <input type="checkbox"/> Health Coverage <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None					
2. First Name		Middle Name		Last Name		Suffix	3. Former Names, if any	4. Relationship to you	
5. Social Security Number		6. Date of birth		7. Birth Country		8. Sex <input type="checkbox"/> M <input type="checkbox"/> F	9. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		
10. Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes		a. If yes, due date	b. How many due?	11. Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island					
12. Hispanic or Latino? (Optional) <input type="checkbox"/> No <input type="checkbox"/> Yes		13. U.S. citizen or national? (Skip #13 & 14 if not applying for assistance) <input type="checkbox"/> No <input type="checkbox"/> Yes							
14. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a through d.									
a. Immigration document type: _____				b. Document ID number: _____					
c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes				d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes					
15. Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a, b, c.									
a. Filing jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____									
b. Claiming dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____									
c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? <input type="checkbox"/> No <input type="checkbox"/> Yes									

Person 3				1. Type(s) of assistance requested for this person: <input type="checkbox"/> Food <input type="checkbox"/> Health Coverage <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None					
2. First Name		Middle Name		Last Name		Suffix	3. Former Names, if any	4. Relationship to you	
5. Social Security Number		6. Date of birth		7. Birth Country		8. Sex <input type="checkbox"/> M <input type="checkbox"/> F	9. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		
10. Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes		a. If yes, due date	b. How many due?	11. Race <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Island					
12. Hispanic or Latino? (Optional) <input type="checkbox"/> No <input type="checkbox"/> Yes		13. U.S. citizen or national? (Skip #13 & 14 if not applying for assistance) <input type="checkbox"/> No <input type="checkbox"/> Yes							
14. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a through d.									
a. Immigration document type: _____				b. Document ID number: _____					
c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes				d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes					
15. Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a, b, c.									
a. Filing jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of spouse: _____									
b. Claiming dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, names of dependents: _____									
c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? <input type="checkbox"/> No <input type="checkbox"/> Yes									

Continue telling us about each person who lives with you. See page 1 for details.

Person 4				1. Type(s) of assistance requested for this person: <input type="checkbox"/> Food <input type="checkbox"/> Health Coverage <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None				
2. First Name		Middle Name		Last Name		Suffix	3. Former Names, if any	4. Relationship to you
5. Social Security Number		6. Date of birth	7. Birth Country		8. Sex <input type="checkbox"/> M <input type="checkbox"/> F	9. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		
10. Pregnant?	a. If yes, due date	b. How many due?	11. Race	<input type="checkbox"/> White	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Native Hawaiian/Pacific Island
<input type="checkbox"/> No	<input type="checkbox"/> Yes							
12. Hispanic or Latino? (Optional)			<input type="checkbox"/> No <input type="checkbox"/> Yes	13. U.S. citizen or national? (Skip #13 & 14 if not applying for assistance)			<input type="checkbox"/> No <input type="checkbox"/> Yes	
14. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a through d.								
a. Immigration document type: _____				b. Document ID number: _____				
c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes				d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes				
15. Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a, b, c.								
a. Filing jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes				If yes, name of spouse: _____				
b. Claiming dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes				If yes, names of dependents: _____				
c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? <input type="checkbox"/> No <input type="checkbox"/> Yes								

Person 5				1. Type(s) of assistance requested for this person: <input type="checkbox"/> Food <input type="checkbox"/> Health Coverage <input type="checkbox"/> Cash <input type="checkbox"/> Child Care <input type="checkbox"/> None				
2. First Name		Middle Name		Last Name		Suffix	3. Former Names, if any	4. Relationship to you
5. Social Security Number		6. Date of birth	7. Birth Country		8. Sex <input type="checkbox"/> M <input type="checkbox"/> F	9. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Not Married		
10. Pregnant?	a. If yes, due date	b. How many due?	11. Race	<input type="checkbox"/> White	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Native Hawaiian/Pacific Island
<input type="checkbox"/> No	<input type="checkbox"/> Yes							
12. Hispanic or Latino? (Optional)			<input type="checkbox"/> No <input type="checkbox"/> Yes	13. U.S. citizen or national? (Skip #13 & 14 if not applying for assistance)			<input type="checkbox"/> No <input type="checkbox"/> Yes	
14. If not a U.S. citizen or national, does this person have eligible immigration status? <input type="checkbox"/> Yes. Complete questions a through d.								
a. Immigration document type: _____				b. Document ID number: _____				
c. Lived in the U.S. since 1996? <input type="checkbox"/> No <input type="checkbox"/> Yes				d. A veteran or active-duty member of the U.S. military? <input type="checkbox"/> No <input type="checkbox"/> Yes				
15. Does this person plan to file a federal tax return for the CURRENT YEAR? <input type="checkbox"/> No. Skip to question c. <input type="checkbox"/> Yes. Complete questions a, b, c.								
a. Filing jointly with a spouse? <input type="checkbox"/> No <input type="checkbox"/> Yes				If yes, name of spouse: _____				
b. Claiming dependents? <input type="checkbox"/> No <input type="checkbox"/> Yes				If yes, names of dependents: _____				
c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? <input type="checkbox"/> No <input type="checkbox"/> Yes								

Tell us about your household situation

1. Is anyone in your household American Indian or Alaska Native? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, complete Appendix B with the application.			
2. Is anyone in your household applying for or already receiving Tribal Commodities? <input type="checkbox"/> No <input type="checkbox"/> Yes			
3. Is anyone in your household applying for or already receiving Foster Care or Adoption Assistance? <input type="checkbox"/> No <input type="checkbox"/> Yes			
4. Was anyone in foster care when they turned 18? <input type="checkbox"/> No <input type="checkbox"/> Yes a. If yes, who? _____			
5. Is anyone in your home currently receiving assistance from another State? <input type="checkbox"/> No <input type="checkbox"/> Yes. If yes, tell us when, where, and the type.			
a. Date	b. City	State	County
c. Type of assistance received _____			
6. Is anyone who is applying for assistance disabled? <input type="checkbox"/> No <input type="checkbox"/> Yes a. If yes, who: _____			
7. Does anyone who is applying have a pending application for Social Security disability? <input type="checkbox"/> No <input type="checkbox"/> Yes			
a. If yes, who: _____			
8. Does anyone who is applying need medical services provided in the home? <input type="checkbox"/> No <input type="checkbox"/> Yes			
a. If yes, who: _____			
9. Does anyone who is applying live in a medical care facility? <input type="checkbox"/> No <input type="checkbox"/> Yes			
a. If yes, who	b. Name of the facility	c. Facility phone	
10. Is anyone listed on this application incarcerated? <input type="checkbox"/> No <input type="checkbox"/> Yes a. If yes, who: _____			

Attach another sheet if you need to provide more information than space allows.

Tell us about your household situation



- If applying for multiple types of assistance, or all household members are over 65 or disabled, **complete this page.**
- If applying for health care only, and all household members are under 65 and not disabled, **skip to page 5.**

1. Has anyone in your household been disqualified from public assistance due to an intentional program violation? No Yes

a. If yes, who:

b. When:

c. State:

2. Has anyone in your household been convicted of a felony involving drugs? No Yes

a. If yes, who:

b. When:

3. Is anyone fleeing to avoid felony prosecution or jail time? No Yes

a. If yes, who:

4. Is anyone currently violating conditions of probation or parole? No Yes

a. If yes, who:

5. Is anyone applying for assistance age 16 to 19 and going to high school? No Yes. If yes, use the table below to tell us who.

Name of student	Name of high school	Expected graduation date

6. Is anyone applying for assistance age 18 to 49 and going to college? No Yes. If yes, use the table below to tell us who.

Name of student	Name of college	Student status	Work study
		<input type="checkbox"/> Full time <input type="checkbox"/> Part time	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> Full time <input type="checkbox"/> Part time	<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> Full time <input type="checkbox"/> Part time	<input type="checkbox"/> No <input type="checkbox"/> Yes

7. If you have children in the home, are they immunized? No Yes

8. If you have children in your home, do any of them have a parent NOT living with them? No Yes. If yes, tell us who they are.

If you answered Yes, you will be required to give information about the absent parent(s) to Child Support Services and open a Child Support case unless you fear harm to yourself or your children.

Child name	Absent parent name	Absent parent Social Security Number	Absent parent Date of birth

Tell us about your household income (required for all types of assistance)

Tell us about all income your household receives. We want to know about the last 30 days, as well as any money received quarterly or annually. Income is money earned (wages or salary) from a job or self-employment, or unearned from sources such as Social Security, child support, unemployment benefits, gifts, rental income, retirement income, etc.

Copy this page or attach another sheet if you need to provide more information than space allows.

Income Source 1 1. Name of person with income:

Income from a job - Tell us about any income this person gets from working a job.

2. Employer name		3. Employer phone		4. Average hours worked each week	
5. Wages/tips (before taxes) \$ _____ paid		<input type="checkbox"/> Hourly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Monthly	6. Income expected to change (raise, hours changed, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Why?
		<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Yearly	

Income from your own business - Tell us about any income this person gets from a business they own.

7. Name of business		a. Type of work	b. Years in business	c. Estimated net income this month
---------------------	--	-----------------	----------------------	------------------------------------

Income from other sources - Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income		b. Amount	c. How often paid				
_____		_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
_____		_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
_____		_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly

Income Source 2 1. Name of person with income:

Income from a job - Tell us about any income this person gets from working a job.

2. Employer name		3. Employer phone		4. Average hours worked each week	
5. Wages/tips (before taxes) \$ _____ paid		<input type="checkbox"/> Hourly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Monthly	6. Income expected to change (raise, hours changed, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Why?
		<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Yearly	

Income from your own business - Tell us about any income this person gets from a business they own.

7. Name of business		a. Type of work	b. Years in business	c. Estimated net income this month
---------------------	--	-----------------	----------------------	------------------------------------

Income from other sources - Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income		b. Amount	c. How often paid				
_____		_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
_____		_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
_____		_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly

Income Source 3 1. Name of person with income:

Income from a job - Tell us about any income this person gets from working a job.

2. Employer name		3. Employer phone		4. Average hours worked each week	
5. Wages/tips (before taxes) \$ _____ paid		<input type="checkbox"/> Hourly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Monthly	6. Income expected to change (raise, hours changed, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes Why?
		<input type="checkbox"/> Weekly	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Yearly	

Income from your own business - Tell us about any income this person gets from a business they own.

7. Name of business		a. Type of work	b. Years in business	c. Estimated net income this month
---------------------	--	-----------------	----------------------	------------------------------------

Income from other sources - Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income		b. Amount	c. How often paid				
_____		_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
_____		_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
_____		_____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly



- If applying for multiple types of assistance, or all household members are over 65 or disabled, **complete this page.**
- If applying for health care only, and all household members are under 65 and not disabled, **skip to page 8.**

Tell us about your vehicles, resources, and property

1. Motor Vehicles - Tell us about all vehicles, including cars, trucks, motorcycles, trailers, boats, snowmobiles, and other recreational vehicles that your household owns.

Owner	Year, make, and model	Current value	Primary use for this vehicle (choose one)
			<input type="checkbox"/> Business <input type="checkbox"/> Get to work <input type="checkbox"/> Work search <input type="checkbox"/> Medical <input type="checkbox"/> Recreational <input type="checkbox"/> Residence <input type="checkbox"/> Income producing <input type="checkbox"/> Personal (other)
			<input type="checkbox"/> Business <input type="checkbox"/> Get to work <input type="checkbox"/> Work search <input type="checkbox"/> Medical <input type="checkbox"/> Recreational <input type="checkbox"/> Residence <input type="checkbox"/> Income producing <input type="checkbox"/> Personal (other)
			<input type="checkbox"/> Business <input type="checkbox"/> Get to work <input type="checkbox"/> Work search <input type="checkbox"/> Medical <input type="checkbox"/> Recreational <input type="checkbox"/> Residence <input type="checkbox"/> Income producing <input type="checkbox"/> Personal (other)

2. Resources - Tell us about all resources your household owns, including cash on-hand, checking and savings accounts, stocks, bonds, mutual funds, 401Ks, IRAs, trusts, CDs, life insurance policies, burial funds, etc.

Name/owner of resource	Resource type	Name of financial institution	Account number	Current value

3. Property - Tell us about all other property (including your home) owned by anyone living in your home.

Name/owner of property	Property type	Property Address	Value	Primary use for this property (choose one)
				<input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other:
				<input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other:
				<input type="checkbox"/> Home <input type="checkbox"/> Rental income <input type="checkbox"/> Business/Self-employment <input type="checkbox"/> Other:

4. Sale or transfer of resources and property - Tell us about everyone in your home who has sold, transferred or given away cash, property, or other assets within the last five years.

Name	Date of Transaction	What Assets	Amount Received	Fair Market Value



- If applying for multiple types of assistance, or all household members are over 65 or disabled, **complete this page.**
- If applying for health care only, and all household members are under 65 and not disabled, **skip to page 8.**

Tell us about your household expenses

Your Food Stamps may increase if you have expenses such as child or adult care costs, child support paid for children not living with you, housing costs, medical costs (including prescriptions) for people with disabilities or who are over 60, and utility costs. However, if you do not report or verify any of these expenses, it will mean that you do not want a deduction for the unreported or unverified expenses.

1. Shelter Expenses - Tell us about your recurring expenses. When telling us the amount of each expense, include only the amount **you** pay. If your mortgage payments include other payments such as irrigation, property taxes, HOA fees, etc., break them out and record them separately below.

Rent per month \$	Mortgage per month \$	2nd Mortgage per month \$	Space rent per month \$
Irrigation \$ per	Property tax \$ per	HOA fees \$ per	Homeowners Insurance \$ per

Check the boxes below for each utility you pay that is NOT included in your rent or mortgage:

Heating Cooling Water Sewer Trash Telephone

Landlord's name

Landlord's contact number

2. Dependent Care Expenses - Use the space below to tell us about any child care, adult disabled care, or elderly care.

Dependent name	Total charge for care	Amount you pay	How often you pay
----------------	-----------------------	----------------	-------------------

Provider name Provider address Provider phone

Dependent name	Total charge for care	Amount you pay	How often you pay
----------------	-----------------------	----------------	-------------------

Provider name Provider address Provider phone

Dependent name	Total charge for care	Amount you pay	How often you pay
----------------	-----------------------	----------------	-------------------

Provider name Provider address Provider phone

3. Individual Expenses - Use the space below to tell us about any individual expenses. Allowable expenses include child support paid and some medical expenses for household members who are disabled or over the age of 60. When telling us the amount of each expense, include only the amount **you** pay.

Name of person with expense	Expense type	Amount	How often paid?
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	

Tell us about your health coverage situation

1. Does anyone who is applying for health coverage want help paying for medical costs from the last 3 months?

No. Skip to #2. **Yes.** Complete questions a. and b.

a. If yes, tell us who

b. If yes, tell us your gross household income (income before taxes) received by your family in each of the last three months:

Last month

Two months ago

Three months ago

2. Is anyone on this application insured by any of the following?

- Medicaid No Yes Who? _____
- CHIP No Yes Who? _____
- Medicare No Yes Who? _____
- TRICARE No Yes Who? _____
- VA Health Care No Yes Who? _____
- Peace Corps No Yes Who? _____

Employer Insurance No Yes Who? _____

Name of insurance: _____

Policy number: _____

Is this COBRA coverage? No Yes

Is this a retiree health plan? No Yes

What services are covered? Check all that apply. Inpatient/outpatient hospital services Lab services

Physicians medical/surgical services X-ray services

Other Insurance No Yes Who? _____

Name of insurance: _____

Policy number: _____

Monthly premium: _____

Is this a limited-benefit plan? No Yes

What services are covered? Check all that apply. Inpatient/outpatient hospital services Lab services

Physicians medical/surgical services X-ray services

3. If not currently receiving coverage, does anyone have access to health insurance from a job? Check "yes" even if the coverage is from someone else's job such as a parent or a spouse.

No **Yes.** Complete Appendix C.

Rights and Responsibilities

I understand that (initial each statement below)...

My signature certifies that the information on this application is true and accurate. I could be sanctioned and required to return any benefit I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.

I consent to the gathering, use and disclosure of my information by the Idaho Department of Health and Welfare or its designees. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.

I consent to the gathering and use of income data, including information from tax returns for determining eligibility for help paying for health coverage in future years (up to 5 years). I will receive notice when this occurs, be able to make changes, and may opt out at any time.

I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide further benefits or services.

I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.

My signature indicates I have received a copy of the Department Privacy Practices.

By applying for benefits for a minor child, a medical support case must be opened, when applicable. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in a loss or decrease of my benefits.

If I receive a Child Support payment in error, Child Support Services will withhold future payments to recover the amount unless I submit written instructions to the contrary.

By applying for heating and energy assistance, I authorize the Department to request information from and/or disclose necessary information to my utility companies for the purpose of determining my eligibility and providing benefits or services until I become ineligible or I request to end the benefits or services.

If I am determined eligible for Medicaid, I choose the plan that is based on my health needs, unless I tell the Self Reliance worker otherwise.

If I am determined eligible for Medicaid, I may be responsible for paying part of the cost of my child's health coverage, and I will be notified of my co-pay amount.

My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my/my child's medical assistance.

I have the right to choose a Healthy Connections Primary Care Doctor, to request referrals for services, and to change the doctor/clinic if my circumstances change.

If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.

If a third party is responsible for my child's disease or injury, I give to Medicaid any rights I may have, or may acquire in the future, to be compensated by the responsible party for any medical benefits I receive for myself/my children.

If I receive Medicaid/Cash Assistance, I am required to report changes in my circumstance, including income, assets, and living situation within ten (10) days of the change.

I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate.

To receive Food Assistance, I may be required to participate in work programs. Failure to do so may result in a loss or decrease in benefits.

It is illegal to give my Quest EBT card away or to trade the benefits on my card for cash, firearms, drugs, or other goods and services. Penalties include fines, imprisonment, and disqualification from future benefits.

If I receive cash assistance (TAFI), I may not withdraw cash benefits, or use cash benefit funds to purchase products and services, in gambling establishments, liquor and tobacco stores, adult entertainment venues, other establishments prohibiting persons under the age of 18, or tattoo, body piercing, or other branding parlors.

Sign Your Signature (must be completed)

Under penalty of perjury, I swear or affirm the information I have provided is true and complete. My signature confirms that I have read and understand the Rights and Responsibilities listed on this page.

Signature of applicant/authorized representative

Date

Signature of applicant/authorized representative

Date

Appendix A

Authorized Representative Form

You can name someone as an authorized representative.

You may give a trusted person, such as a friend, partner, or third party representative permission to talk about this application with us, see your information, and act for you on all matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative."

If you ever need to cancel or change your authorized representative, contact the Department.

If you're a legally appointed representative for someone on this application, submit proof with the application.

Tell us who you want to name as your authorized representative

First Name		Middle Name		Last Name	
Address				Apartment or suite number	
City			State	Zip Code	County
Phone	Phone type (choose one) <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		Email		
Organization Name (if third party representative)				Organization ID (if applicable)	

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with the Department.

Signature of Applicant

Date

Appendix B

American Indian or Alaska Native Family Member

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Assistance.

Tell us about your American Indian or Alaska Native family member(s).

American Indians (AI) and Alaska Natives (AN) can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more than three people to include, make a copy of this page and attach with your Application for Assistance.

Person 1

1. First Name	Middle Name	Last Name
2. Is this person a member of a federally recognized tribe? <input type="checkbox"/> No <input type="checkbox"/> Yes b. If yes , name of tribe: _____		
3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? <input type="checkbox"/> No <input type="checkbox"/> Yes		
b. If no , is this person eligible to receive these services? <input type="checkbox"/> No <input type="checkbox"/> Yes		
4. List any income (amount and how often) reported on the application that includes money from:		
▪ Per capita payments from a tribe that come from natural resources, usage rights, or royalties		Amount: \$ _____
▪ Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)		Frequency: _____
▪ Money from selling things that have cultural significance		

Person 2

1. First Name	Middle Name	Last Name
2. Is this person a member of a federally recognized tribe? <input type="checkbox"/> No <input type="checkbox"/> Yes b. If yes , name of tribe: _____		
3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? <input type="checkbox"/> No <input type="checkbox"/> Yes		
b. If no , is this person eligible to receive these services? <input type="checkbox"/> No <input type="checkbox"/> Yes		
4. List any income (amount and how often) reported on the application that includes money from:		
▪ Per capita payments from a tribe that come from natural resources, usage rights, or royalties		Amount: \$ _____
▪ Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)		Frequency: _____
▪ Money from selling things that have cultural significance		

Person 3

1. First Name	Middle Name	Last Name
2. Is this person a member of a federally recognized tribe? <input type="checkbox"/> No <input type="checkbox"/> Yes b. If yes , name of tribe: _____		
3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? <input type="checkbox"/> No <input type="checkbox"/> Yes		
b. If no , is this person eligible to receive these services? <input type="checkbox"/> No <input type="checkbox"/> Yes		
4. List any income (amount and how often) reported on the application that includes money from:		
▪ Per capita payments from a tribe that come from natural resources, usage rights, or royalties		Amount: \$ _____
▪ Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)		Frequency: _____
▪ Money from selling things that have cultural significance		

Appendix C

Health Coverage from Jobs

Tell us about the job that offers coverage

Complete the questions below if someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage. If you need help answering the questions about your employer's health plan, please contact your employer.

Employee Information

1. First Name	Middle Name	Last Name	2. Social Security Number
---------------	-------------	-----------	---------------------------

Employer Information

3. Name	4. Identification Number (EIN)	
5. Address	6. Phone	
7. City	8. State	9. Zip Code
10. Who can we contact about employee health coverage at this job?		
11. Phone	12. Email	

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

No. Stop here and submit this form with your application. **Yes.** Complete the rest of this form.

a. If you're in a waiting or probationary period, when can you enroll in coverage? _____

b. List everyone who is eligible for coverage from this job: _____

Tell us about the health plan offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard?* No Yes

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Quarterly Yearly

16. What change will the employer make for the new plan year (if known)?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for that plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Quarterly Yearly

c. Date of change: _____

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Idaho Health Plan Coverage

*A Benefits Guide to Medicaid, CHIP,
& Premium Assistance*



Idaho
Medicaid
Card

JOHN Q. SMITH

MID 1234567

0000

2014



IDAHO DEPARTMENT OF
HEALTH & WELFARE



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Idaho Health Plan Coverage

Prevention, Wellness, and Responsibility

Idaho cares that you get the health coverage that meets your needs. Whether you're covered through the Children's Health Insurance Program (CHIP) or Medicaid, Idaho's public health plans are designed to meet your health care needs.

These plans do more to help you improve your overall health, find new health issues early, and manage your current health issues.

People are different, and so are their health care needs. Idaho offers three different benefit plans to meet different healthcare needs:

The Basic Plan is for low-income children and adults with eligible dependent children. This plan provides health, prevention, and wellness benefits for children and adults who don't have special health needs. Most participants will be in this benefit plan.

The Enhanced Plan is for individuals with disabilities or special health needs. This plan has all the benefits of the Basic Plan, plus additional benefits.

The Medicare-Medicaid Coordinated Plan is for individuals who are eligible for both Medicaid and Medicare. The Department of Health and Welfare has partnered with insurance companies to provide coordinated health coverage between Medicare Part A, Part B, Part D, and Medicaid through Medicare Advantage plans. There is no cost to you when you

follow the plan regulations. Medicare Part D might still require you to pay a co-payment depending on your income level.

The benefits you get are based on your health needs. When you apply, we'll ask about your current health conditions and needs.

If you're enrolled in the Basic Plan and your health changes, you might need to get an assessment to find out if you should be placed in the Enhanced Plan.

Beginning September 1, 2013, people enrolled in the Basic or the Enhanced Plans will be automatically enrolled in the Idaho Behavioral Health Plan (IBHP). This plan is used for outpatient behavioral health services (such as mental health counseling or substance use disorder services) that are provided by Optum Idaho, a managed care company contracted by Idaho Medicaid.

See pages 8 to 20 in this booklet for more information about the Basic Plan, the Enhanced Plan, The Medicare-Medicaid Coordinated Plan, and the Idaho Behavioral Health Plan.

It's important to use your health services wisely. Idaho cares about helping you improve your health, find new health issues early, and manage your current health issues. You can help by making healthy choices in order to stay well and make your health plan work for you.

To get more details, please visit: www.healthandwelfare.idaho.gov (click on "medical" then "medicaid").



Important Numbers

The first time you're found eligible for Idaho health insurance coverage, you'll receive a permanent identification (ID) card with your ID number on it. This number identifies you for health plan coverage. More information about the ID card is on page 26.

For information, or to find out about the status of your application for health plan coverage for families with children, call the Family Medicaid Unit toll free at (866) 326-2485.

For information about nursing home assistance or the status of your application for nursing home coverage, call the Long Term Care Unit toll free at (866) 255-1190.

If you're over 65, receiving Social Security benefits due to disability, or if you're applying for Medicaid for an elderly person with a disability, please call the customer service line toll free at (877) 456-1233.

To find a doctor in your area or change doctors, contact Healthy Connections. The Healthy Connections office numbers are listed on page 33.

To find an Idaho Behavioral Health Plan (IBHP) provider, contact Optum Idaho at (855) 202-0973.

For information about dental coverage or to find a dentist in your area, contact Idaho Smiles at (800) 936-0978 or visit their Web site at www.dentaquestgov.com.

To get help with other services in the Department of Health and Welfare, call the Idaho CareLine (2-1-1 or (800) 926-2588) or call (877) 456-1233.



If you have questions about your covered services, please call the participant line at (866) 686-4752.

Reasons you might call the participant line are:

- If a doctor or medical service reports you to a collection agency or if you get a bill that you think your health plan should pay.
- If you want to know if a service needs a Healthy Connections referral or prior authorization.
- If you need to know if an item or service is covered.



Don't call for eligibility questions; contact the customer service line toll free at (877) 456-1233.

How Do I Apply for Health Plan Coverage?

Applying

To get Idaho Health Plan coverage through Medicaid or CHIP, you must complete an application.

You can do this in several ways:

- Call the Idaho CareLine (2-1-1 or (800) 926-2588) and request an application.
- Call the customer service line toll free at (877) 456-1233 to apply over the phone.

- 
- Print the application form at www.healthandwelfare.idaho.gov. You can also apply online and if you qualify for Medicaid or CHIP, they will send us the information.

Help completing your application

- Ask for the application in English or Spanish.
- Ask for an interpreter to help you. This help is free.
- Have a friend or relative help you. Parents and guardians can apply for their children.

Turning in your application

- Fax your application to (208) 334-6912.
- Email your application to mybenefits@dhw.idaho.gov.
- Mail your application to:
Department of Health and Welfare
PO Box 83720
Boise, ID 83720

- If you are applying for help with nursing home costs, fax or mail your application to the Long Term Care Unit (*see page 32 for contact information*).

After you turn in your application, your case will be assigned to a Self Reliance Specialist who will check to see if you're eligible. Sometimes more information is needed. You might get a phone call or letter asking for more information, so it's important for you to tell us if your address or phone number changes. You should report changes to the office where you applied for coverage or call us toll free at **(866) 326-2485** or **(877) 456-1233**.

You will be sent a letter within 45 days after you turn in your application telling you if you're eligible for health plan coverage. If you're eligible, you'll receive an ID card within two weeks unless you have received an ID card before. *See page 26 to learn more about your ID card.*

If you have questions about your application, you can call (877) 456-1233.

Your Responsibilities

You're responsible for providing true and complete information about your circumstances

This includes your income, the size of your family, your current address, and other information that helps the Department of Health and Welfare decide whether you should continue to be eligible for health plan coverage.

You're responsible for reporting changes in your circumstances

If your income, resources, living arrangements, family size, or other circumstances change, it can affect your eligibility. Each program has different reporting requirements. It's your responsibility to let your local Health and Welfare office know about these changes. If you have private health care insurance and your coverage under that policy changes, you need to let your local Health and Welfare office know (*see page 34 for more information*).

You're responsible for paying for care that requires a Healthy Connections referral, if you don't get a referral before receiving the care

When you applied for coverage you were asked to choose a Healthy Connections doctor. A letter will be sent to you to confirm your choice or ask you to reselect. If you don't choose, a primary care doctor will be assigned to you.

Your Healthy Connections primary care doctor must know about any health conditions you might have in order to make necessary referrals for your care. Your primary care doctor might not make referrals if you've never been seen in that office or it's been a while since you were last seen. It's your responsibility to call your Healthy Connections primary care doctor and ask if you need to be seen before a referral can be made. Your health plan won't pay for most services without a referral. Idaho Behavioral Health Plan services don't require a Healthy Connections referral.

You're responsible for making sure you're accessing care from an Idaho Medicaid Provider

Whether you receive care in Idaho or in another state, Idaho Medicaid won't cover the services you receive if the provider isn't an Idaho Medicaid provider. It's your responsibility to ask if the provider you're receiving services from is an Idaho Medicaid provider. Idaho Behavioral Health providers who are enrolled in the Optum Idaho provider network can provide Idaho Behavioral Plan services.

Cost Sharing

Co-Payments

You might be required to pay for some of the costs of your Medicaid insurance coverage through co-payments and premium payments.

Medicaid providers might charge a co-payment for some routine, non-emergency services. These include:

- Using the emergency room when it's not an emergency
- Using emergency medical transportation when it's not an emergency
- Chiropractic care
- Occupational therapy
- Optometry
- Physical therapy
- Podiatry
- Speech therapy
- Doctor visits

NOTE: If a doctor decides you need emergency treatment, you won't have to pay a co-payment for any of these services that are used during that treatment.

If you're on the Aged and Disabled Waiver or the Developmental Disability Waiver, you might be required to pay a share of cost in the form of a co-payment for the services you receive under the waivers.

Your co-payment amount will depend on your age, your income, and other factors. Medicaid will let you know if you're required to pay a co-payment and how much you'll have to pay.

Premiums

You might also have to pay a premium:

- If your child is placed on the Basic Plan (\$0, \$10, or \$15 a month, based on your income)
- If your child qualifies for the Home Care for Certain Disabled Children Program (Katie Beckett). If you're child qualifies for this program, Medicaid will send you a letter with a suggested, voluntary premium amount that is based on your income. If you're unable to pay the premium amount, your child's Medicaid eligibility won't be affected.



Medicaid or Medicare, What's the Difference?

People sometimes confuse Medicaid and Medicare. They are not the same.

Medicaid

Medicaid is a state program you might qualify for if your income is low and you match one of these descriptions:

- You're pregnant.
- You're a child or a teenager.
- You're an adult with an eligible child.
- You have a disability.
- You're age 65 or older.
- You're blind.
- You need nursing home care.
- You need long-term care services and supports at home or in the community.

If you or someone in your family needs health care, you should apply for Medicaid even if you aren't sure you qualify. Some income and resources aren't counted when determining your eligibility. For example, owning your home might not stop you from getting Medicaid.

Medicare

Medicare is a federal program that provides health coverage if you match one of these descriptions:

- You're age 65 or older.
- You're any age and have kidney failure or a long-term kidney disease.
- You have a total permanent disability.

Some people qualify for both Medicaid and Medicare. If you qualify for both, you'll receive all Medicaid covered services even if Medicare doesn't cover the services. If you're eligible for Medicare, you must have it or apply for it to receive Medicaid.

Some people who don't qualify for regular Medicaid are eligible for Qualified Medicare Beneficiary programs where Medicaid helps pay for Medicare costs including:

- Monthly Medicare premiums
- Co-insurance
- Deductibles



For information about Medicare prescription drug coverage, log onto www.medicare.gov.

For more information about Medicare, call (800) 633-4227.

Which Plan Is Right for Me?

It's always a good idea to ask your primary care doctor or pharmacist if your health plan covers the service or item you need.

There are some limits to these services, and some might require you or your primary care doctor to get prior authorization from the Medicaid Division first. *See page 28 for more information about prior authorizations.*

Some services are only covered in the Enhanced Plan. If you're in the Basic Plan and your health changes, you might need to get an assessment to see if you should change to the Enhanced Plan and get additional services. Idaho Behavioral Health Plan services are available to you if you're on the Basic or the Enhanced Plan.

The Basic Plan

The Basic Plan includes all of the preventive services recommended by the United States Preventive Task Force including the following prevention benefits to help you stay healthy:

Annual physical – adults

- Limited to once every 12 months..
- One screening mammogram per year for women over age 40.

Well-child checks

- Head-to-toe physical and developmental check-up. The number of well-child checks that a child needs each year depends on the child's age. All check-ups recommended by the American Academy of Pediatrics are covered.



Help your child stay healthy

Make sure your children get well-child checks

It's just as important to take your children for well-child checks as it is to take them to the doctor when they're sick.

Idaho health plans can cover medically necessary services that your doctor orders under Early Periodic Screening, Diagnosis and Treatment (EPSDT). See page 16 for more information on EPSDT services.

You'll receive letters to remind you to schedule well-child checks. Wellness services for children through Idaho health plans are always free of charge.

Which Plan Is Right for Me?

Continued

Immunizations

Provided in a doctor's office, a free clinic, or through your local District Health Department.

Ask to have your child's immunizations recorded into Idaho's Immunization Reminder Information System (IRIS). IRIS helps your doctor keep track of which of your child's immunizations are due and when. If you move or change doctors, any enrolled office can retrieve your child's records.

Lead Screening

- Testing in a doctor's office.
 - Lead poisoning doesn't have any signs or symptoms.
 - Lead poisoning can lower a child's IQ and learning capacity.

Your child should be tested at age 12 months and again at age 24 months. All children under the age of 6 should be tested, if they haven't previously been tested.



For information about immunizations, lead screening, or to ask for a copy of "Get the Lead Out" HW-0243, call the Idaho CareLine (2-1-1 or (800) 926-2588).

The Basic Plan also covers the following services:

Chiropractic Services

- Limited to 6 visits during a calendar year.
 - Doesn't pay for x-rays taken by a chiropractor.

Counseling Services

See Behavioral Health Services on page 11.

Dental Services

- Idaho Smiles (DentaQuest) covers the following dental care:
 - Children up to age 21 for basic and preventive dental care, which includes check-ups, x-rays, fillings, oral surgery, orthodontics when necessary, emergency dental care, and other medically necessary treatment.
 - Disabled adults age 21 and older who are receiving Aged and Disabled or Developmental Disabilities waiver services can get dental services including exams, fillings, dentures, and other covered services.
 - Pregnant women can receive dental services including exams, fillings, and other covered dental services.
 - All other adults age 21 and older who are not receiving waiver services are only covered for emergency dental treatments for pain or infection.



For information, call the Idaho Smiles customer service line at (800) 936-0978 or visit their Web site at www.dentaquestgov.com

Which Plan Is Right for Me?

Doctor and Nurse Office Visits

- Exams or treatments by a doctor, physician assistant, or nurse practitioner.
- Surgical and other treatment services performed by a doctor.
- Diagnostic lab and radiology services.

Hearing Services

- Adults
 - Hearing aids for adults are not covered.
 - Hearing tests are covered when ordered by your doctor.
- Children up to age 21
 - Children can get replacement hearing aids with prior authorization.
 - Exam and testing once each calendar year when ordered by a doctor.
 - Batteries, follow-up testing, and repairs from normal use.
 - Doesn't pay for lost, misplaced, stolen, or destroyed hearing aids.

Home Health Services

- Ordered by a doctor.
 - Limited to 100 visits during a calendar year, including all visits such as skilled nursing, aide visits, speech language pathology, occupational therapy, and physical therapy.

Hospital Services

- Inpatient Services.
 - Semi-private room, prescription drugs, lab tests, and other services when you're in the hospital.
 - Lab, x-ray, and other tests ordered by your doctor.
 - Physical therapy and other services ordered by your doctor.
 - Your doctor might need to get prior authorization for some hospital services from Medicaid's Quality Improvement Organization. To call, dial (800) 783-9207.



- Outpatient Services.



The emergency room isn't for routine medical care. If you're not sure you have an emergency, call your doctor anytime day or night for medical advice (see page 27 for more information about emergency room use).

Interpretation Services

- Might pay to help you communicate with your doctor, if English isn't your primary language.

Which Plan Is Right for Me?

Continued

Medical Equipment and Supplies

- Prescribed by a doctor.
- Artificial limbs and braces.
 - *To replace portions of the body that are weak or missing.*
- Special shoes or inserts for diabetics.
- Wheelchairs.
 - *You must have a doctor's order and an evaluation by an occupational or physical therapist to determine the most appropriate and the least costly wheelchair to meet your medical needs.*

Behavioral Health Services

- Inpatient psychiatric services.
 - *Limited to ten days during a calendar year.*
- Outpatient behavioral health services included in the Idaho Behavioral Health Plan program.
 - *Includes community-based treatment services to minimize symptoms of mental illness and substance use disorders."*
 - *Includes assessment and planning, psychological and neuropsychological testing, psychotherapy (individual, group, and family), pharmacologic management, partial care treatment, behavioral health nursing, community-based rehabilitation, substance use disorder treatment services, drug screening, and case management.*
 - *Services are available when medically necessary to meet an individual's treatment needs.*



Treatment services are provided by professionals enrolled in the Optum Idaho provider network. Contact Optum Idaho at (855) 202-0973 or www.OptumIdaho.com for more benefit details.

Podiatry

- Care of your feet and ankles.
 - *Limited to severe conditions from your mid-calf down.*
 - *Limited to treatment for chronic disease related care (such as diabetes) for adults age 21 and older.*
 - *Doesn't pay for routine treatment of your corns, warts, toenails, etc.*

Pregnancy and Family Planning Related Services

- PAP test performed during family planning or at yearly physical.
- Family planning, counseling, prescription, and supplies to prevent pregnancy.
- Sterilization.
 - *You must sign legal consent forms at least thirty days in advance. You can have the surgery on the thirty-first day.*
 - *Doesn't pay for sterilization if the person is under the age of 21, or if the person isn't capable of giving informed consent.*

Which Plan Is Right for Me?

- Prenatal, delivery, and postpartum services provided by a doctor, an RN certified nurse midwife, or a licensed midwife.
 - *If you're only eligible because you're pregnant, this plan will only pay for your pregnancy and for services related to your pregnancy up to 60 days after your pregnancy ends.*

- Doesn't pay for fertility related services.

Prescription Drugs

- Idaho health plans cover medicines prescribed by your doctor unless they're covered by Medicare.
 - *Some types of medicines and some brand name prescription drugs require prior authorization. Your pharmacist or provider will know which medicines need prior authorization and will submit the request for you.*

- Some non-prescription items are covered if your doctor orders them:
 - *Disposable insulin syringes and needles.*
 - *Shampoo treatment for head lice.*
 - *Most iron tablets.*

Prevention Benefits – Annual Physicals and Well-Child Checks (See page 8).



School-Based Services

- The school might test your child and might determine that your child is eligible for services under an Individualized Educational Plan (IEP) or Individualized Family Services Plan (IFSP).
- With your permission, your child's school can bill Medicaid or CHIP for the services.
- School-based services won't count against the limitations of the other services your child might be getting.

Which Plan Is Right for Me?

Continued

- Ask your child's school if they bill Medicaid or CHIP.
- Give your child's ID number and the name of your child's doctor to the school.
- Tell the school if your child is working with other therapists or doctors.

Substance Use Disorder Services

- Includes inpatient treatment services in a hospital - See Hospital Services on pg. 10.
 - *Outpatient treatment services are available from a substance use disorder agency enrolled in the Idaho Behavioral Health Plan provider network.*
 - *Includes eligibility intake screening, clinical assessment, drug/alcohol testing, individual and group counseling, and limited case management services.*
 - *Inpatient treatment in a residential treatment facility is not included in the Idaho Behavioral Health Plan.*



Contact Optum at
(855) 202-0973
for more information.

- Charges are decided on a sliding-fee scale.
- Doesn't pay for inpatient treatment in a residential treatment facility.
- Must obtain an intake eligibility screening and clinical assessment.

Physical, Occupational, and Speech Therapies

- Covered as an outpatient hospital service, in schools, and by independent therapists.
- Some service limits apply. Your therapist may be able to continue treatment beyond service limits under some circumstances.
- Inform your therapist any time you receive therapy services from another provider to avoid problems with service limits.

Transportation (Non-Emergency)

If you have a medical appointment but you don't have a car, can't operate a car, or don't have a friend or family member who can take you, you can request transportation through Medicaid's non-emergency medical transportation provider, American Medical Response (AMR).

- AMR will review your request and decide if Medicaid will pay for your transportation. AMR will review your request based on the least expensive transportation available and the closest available Medicaid provider or service.
- If you've been referred for medical care outside your community, AMR might ask for a referral from your doctor before they'll schedule your transportation.
- You need to call at least 48 hours before your appointment.

Which Plan Is Right for Me?



Call AMR toll free at
(877) 503-1261.

Vision Services

- For adults age 21 and older.
 - *Limited to treatment for acute needs such as removal of foreign objects in the eye.*
 - *Adults with chronic diseases such as diabetes or glaucoma that require regular eye care can get eye exams once every year.*
- For children under age 21.
 - *The doctor who does the exam might not be the provider who supplies your glasses. Be sure to ask if your doctor orders glasses from the Medicaid supplier.*
 - *Covers frames and lenses when needed.*
 - *Doesn't pay for transition or progressive lenses for any age, or tints unless an extreme condition makes it medically necessary.*

- Contacts.
 - *Contacts are covered if your vision can't be corrected with glasses. Contacts for convenience or cosmetic reasons aren't covered.*
 - *Surgery on the cornea for myopia is not covered.*

Other Covered Services

- Nutritional support therapy when medically necessary and ordered by your doctor.
- Diabetes training.
 - *Limited to 12 individual hours or 24 group hours every five years.*



If you're under the age of 21, you can get additional services if your doctor says they are medically necessary and they are prior authorized by Medicaid. See page 16 for more information on EPSDT services.

What is Preventive Health Assistance?

Preventive Health Assistance (PHA) has two benefits designed to help you and your family live a healthy lifestyle.

Behavioral PHA – Weight Management or Tobacco Cessation.

To qualify for this benefit, you must complete a health questionnaire, which you can get by calling the PHA unit or printing it from the PHA Web site. The questionnaire must indicate that you or your child over the age of five:

- Have a Body Mass Index (BMI) in the obese or underweight range and want to improve your health through weight management — or
- Want to quit using tobacco.

If you qualify for PHA benefits, you can earn points and use them (one point=\$1) to buy items or services that will help you live a healthy lifestyle. After you're awarded the points, they can be used at PHA approved businesses to help pay for things like weight management program fees or tobacco cessation products.

You can't receive both Weight Management and Tobacco Cessation benefits at the same time. The maximum benefit is 200 points a year.



Beginning January 1, 2014, Tobacco Cessation benefits will no longer be a PHA benefit. You will be able to get help with tobacco cessation from your primary care provider and your pharmacy.

Wellness PHA Benefit – If your child is on the Basic Plan and you pay a monthly premium (\$10 or \$15) for your child's medical coverage, you can earn points for keeping your child's well-child checks and immunizations current. Wellness points (one point = \$1) are used to help pay your monthly premiums. You will automatically receive more information if your child is eligible for the Wellness PHA benefit.

Wellness PHA points can't be exchanged for vouchers. Wellness PHA points can only be used to pay your monthly premium.

For more information about PHA, please visit our Web site at www.medicaid.idaho.gov (click on the Preventive Health Assistance link) or call us toll free at (877) 364-1843.



Help Your Child Stay Healthy

Well-Child Checks

Medicaid pays for well-child checks. Well-child checks are routine health checks for your child. They are an important part of keeping your child healthy. They allow time for you, your child, and your child's doctor to get to know one another and address any health concerns you may have about your child. They help your doctor find health problems early, so your child can be treated before they get worse.

Children need well-child checks as indicated below:

Well-Child Check Schedule

Age	✓	✓	✓	✓	✓	✓
Babies	At 1 Week and 1 Month	2 Month	4 Month	6 Month	9 Month	12 Month
1-3 yr	15 months	18 months	24 months	30 months	36 months	
3-19 yr	1 check-up every year					

During a well-child check your doctor should discuss any health concerns you have about your child and do the following activities:

- Do a comprehensive health and development history of your child
- Do a physical examination which includes measuring your child's height and weight
- Discuss eating or nursing habits
- Screen for developmental and behavioral issues
- Do age appropriate vision, hearing, and dental screens
- Give any appropriate immunizations
- Order any needed lab tests
- Perform a lead test at 12 and 24 months

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Medicaid pays for EPSDT services. These services are provided to children under the age of 21 who are enrolled in any plan offered by Idaho Medicaid.

EPSDT services include any necessary care to correct or lessen a physical or mental defect even if the service isn't covered under the Idaho Medicaid State Plan. Your provider can help you schedule appointments if needed.



If your child needs transportation to an EPSDT appointment, *contact AMR for assistance* (at least 48 hours in advance) at (877) 503-1261.

EPSDT services must be prior authorized. Your provider must complete and submit a Request for Authorization (RAS) packet. The packet can be downloaded from our website at www.modernizemedicaid.idaho.gov or requested by emailing: EPSDTrequest@dhw.idaho.gov



Optum Idaho will process EPSDT requests for outpatient behavioral health services for individuals enrolled in the IBHP. Go to the Optum Idaho website at www.optumidaho.com for more information.

The Enhanced Plan

If you're in this plan, you can get all of the services of the Basic Plan, plus the following services:

Developmental Disability Services

To apply for services, contact your local Regional Program office. You can find the phone numbers and addresses on page 34. These services include:

- Developmental therapy, physical therapy, speech therapy, occupational therapy, psychotherapy, and intensive behavioral interventions. See limits listed under Therapy (page 13) and Substance Use Disorder Services (page 13).
- Service coordination (Case Manager). See Service Coordination section on page 18.

Home and Community-Based Services (HCBS)

- Supportive services needed to live at home, in a residential assisted living facility (RALF), or certified family home (CFH), instead of living in an institution such as a nursing home or an intermediate care facility (ICF/ID) for people with a developmental or intellectual disability.
- Home and Community-Based Services are available for both children and adults with developmental disabilities.

Hospice Care

- In-home care for the terminally ill with six months or less to live.

Idaho Behavioral Health Plan (IBHP)

- Outpatient behavioral health services are available to individuals on the Basic or Enhanced Plans.
- See Behavioral Health Services on page 11 of this booklet.

Nursing Homes

- Covered if your doctor says you need to be in a nursing home and the Medicaid Division finds that you need nursing home level-of-care.

Personal Care Services (PCS)

- Services provided in your home.
 - Might help with services that give individuals more independence and a better quality of life in their home or residence.
 - Limited to 16 hours a week.
 - If your medical condition requires more than 16 hours a week, you might be eligible for one of the Home and Community-Based Waivers or EPSDT services for children. For details, call your local Medicaid office (see page 34).

The Enhanced Plan

Service Coordination

If you qualify for service coordination, you'll have a service coordinator to help you gain access and coordinate your necessary care and services.

You can only have one kind of service coordination. If you qualify for more than one kind, you must choose the kind you want. The kinds of service coordination are:

- Developmental Disability.
 - Adults age 18 years old or older.
 - Requires prior authorization.
- Children.
 - Children up to age 21.
 - Must have a developmental delay or other medical condition that requires the child to be seen by many service providers.
 - A service coordination plan must be developed and authorized before services can begin. If your child is age 0-3, the service coordination agency must work through the Idaho Infant Toddler network of providers.
- Outpatient Behavioral Health Services (IBHP).
 - Service coordination services for children with a serious emotional disorder are offered in the Idaho Behavioral Health Plan. See Behavioral Health Services on page 11 of this booklet.
- Personal Care Services.
 - Children who get personal care services.



If you're under the age of 21, you can get additional services if your doctor says they are medically necessary and they are prior authorized by

Medicaid. See page 16 for more information on EPSDT services.

Women's Health Check

Some women might qualify for free breast and cervical health screening. You must be diagnosed with cancer by a Women's Health Check provider to have your cancer treatment paid for. You might qualify if you're:

- Low income.
- Don't have insurance coverage for mammograms or Pap tests.
- Age 50 to 64.
- Age 18 to 49 and haven't had a Pap test in five years or longer, have never had a Pap test, or have symptoms for cervical cancer.
- Referred by a doctor for symptoms suspicious for breast cancer.

Call the Idaho CareLine (2-1-1 or (800) 926-2588) to connect with a Women's Health Check provider to see if you qualify.



Medicaid for Workers with Disabilities

Medicaid for Workers with Disabilities is an optional Medicaid program. Individuals who participate in Medicaid for Workers with Disabilities get the same services they would under the Enhanced Plan. This option also:

- Allows working Idahoans with disabilities to get Medicaid benefits by paying a sliding-scale premium which is based on their income.
- Allows Idahoans with disabilities to continue working or seek competitive employment without having to worry about losing health care coverage.
- Encourages Idahoans with disabilities to:
 - Increase independence.
 - Reduce dependence on public assistance.

Who is eligible for Medicaid for Workers with Disabilities?

You are eligible to participate if you:

- Are at least 16 years old, but under age 65.
- Have a disability.
- Are working or self-employed.
- Have a countable income that is less than 500% of the Federal Poverty Guideline.
- Have a gross earned income that is at least 15% of your total gross income.
- You have countable resources that are less than \$10,000 for an individual or \$15,000 for a couple.

How much will my premium be?

You might have to pay \$0, \$10, or up to 7.5% of your income, depending on how much you make.

For more information, call (877) 456-1233.

The Medicare-Medicaid Coordinated Plan

If you participate in this optional plan, you can get most of your medical services from the Medicare Advantage Plan.

If you're eligible for both Medicare Part A and Part B (dual-eligible), you can choose to sign up for this plan if it's offered in your county. This benefit plan, called the Medicare-Medicaid Coordinated Plan, provides coordinated benefits and expanded coverage in the areas of vision, hearing, and dental services. Most people that are currently eligible in the Enhanced Plan can choose this new plan.

Services covered under the Medicare-Medicaid Coordinated Plan are shown in the table below. Medicare Advantage providers will bill the Medicare Advantage Plan directly for these services. Medicaid providers will bill Medicaid directly for Medicaid covered services shown on the table below.

Medicare-Medicaid Coordinated Plan Services

Benefit	Medicare Advantage Plan	Medicaid
Hospital Services	X	
Outpatient Services	X	
Emergency Hospital Services	X	
Ambulatory Surgical Center Services	X	
Physician Medical Services	X	
Physician Surgical Services	X	
Certified Pediatric or Family Nurse Practitioner Services	X	
Physician Assistant Services	X	
Chiropractor Services	X	
Podiatrist Services	X	
Certified Nurse-Midwife Services	X	
Primary Care Case Management	X	
Adult Physicals	X	
Screening Mammography Services	X	
Prevention & Health Assistance Benefits (includes health/wellness education and intervention services such as disease management, tobacco cessation programs, or weight management)		X

Medicare-Medicaid Coordinated Plan *(continued)*

Benefit	Medicare Advantage Plan	Medicaid
Laboratory and Radiological Services	X	
Prescribed Drugs under Medicare Part D	X	
Prescribed Drugs not covered by Medicare Part D	X	
Family Planning Services	X	
Inpatient Psychiatric Services	X	
Outpatient Mental Health Services	X	
Home Health Care	X	
Therapy Services	X	
Speech, Hearing, and Language Services	X	
Medical Equipment and Supplies	X	
Specialized Medical Equipment and Supplies	X	
Prosthetic Devices	X	
Vision Services	X	
Medical and Surgical Services	X	
Rural Health Clinics	X	
Federally Qualified Health Center Services	X	
Indian Health Services	X	
Medical Transportation	X	
Nursing Facility Services (100 days or less)	X	
Nursing Facility Services		X
Personal Care Services		X
Other Home & Community Based Services		X
Hospice Care	X	
Intermediate Care Facility Services (for individuals with a developmental or intellectual disability)		X
Developmental Disability Agency Services		X

Premium Assistance

Premium assistance helps you buy private health insurance. There are two premium assistance programs: Access to Health Insurance for adults, and the Access Card for children.

Access to Health Insurance

Access to Health Insurance helps you pay for employer-sponsored health insurance. It pays up to \$100 each month for qualifying employees and their spouses. To participate:

- You or your spouse must work for a small business with 2 to 50 employees.
- Your employer must agree to sign up for the program.



Beginning January 1, 2014, income requirements for this program will change.

The Access Card

If your children are eligible, you can choose to enroll them in the Access Card program instead of the Basic Plan. The Children's Access Card program helps you pay for private insurance for your children. You can buy employer-sponsored insurance or buy an individual plan. The Access Card pays up to \$100 for each child, each month (monthly maximum of \$300 per family). You pay the co-payments and deductibles for the health plan you choose.

If your child loses private insurance paid for by the Access Card, your child can switch to the Basic Plan.



Beginning January 1, 2014, the Access Card for children will no longer be available.

For more information, call the Idaho CareLine (2-1-1) or Family Medicaid (see page 32).



Primary Care Program

Idaho Medicaid provides primary and specialty care services through a managed care system. The Healthy Connections and Health Home Program benefit plans will help you access medical care and manage your health care needs. Enrollment in the Primary Care Program is required for most participants.

Enrollment

- If you already have a primary care provider, you can continue to go to that provider.
- If you don't have a primary care provider, you'll need to choose one who participates in the Primary Care Program.
- There's a list of primary care providers you can choose from at www.healthyconnections.idaho.gov.

 ***Make an appointment with your primary care provider as soon as you're enrolled in the Primary Care Program. Otherwise, your primary care provider may not be able to make referrals for your care.***

- If you don't choose one, Idaho Medicaid will match each family member with a participating provider.
- Your primary care provider will provide all of your basic health care needs, refer you to a specialist when necessary, or refer you to the hospital if needed.
- Your primary care provider will decide if you're eligible to participate in the Idaho Medicaid Health Home benefit plan that can help you manage health issues such as diabetes, asthma, or behavioral health.
- You can change your primary care provider by calling The Primary Care Program as soon as you know you're changing. Most changes will be effective the first of the next month.
- You'll get a letter in the mail confirming enrollment or changes with your primary care provider. Please read it carefully and call The Primary Care Program if you have questions.
- You should call your primary care provider anytime you need medical advice, even after hours or on holidays.

Primary Care Program

Referrals

You might not be able to get a referral for other health care services if you haven't seen your primary care provider. If you are enrolled in the Idaho Behavioral Health Plan (IBHP), you aren't required to get a Healthy Connections referral for your outpatient behavioral health services. It's your responsibility to call your primary care provider to find out if you need to be seen before a referral can be made. It's very important for you to:

- Talk with your primary care provider before going to another provider or getting other medical services.
- Have a referral before you go to a provider who isn't your primary care provider or you might have to pay the bill.
- Contact the provider's office you're referred to right away to make an appointment and establish care.
- Understand that a referral does not change or stop just because your primary care provider changes.

You don't need a referral from your provider for:

- Anesthesiology Services.
- Audiology Services.
- Dental care.
- Chiropractic care.
- Family planning at District Health or other family planning agencies.

- Flu shots (without an office visit).
- Hospital admissions through the emergency room.
- Immunizations (without an office visit).
- Intermediate care facility/intellectually disabled services (developmentally disabled).
- Indian health clinic visits.
- Laboratory services.
- Nursing facility services.
- Personal care services case management.
- Personal care services.
- Pharmacy services.
- Prescription drugs.
- Podiatry (foot care) in podiatrist's office.
- Radiological services.
- Screening mammograms (40 or older).
- Tests for sexually transmitted diseases.
- Urgent care visits when your primary care provider's office is closed.
- Pregnancy related services when provided or ordered by an OB specialist.
- Vision services.
- Waiver services for the aged and disabled or those with traumatic brain injury.
- Children's developmental disability services.
- Mental health services.
- Substance abuse services.

Primary Care Program

Call the Primary Care Program

- If you need help choosing a primary care provider.
- If you want to change your primary care providers.
- If you're moving to a new area call the Primary Care Program to find a new primary care provider. Otherwise, you'll have to get a referral from your previous provider to get care in your new area.



Call the customer service line toll free at **(866) 326-2485** to report address changes.

Be a good patient!

- Call in advance for an appointment. You might not get an appointment the same day you call.
- When you make an appointment or seek care from any health care provider who bills Medicaid, tell them you're enrolled in Healthy Connections or the Health Home Program.
- Show your ID card and any other insurance card at every appointment (see page 31 for information about reporting changes in other insurance).

- When scheduling an appointment, tell the receptionist how many family members need to be seen and the reason so enough time can be scheduled for each appointment.
- Be on time to your appointments.
- Follow your treatment plan.
- If possible, avoid bringing your children to an appointment unless the appointment is for them.
- Call if you need to cancel your appointment, at least 24 hours in advance when possible. Your primary care provider can choose to stop providing care to you or a family member if you miss appointments or don't follow your treatment plan.

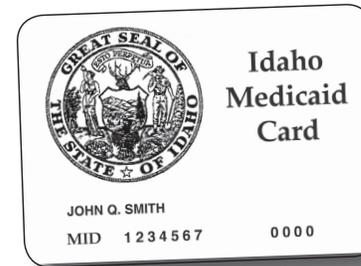
Primary Care Program grievance procedure

Call your local Primary Care Program to talk about concerns or questions you have. If the Primary Care Program can't fix the issue, you have the right to file a written grievance with them. We'll review your problem again and you'll get an answer in writing.

If you're still not satisfied, you have the right to file for a hearing. You can ask for a hearing by writing directly to the address on your grievance response letter.

Your Identification Card

The first time you're found eligible for Idaho health insurance coverage, you'll receive a permanent identification (ID) card.



Your card will come in the mail. It's important that you call your local Health and Welfare office if you don't receive your card within 14 days after you get the letter telling you that you're eligible.



If you lose your card, call (866) 326-2485



Remember, your ID card is permanent. Don't throw it away, keep it!

- If you lose benefits and then get benefits again, you'll use the same card and ID number.

- Keep your card in your purse or wallet so that you'll have it with you to show to your doctor, dentist, or pharmacy. You might have to show picture ID in addition to your Medicaid card.
- Always show your ID card and ask before you get medical services if the provider will accept your ID card as payment. Ask even when your doctor refers you to a specialist. Not all doctors accept the Idaho Health Plan.
- The state's payment for services is considered payment in full, regardless of the billed amount.

Important – Report name changes to your local Health and Welfare office or by calling (866) 326-2485. Your card might not work at providers' offices if you're going by a different name than what appears on your ID card.

When to Use the Emergency Room (ER)

You should call your doctor for advice if you or your family member get sick or injured. If you're not sure you have an emergency, call your doctor for advice anytime. If your primary care doctor's office is closed, it's okay to go to an urgent care facility without a referral from your doctor. Your medical records from these visits will be supplied to your primary care doctor. **It's important to remember that an urgent care facility is not the same as the ER.**

Co-Payments for using emergency services

You might have to make a co-payment for using emergency services when you don't have an emergency medical condition. It's important to only use emergency services, like the hospital ER and ambulance services, when they're really needed. You can help keep Medicaid costs down by using appropriate services and working with your Healthy Connections doctor.

The American College of Emergency Physicians and The American Academy of Pediatrics have each listed warning signs to help you decide if you should go to the ER. Those two lists are compiled here:

- Difficulty breathing or shortness of breath
- Chest or upper abdominal pain or pressure
- Fainting, sudden dizziness, and weakness
- Changes in vision
- Confusion or changes in mental status
- Any sudden or severe pain
- Uncontrolled bleeding
- Severe or persistent vomiting or diarrhea
- Coughing or vomiting blood
- Suicidal feelings

- Difficulty speaking
- Unusual abdominal pain
- Neck stiffness or rash with fever
- Fever in a newborn
- Head injury with loss of consciousness, confusion, headache, or vomiting
- Burns
- Poisoning



Call your poison control center at: **(800) 222-1222** or **(800) 860-0620** at once if your child has swallowed a suspected poison or another person's medication, even if your child has no signs or symptoms.



Call your pediatrician if you think your child is ill. Call **9-1-1** for help if you're concerned that your child's life might be in danger or that your child is seriously ill or injured.

In addition, every parent should be prepared. Part of that preparation includes learning CPR and basic first aid. For classes near you, contact your pediatrician, the American Red Cross, or the American Heart Association.

Important Information to Remember

- Emergency rooms and ambulances can charge you a co-payment for using these services when the situation isn't an emergency.
- The emergency room is not an appropriate place to get routine care, call your primary care provider first, or call the Primary Care Program if you need a primary care provider.
- Medicaid is partnering with primary care providers to identify participants who misuse or abuse emergency services.

What is Prior Authorization?

Prior authorization means you or your provider must get approval from Medicaid or its representatives before you get a service, or you might have to pay the bill.

Usually your doctor, healthcare provider, or pharmacist will request prior authorization for you. You might have to request prior authorization for yourself or your family for other services like transportation.

Prior authorization is different than a Healthy Connections referral:

- A prior authorization is approval from the Department for specific services.
- A Healthy Connections referral is approval from your primary care doctor for services.

You or your provider will need to get prior authorization for the following list of services:

- Transportation through AMR for non-emergency medical services.
- Some medical equipment and supplies.
- Home and Community-Based Waiver Services.
- Some inpatient and outpatient hospitalizations or medical procedures.
- Some vision services.
- Some dental services.
- Personal care services.
- Private duty nursing.

- Physical, occupational, and speech therapy – beyond service limits.
- Some medicines and most brand name drugs when generics are available.
- Developmental disability agency services.



Outpatient behavioral health services offered through the Idaho Behavioral Health Plan may require prior authorization. For more information, please go to www.optumidaho.com.

There might be other services not listed that need prior authorization. Your doctor or health care provider usually knows when you need prior authorization, but if you have questions call (888) 239-8463.



If a service requires prior authorization, you must get it from Medicaid before getting the service.

Important Information

Your Rights

When you're eligible for Idaho's health insurance plan coverage, you have certain guaranteed rights.

You have the right to fair treatment

You have the right to all covered benefits without regard to race, color, national origin, disability, sex, or age.

If you believe that anyone in Health and Welfare has discriminated against you because of your race, color, national origin, disability, sex, or age, **you can file a complaint by contacting:**

Civil Rights Manager
Idaho Department of Health and Welfare
PO Box 83720
Boise, Idaho 83720-0036
(208) 334-5617 (voice) or
(208) 334-4921 (TDD)

You can also file a complaint by contacting:

U.S. Department of Health and Human Services (HHS)
Director, Office for Civil Rights
Room 506-F, 200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0403 (voice) or
(202) 619-3257 (TDD)

HHS is an equal opportunity provider and employer.

You have the right to timely and accurate notice

Written notifications must be mailed to you before your eligibility is ended.

You have the right to make decisions about your health care

Your provider must discuss your options with you before you start medical treatment.



You should let your family and your doctor know your wishes before you become too ill to make a decision about your medical treatment. *For a Living Will and a Durable Power of Attorney for Health Care, go to*

www.healthandwelfare.idaho.gov
(click on the Medical link then Certified Family Homes on the right side of the page).

You have the right to file an appeal



This is very important!
If you disagree with a decision regarding your **eligibility** coverage, or if you feel that your medical needs have not been properly met, you can file an appeal. If you need file an appeal for outpatient behavioral health services that are included in the Idaho Behavioral Health Plan, you should file it with Optum Idaho. To request an appeal, contact your regional office and ask for a "Fair Hearing Form." Complete the form and send it and a copy of the disputed notice to the address below. For eligibility appeals, the Department of Health and Welfare must receive your appeal in writing within 30 days from the date the notice was mailed.

For appeals of **denied services**, the Department of Health and Welfare must receive your appeal in writing within 28 days.

If the Department receives your appeal within the 28 days, they'll review the decision. This review might include a hearing. If the Department receives your appeal after the 28 days, you lose the right to appeal.

Send your appeals to:
Hearing Coordinator
Idaho Department of Health and Welfare
PO Box 83720
Boise, ID 83720-0036

If a hearing is scheduled, you'll receive a letter with the location and time of your hearing. During the hearing, you can have anyone you want present to represent you. You don't need an attorney but you can hire an attorney at your own expense if you want one.

Fraud, Abuse, and Misuse



Everyone in your family who's eligible for health benefits will get their own Medicaid card with their name listed on the card. It's against the law for anyone else to use the card.

If you knowingly break rules, you can lose your coverage. You can also be prosecuted and you might have to pay for the benefits you received but weren't entitled to.

If you think someone who's getting assistance from the state is abusing the programs or you think a provider is improperly billing for

Estate Recovery

When you get Medicaid benefits and are over 55, you can't give your property away to others.

After you and your spouse pass away, your money and property will be used to repay Medicaid.

Under certain conditions, your children can request a Hardship Waiver.

services they haven't provided, you should report this to Medicaid.



*To report participant fraud, call the Idaho CareLine at 2-1-1 or **(800) 926-2588**.*

To report provider fraud, download the complaint form at

www.healthandwelfare.idaho.gov
(click on the Provider link then on File a Fraud Complaint). Fill out the form and mail it to:

Medicaid Fraud & Program Integrity Unit
Bureau of Audits & Investigations
PO Box 83720
Boise, Idaho 83720-0036
or FAX it to **(208) 334-2026**.

*For more information call the Medicaid Recovery Office at **(866) 849-3843**, or call the Idaho CareLine **(2-1-1 or (800) 926-2588)** and ask for a copy of "Property Liens and Estate Recovery" #HW-0474.*



Other Medical Insurance

If you have Medicare, Blue Cross, Blue Shield, or any other medical insurance, you must tell your Health and Welfare worker. Your other insurance must pay before Medicaid will pay. If your insurance has changed or stopped in the last six months, you need to give your Health and Welfare worker your new insurance plan information or say why you stopped your insurance. If you don't, your children might not be able to get Idaho health insurance plan coverage.



For instructions about how to pay Medicaid, call the Financial Recovery Unit at (208) 287-1150 or the Department's third party recovery contractor – (HMS) in the Boise area at (208) 375-1132 or toll free at (800) 873-5875.

Health Insurance Premium Payment Program (HIPP)

If you have Medicaid and have other health insurance available, such as employer sponsored group coverage, ask your Health and Welfare worker about HIPP. If you or your children qualify, the Department might pay the premiums, deductibles, and co-payments for your other insurance.

For more information, call the Idaho CareLine (2-1-1 or (800) 926-2588) and ask for publication #HW-0905 Health Insurance Premium Payment.



If your primary insurance ends or changes, call Health Management Systems (HMS) at (208) 375-1132, option 0, or toll free at (800) 873-5875. HMS has no control over your benefits. For information about benefits, call Molina Medicaid Solutions participant line at 1(866) 686-4752.

If Medicaid pays a bill and you get money from your other insurance, you must give the money to Medicaid. You're responsible for helping Medicaid collect money from another insurance plan or a responsible person such as a non-custodial parent. The provider of the services will need to re-bill or do an adjustment.

Application and Customer Service Information

Family Medicaid

150 Shoup Ave., Suite 5
Idaho Falls, 83402

(866) 326-2485

FAX (208) 528-5980

Long Term Care

No office locations available

(866) 255-1190

FAX (208) 799-5048

Customer Service Line and Application Processing Center Department of Health and Welfare

PO BOX 83720
Boise, ID 83720

Local Healthy Connections Offices

Local offices can tell you about available primary care doctors in your area and help you with changes or questions about Healthy Connections (see pages 23-25 for specific program information). For more information, please visit our Web site at www.healthyconnections.idaho.gov.

Region 1 – Coeur d’Alene
 Benewah, Bonner, Boundary, Kootenai, and Shoshone counties
 1120 Ironwood Dr., Suite 102,
 Coeur d’Alene, ID 83814
 (208) 666-6766 or (800) 299-6766
 FAX (208) 769-1473

Region 2 – Lewiston & Moscow
 Clearwater, Idaho, Latah, Lewis, and Nez Perce counties
 1118 F St., Lewiston, ID 83501
 (208) 799-5088 or
 (800) 799-5088
 FAX (208) 799-5167

Region 3 – Caldwell, Nampa, & Payette
 Adams, Canyon, Gem, Owyhee, Payette, and Washington counties
 3402 Franklin Rd., Caldwell, ID 83605, or 515 N. 16th St., Payette, ID 83661
 (208) 642-7006 or (208) 455-7244 or
 (888) 528-5861
 FAX (888) 532-0014

Region 4 – Boise
 Ada, Boise, Elmore, and Valley counties
 1720 Westgate, Suite B, Boise, ID 83704
 (208) 334-4676 or (888) 528-5861
 FAX (888) 532-0014

Region 5 – Twin Falls & Burley
 Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, and Twin Falls counties
 601 Poleline Rd., Suite 3,
 Twin Falls, ID 83301
 (208) 736-4793 or (800) 528-5861
 FAX (888) 532-0014

Region 6 – Pocatello
 Bannock, Bear Lake, Bingham, Caribou, Franklin, Oneida, and Power counties
 1090 Hiline Rd., Suite 202,
 Pocatello, ID 83201
 (208) 235-2927 or (888) 528-5861
 FAX (888) 532-0014

Region 7 – Idaho Falls
 Bonneville, Butte, Clark, Custer, Fremont, Jefferson, Lemhi, Madison, and Teton counties
 150 Shoup Ave., Suite 4,
 Idaho Falls, ID 83402
 (208) 528-5794 or (888) 528-5861
 FAX (888) 532-0014

Healthy Connections Customer Service
 Toll free: (888) 528-5861
 Espanol: (800) 378-3385
 FAX: (888) 532-0014
 Email: hccr7@dhw.idaho.gov

Regional Program Offices

Local offices help with developmental disability service applications, home and community-based waivers, and children’s services.

Region 1 – Coeur d’Alene
 1120 Ironwood Dr.
 Coeur d’Alene, Idaho 83814
 (208) 769-1567

Region 2 – Lewiston
 1118 F Street
 Lewiston, Idaho 83501
 (208) 799-4430

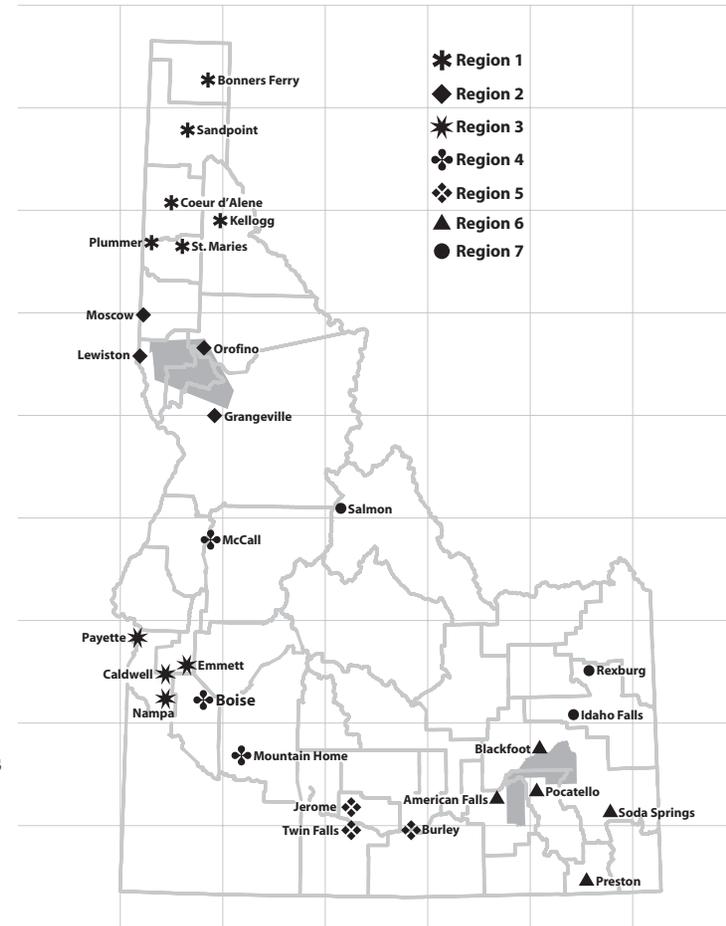
Region 3 – Caldwell
 3402 Franklin Rd.
 Caldwell, Idaho 83605
 (208) 455-7150

Region 4 – Boise
 1720 Westgate Dr.
 Boise, Idaho 83704
 (208) 334-0940

Region 5 – Twin Falls
 601 Poleline Rd.
 Twin Falls, Idaho 83301
 (208) 736-3024

Region 6 – Pocatello
 1070 Hiline Road
 Pocatello, Idaho 83201
 (208) 239-6260

Region 7 – Idaho Falls
 150 Shoup Ave.
 Idaho Falls, Idaho 83402
 (208) 528-5750





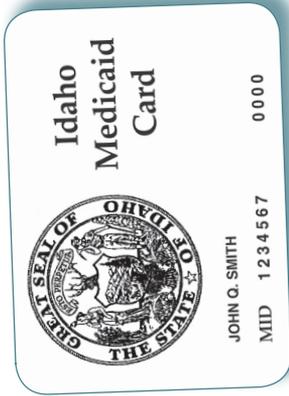
IDAHO DEPARTMENT OF
HEALTH & WELFARE

P.O. Box 83720
Boise, Idaho 83720-0036

Place
Postage
Here

Idaho Health Plan Coverage

*A Benefits Guide to Medicaid,
CHIP, and Premium Assistance*



To:



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

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

Select one of the following:

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

Name of benefit package:

Selection of the Section 1937 Coverage Option

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

- Benchmark Benefit Package.
- Benchmark-Equivalent Benefit Package.

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

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

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

Selection of Base Benchmark Plan

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

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

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

1. The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
2. The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.



Alternative Benefit Plan

PRA Disclosure Statement

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.20130801

TN NO: 14-0003 ABP3 Approval Date: 06/04/2014
Idaho ENH Effective Date: January 1, 2014



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

Alternative Benefit Plan Cost-Sharing

ABP4

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

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

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

No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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

V.20130807

TN NO: 14-0003 ABP4 Approval Date: 06/04/2014
Idaho ENH Effective Date: January 1, 2014



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

Benefits Description	ABP5
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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: <input type="text" value="None"/>		<input type="button" value="Remove"/>
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: <input type="text" value="Chiropractic Care"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Authorization required in excess of limitation"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="6 Visits"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text" value="The Department will review for medical necessity and prior authorize chiropractic services after the initial six visits per year."/>		
Benefit Provided: <input type="text" value="Radiation Therapy"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: <input type="text" value="Renal Dialysis"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	



Alternative Benefit Plan

Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	<input type="button" value="Remove"/>
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: <input type="text" value="Respiratory Therapy"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: <input type="text" value="Enterostomal Therapy"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		
Benefit Provided: <input type="text" value="Home IV Therapy"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	



Alternative Benefit Plan

Authorization: <input type="text" value="None"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	<input type="button" value="Remove"/>
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input type="text"/>		

Benefit Provided: <input type="text" value="Hospice"/>	Source: <input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input 1937="" base="" benchmark."="" benefits"="" excess="" for="" in="" of="" other="" provided="" services="" the="" type="text" value="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 "/>		



Alternative Benefit Plan

<input checked="" type="checkbox"/> Essential Health Benefit 2: Emergency services		Collapse All <input type="checkbox"/>															
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Emergency Room Services"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/></td><td style="width: 10%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/></td></tr></table>			Benefit Provided: <input style="width: 95%;" type="text" value="Emergency Room Services"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Medicaid State Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>		
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		<input type="button" value="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

Benefit Provided:

Delivery and All Inpatient Services-Maternity Care

Source:

Base Benchmark Small Group

Remove

Authorization:

None

Provider Qualifications:

Selected Public Employee/Commercial Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Add



Alternative Benefit Plan

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

Collapse All

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:	Source:	Remove
Substance Abuse Disorder Inpatient Services	Secretary-Approved Other	
Authorization:	Provider Qualifications:	
Prior Authorization	Other	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:		
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:	Source:
Community-Based Rehabilitation Services	Secretary-Approved Other
Authorization:	Provider Qualifications:
Prior Authorization	Other
Amount Limit:	Duration Limit:
None	None
Scope Limit:	
None	
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:	
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.	



Alternative Benefit Plan

- 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:



Alternative Benefit Plan

- 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:		Source:	
<input type="text" value="MH/BH Outpatient: ECT Therapy"/>		<input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization:	<input type="text" value="Prior Authorization"/>	Provider Qualifications:	<input type="text" value="Selected Public Employee/Commercial Plan"/>
Amount Limit:	<input type="text" value="None"/>	Duration Limit:	<input type="text" value="None"/>
Scope Limit:	<input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:			
<input type="text"/>			
Benefit Provided:		Source:	
<input type="text" value="MH/BH Outpatient Services:Med Management"/>		<input type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>
Authorization:	<input type="text" value="Prior Authorization"/>	Provider Qualifications:	<input type="text" value="Selected Public Employee/Commercial Plan"/>
Amount Limit:	<input type="text" value="None"/>	Duration Limit:	<input type="text" value="None"/>
Scope Limit:	<input type="text" value="None"/>		
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:			
<input type="text"/>			
			<input type="button" value="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.):

- Limit on days supply
- Limit on number of prescriptions
- Limit on brand drugs
- Other coverage limits
- Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

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

<input checked="" type="checkbox"/> Essential Health Benefit 8: Laboratory services	Collapse All <input type="checkbox"/>															
<table style="width: 100%; border: none;"><tr><td style="width: 50%; border: none;">Benefit Provided: <input style="width: 95%;" type="text" value="Diagnostic Test (X-ray & Lab Work)"/></td><td style="width: 40%; border: none;">Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/></td><td style="width: 10%; border: none; text-align: center;"><input type="button" value="Remove"/></td></tr><tr><td style="border: none;">Authorization: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Provider Qualifications: <input style="width: 95%;" type="text" value="Selected Public Employee/Commercial Plan"/></td><td style="border: none;"></td></tr><tr><td style="border: none;">Amount Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;">Duration Limit: <input style="width: 95%;" type="text" value="None"/></td><td style="border: none;"></td></tr><tr><td colspan="3" style="border: none;">Scope Limit: <input style="width: 95%;" type="text" value="None"/></td></tr><tr><td colspan="3" style="border: none;">Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/></td></tr></table>		Benefit Provided: <input style="width: 95%;" type="text" value="Diagnostic Test (X-ray & Lab Work)"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>	Authorization: <input style="width: 95%;" type="text" value="None"/>	Provider Qualifications: <input style="width: 95%;" type="text" value="Selected Public Employee/Commercial Plan"/>		Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>		Scope Limit: <input style="width: 95%;" type="text" value="None"/>			Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: <input style="width: 95%; height: 20px;" type="text"/>		
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Benefit Provided: <input style="width: 95%;" type="text" value="Imaging (CT/PET Scans, MRIs)Includes Nuclear Care"/>	Source: <input style="width: 95%;" type="text" value="Base Benchmark Small Group"/>	<input type="button" value="Remove"/>														
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Amount Limit: <input style="width: 95%;" type="text" value="None"/>	Duration Limit: <input style="width: 95%;" type="text" value="None"/>															
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<input type="button" value="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.

Remove

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.

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



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:

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

<input type="checkbox"/> Other Covered Benefits from Base Benchmark	Collapse All <input type="checkbox"/>
---	---------------------------------------



Alternative Benefit Plan

<input checked="" type="checkbox"/> Base Benchmark Benefits Not Covered due to Substitution or Duplication		Collapse All <input type="checkbox"/>
Base Benchmark Benefit that was Substituted: <input type="text" value="Residential Treatment"/>	Source: Base Benchmark	<input type="button" value="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:		
<input type="text" value="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."/> <input type="text" value="This is an IMD."/>		
Base Benchmark Benefit that was Substituted: <input type="text" value="Partial Hospitalization"/>	Source: Base Benchmark	<input type="button" value="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:		
<input type="text" value="The Department substitutes Community-Based Rehabilitation Services and Partial Care Treatment for Partial Hospitalization (part of the EHB Mental/Behavioral Health Outpatient services)."/> <input type="text" value="This is an IMD."/>		
		<input type="button" value="Add"/>



Alternative Benefit Plan

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



Alternative Benefit Plan

<input type="text"/>		<input type="button" value="Remove"/>
Other 1937 Benefit Provided: <input type="text" value="Private-Duty Nursing"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Other"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="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: <input type="text" value="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: <input type="text" value="Licensed Midwife"/>	Source: Section 1937 Coverage Option Benchmark Benefit Package	



Alternative Benefit Plan

Authorization: <input type="text" value="Other"/>	Provider Qualifications: <input type="text" value="Medicaid State Plan"/>	<input type="button" value="Remove"/>
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="Services include antepartem, intrapartum, up to six (6) weeks of postpartum maternity care, and up to six weeks of newborn care."/>		
Other: <input type="text" value="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: <input type="text" value="Orthodontia: Child"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other: <input type="text" value="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: <input type="text" value="Optometrist and Ophthalmologist Services: Adults"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	
Authorization: <input type="text" value="Authorization required in excess of limitation"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="One pair glasses or contacts post cataract surgery"/>	Duration Limit: <input type="text" value="None"/>	



Alternative Benefit Plan

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 services 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.



Alternative Benefit Plan

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



Alternative Benefit Plan

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:



Alternative Benefit Plan

- 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.

Remove

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.

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).



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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 .



Alternative Benefit Plan

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 field 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.



Alternative Benefit 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



Alternative Benefit Plan

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.



Alternative Benefit Plan

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.



Alternative Benefit Plan

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)):



Alternative Benefit Plan

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

Authorization:

Prior Authorization

Amount Limit:

None

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Provider Qualifications:

Other

Duration Limit:

None



Alternative Benefit Plan

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,



Alternative Benefit Plan

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.



Alternative Benefit Plan

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.

Remove

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.

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: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	<input type="button" value="Remove"/>
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other: <input type="text" value="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: <input type="text" value="Durable Medical Equipment"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	<input type="button" value="Remove"/>
Authorization: <input type="text" value="Prior Authorization"/>	Provider Qualifications: <input type="text" value="Selected Public Employee/Commercial Plan"/>	
Amount Limit: <input type="text" value="None"/>	Duration Limit: <input type="text" value="None"/>	
Scope Limit: <input type="text" value="None"/>		
Other: <input type="text" value="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: <input type="text" value="Podiatrist Services"/>	Source: <input type="text" value="Section 1937 Coverage Option Benchmark Benefit Package"/>	



Alternative Benefit Plan

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	



Alternative Benefit Plan

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 in 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]



Alternative Benefit Plan

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.



Alternative Benefit Plan

~ 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))



Alternative Benefit Plan

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



Alternative Benefit Plan

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

Provider Qualifications:

Authorization:

Other

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



Alternative Benefit Plan

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



Alternative Benefit Plan

- 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

<input type="checkbox"/> 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 <input type="checkbox"/>
---	---------------------------------------

PRA Disclosure Statement

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V.20130808



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C-

Benefits Assurances

ABP7

EPSDT Assurances

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

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

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

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

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

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

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

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

- State/territory provides additional EPSDT benefits through fee-for-service.
- State/territory contracts with a provider for additional EPSDT services.

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

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

Prescription Drug Coverage Assurances

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

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

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

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



Alternative Benefit Plan

Other Benefit Assurances

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

PRA Disclosure Statement

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V.20130807

TN NO: 14-0003 ABP7 Approval Date: 06/04/2014

Idaho ENH Effective Date: January 1, 2014



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

Service Delivery Systems

ABP8

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

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

Select one or more service delivery systems:

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

- Fee-for-service.
- Other service delivery system.

Managed Care Options

Managed Care Assurance

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

Managed Care Implementation

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

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

PAHP: Prepaid Ambulatory Health Plan

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

No

- The Alternative Benefit Plan will be provided through a prepaid ambulatory health plan (PAHP) consistent with applicable managed care requirements (42 CFR Part 438, and section 1937 of the Social Security Act).
- PAHPs are paid on a risk basis.
- PAHPs are paid on a non-risk basis.

PAHP Procurement or Selection Method

Indicate the method used to select PAHPs:



Alternative Benefit Plan

Competitive procurement method (RFP, RFA).

Other procurement/selection method.

Describe the method used by the state/territory to procure or select the PAHPs:

Other PAHP-Based Service Delivery System Characteristics

List the benefits or services that will be provided apart from the PAHP, and explain how they will be provided. Add as many rows as needed.

	Benefit/service	Description of how the benefit/service will be provided	
+	The only dental service provided outside the PAHP is for fluoride varnish.	Pediatricians who have been trained may bill for providing fluoride varnish.	X
+	Interpretation services	Dentists bill Medicaid directly for Interpretation services	X

PAHP service delivery is provided on less than a statewide basis.

PAHP Participation Exclusions

Individuals are excluded from PAHP participation in the Alternative Benefit Plan:

General PAHP Participation Requirements

Indicate if participation in the managed care is mandatory or voluntary:

Mandatory participation.

Voluntary participation. Indicate the method for effectuating enrollment:

Describe method of enrollment in PAHPs:

All participants enrolled in the Enhanced Alternative Benefit Plan are eligible to receive full dental benefits from the PAHP. The single state agency enrolls and disenrolls participants for Medicaid coverage. An eligibility data file is sent to the Contractor daily. The contract requires the dental benefit administrator to enroll or disenroll based solely on the eligibility information supplied by the single state agency. If a participant loses Medicaid eligibility, they are disenrolled from the dental plan, but are automatically reenrolled with the Contractor when they again become Medicaid eligible with no waiting period for enrollment.

Additional Information: PAHP (Optional)

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

PRA Disclosure Statement

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Alternative Benefit Plan

V.20130718

TN NO: 14-0014 ABP8 Supersedes 14-0003 Approval Date: 10/21/14

Idaho

Effective Date: July 1, 2014



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

Service Delivery Systems

ABP8

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

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

Select one or more service delivery systems:

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

- Fee-for-service.
- Other service delivery system.

Managed Care Options

Managed Care Assurance

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

Managed Care Implementation

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

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

PCCM: Primary Care Case Management

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

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

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

PCCM Payments

Specify how payment for services is handled:

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



Alternative Benefit Plan

Other:

Additional Information: PCCM (Optional)

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

Fee-For-Service Options

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

- Traditional state-managed fee-for-service
- Services managed under an administrative services organization (ASO) arrangement

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

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

Additional Information: Fee-For-Service (Optional)

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

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V.20130718

TN

NO: 14-0003

ABP8

Approval Date: 06/04/2014

Idaho

ENH

Effective Date: January 1, 2014



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

Service Delivery Systems

ABP8

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

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

Select one or more service delivery systems:

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

- Fee-for-service.
- Other service delivery system.

Managed Care Options

Managed Care Assurance

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

Managed Care Implementation

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

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

PAHP: Prepaid Ambulatory Health Plan

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

Yes

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

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

Identify the date the managed care program was approved by CMS:



Alternative Benefit Plan

Describe program below:

The Department covers community-based outpatient behavioral health services through a PAHP contract. The implementation date of the managed care delivery system was September 1, 2013.

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

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

Through the implementation of a managed care system under a 1915(b) waiver, Idaho seeks to achieve the following goals:

Short Term Goals:

- * Enrollment of sufficient number of competent professionals to deliver core services; Successful claims processing; Improved identification of Members who meet program qualifications for behavioral health treatment; and Successful transition process for both providers of services (agencies and individual practitioners) and Members.

Intermediate Goals:

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

Long Term Goals:

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

Additional Information: PAHP (Optional)

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

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V.20130718



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

Employer Sponsored Insurance and Payment of Premiums

ABP9

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

Yes

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

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

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

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

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

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

The state/territory otherwise provides for payment of premiums.

No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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TN NO: 14-0003 ABP9 Approval Date: 06/04/2014

Idaho ENH Effective Date: January 1, 2014



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

General Assurances

ABP10

Economy and Efficiency of Plans

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

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

Yes

Compliance with the Law

- The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.
- The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).
- The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

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V.20130807

TN NO: 14-0003 ABP10 Approval Date: 06/04/2014

Idaho ENH Effective Date: January 1, 2014



Alternative Benefit Plan

OMB Control Number: 0938-1148

OMB Expiration date: 10/31/2014

Attachment 3.1-C- N

Payment Methodology

ABP11

Alternative Benefit Plans - Payment Methodologies

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

An attachment is submitted.

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V.20130807

TN NO: 14-0003 ABP11 Approval Date: 06/04/2014

Idaho ENH Effective Date: January 1, 2014

Preventative Health Assistance

Medicaid will pay provider charges for weight management services not to exceed two hundred dollars (\$200.00) per Medicaid participant paid annually. The State does not set a standard fee rate for each type of service as this benefit may be billed incrementally or in one billing for a package of services. The dollar amount the participant has available for billable services and the type of service the participant is eligible to receive is indicated on each prior authorization which the participant presents to the provider prior to receiving services.

Participants must complete an enrollment application for the program and return it to the state. The application requires a physician's signature, information on body mass index (BMI), and the provider that the beneficiary wishes to use. Services are authorized or denied based on the information provided. Providers may then provide the services and bill Medicaid for weight management services.