

ALTERNATIVE BENEFITS  
STATE PLAN AMENDMENT  
BASIC BENCHMARK PLAN FOR  
LOW-INCOME CHILDREN and WORKING AGE-ADULTS

1937(a),  
1937(b)

X / The State elects to provide alternative benefits under Section 1937 of the Social Security Act.

A. Populations

The State will provide the benefit package to the following populations:

a. \_\_\_ / Required Populations who are full benefit eligible individuals in a category established on or before February 8, 2006, will be required to enroll in an alternative benefit package to obtain medical assistance except if within a statutory category of individuals exempted from such a requirement.

List the population(s) subject to mandatory alternative coverage:

NONE

b. X / Opt-In Populations who will be offered opt-in alternative coverage and who will be informed of the available benefit options prior to having the option to voluntarily enroll in an alternative benefit package.

List the populations/individuals who will be offered opt-in alternative coverage:

AFDC-Related Individuals  
Pregnant Women  
Low-Income Children

For the opt-in populations/individuals, describe the manner in which the State will inform each individual that such enrollment is voluntary, that such individual may opt out of such alternative benefit package at any time and regain immediate eligibility for the regular Medicaid program under the State plan.

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See Section 2.D of Attachment

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For the ~~opt-in~~ populations/individuals, provide a description of the benefits available under the alternative benefit package and a comparison of how they differ from the benefits available under the regular Medicaid program, as well as an assurance that the State will inform each individual of this information.

Covered services, including new benefits adding prevention services, adult physicals, and prevention and health assistance benefits are identified in Section 3.

c. X / Geographical Classification

States can provide for enrollment of populations on a statewide basis, regional basis, or county basis.

List any geographic variations:

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See Section 1.E of Attachment

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Please provide a chart, listing eligible populations (groups) by mandatory enrollment, ~~opt-in~~ enrollment, geography limitations, or any other requirements or limitations.

B. Description of the Benefits

X / The State will provide the following alternative benefit packages (check all that apply). *Basic Plan*

1937(b)

1. X / Benchmark Benefits

a. \_\_\_ / FEHBP-equivalent Health Insurance Coverage - The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(1) of Title 5, United States Code.

b. \_\_\_ / State Employee Coverage - A health benefits coverage plan that is offered and generally available to State employees within the State involved. Attach a copy of the State's employee benefits plan package.

c. \_\_\_ / Coverage Offered Through a Health Maintenance Organization (HMO) - The health

insurance plan that is offered by an HMO (as defined in section 2791 (b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State involved. Attach a copy of the HMO's benefit package.

d. X / Secretary-approved Coverage - Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide a description of the State's plan. Provide a full description of the benefits package including the benefits provided and any applicable limits.

Covered services, including new benefits adding prevention services, adult physicals, and prevention and health assistance benefits are identified in Section 3.

2. / Benchmark-Equivalent Benefits.

Specify which benchmark plan or plans this benefit package is equivalent to, and provide the information listed above for that plan: —

a. \_\_\_ / The State assures that the benefit package(s) have been determined to have an actuarial value equivalent to the specified benchmark plan or plans in an actuarial report that: 1) has been prepared by an individual who is a member of the American Academy of Actuaries; 2) using generally accepted actuarial principles and methodologies; 3) using a standardized set of utilization and price factors; 4) using a standardized population that is representative of the population being served; 5) applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and 6) takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of

premiums) under that coverage. Attach a copy of the report.

b. \_\_\_/ The State assures that if the State provides additional services under the benchmark benefit package(s) from anyone of all the following categories: 1) prescription drugs; 2) mental health services; 3) vision services, and/or 4) hearings services, the coverage of the related benchmark-equivalent benefit package(s) will have an actuarial value that is at least 75 percent of the actuarial value of the coverage of that category of services included in the benchmark benefit package. Attach a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c. \_\_\_/ The State assures that the actuarial report will select and specify the standardized set and populations used in preparing the report.

(1) \_\_\_/ **Inclusion of Basic Services** - This coverage includes benefits for items and services within the following categories of basic services: (Check all that apply).

\_\_\_/ Inpatient and outpatient hospital services

\_\_\_/ Physicians' surgical and medical services

/ Laboratory and x-ray services

\_\_\_/ Well-baby and well-child care services as defined by the State, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices

\_\_\_/ Other appropriate preventive services, as designated by the Secretary

\_\_\_/ Clinic services (including health center services) and other ambulatory health care services

\_\_\_/ Federally qualified health care services

/ Rural health clinic services

\_\_\_/ Prescription drugs

\_\_\_/ Over-the-counter medications

\_\_\_/ Prenatal care and pre-pregnancy family services and supplies

\_\_\_/ Inpatient Mental Health Services not to exceed 30 days in a calendar year

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\_\_\_/ Outpatient mental health services furnished in a State-operated facility and including community-based services

\_\_\_/ Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)

\_\_\_/ Disposable medical supplies including diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formulas and dietary supplements

Nursing care services, including home visits for private duty nursing, not to exceed 30 days per calendar year

/ Dental services

\_\_\_/ Inpatient substance abuse treatment services and residential substance abuse treatment services not to exceed 30 days per calendar year

Outpatient substance abuse treatment services

Case management services

/ Care coordination services

Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders

\_\_\_/ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services

\_\_\_/ Premiums for private health care insurance coverage

Medical transportation

\_\_\_/ Enabling services (such as transportation, translation, and outreach services)

Any other health care services or items specified by the Secretary and not included under this section

(2) Additional benefits for voluntary opt-in populations:

\_\_\_/ Home and community-based health care services

Nursing care services, including home visits for private duty nursing

Attach a copy of the benchmark-equivalent plan including benefits and any applicable limitations.

(3) Wrap-around/Additional Services

- a. X / The State assures that wrap-around or additional benefits will be provided for individuals under 19 who are covered under the State plan under section

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1902(a)(10)(A) to ensure early and periodic screening, diagnostic and treatment services are provided when medically necessary. Wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, these individuals receive the full EPSDT benefit, as medically necessary. Attach a description of the manner in which wrap-around or additional services will be provided to ensure early and period screening, diagnostic and treatment services are provided when medically necessary (as determined by the State).

b.  X  / the State has elected to also provide wrap-around or additional benefits.

The state of Idaho has elected to cover children up to the age of twenty – one (21) under EPSDT.

Attach a list of all wrap-around or additional benefits and a list of the populations for which such wrap-around or additional benefits will be provided.

C. Service Delivery System

Check all that apply.

1.  X  / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider.

2.  X  / The alternative benefit package will be furnished on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a) (25) and 1905(t) of the Social Security Act.

3.   / ~~The~~ alternative benefit package will be furnished through a managed care entity consistent with applicable managed care requirements.

4.   Alternative benefits provided through premium assistance for benchmark-equivalent in employer-sponsored coverage.

5.   / Alternative benefits will be provided through a combination of the methods described in item 1-4. Please specify how this will be accomplished.

D. Additional Assurances

a. X / The State assures that individuals will have access, through benchmark coverage, benchmark-equivalent coverage, or otherwise, to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

b. X / The State assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb).

E. Cost Effectiveness of Plans

Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles.

F. Compliance with the Law

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

G. Implementation Date

X / The State will implement this State Plan amendment on (July 1, 2006).

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

**SECTION 1: GENERAL OVERVIEW**

**1.A ADMINISTRATIVE AUTHORITIES**

As a condition for receipt of Federal funds under Titles XIX and XXI of the Social Security Act, the Idaho Department of Health and Welfare submits the following Basic Benchmark Benefit Package, and hereby agrees to administer the program in accordance with the provisions of Titles XI, XIX and XXI of the Act, and all applicable Federal regulations and other official issuances of the US Department of Health and Human Services.

*The Idaho Department of Health and Welfare is the single State agency designated to administer or supervise the administration of the Medicaid program under Titles XIX and XXI of the Social Security Act. (All references to "the Department" mean the Idaho Department of Health and Welfare.)*

*The health benefits coverage available under the Basic Benchmark Benefit Package provides appropriate coverage for the applicable populations as determined by the Secretary of the US Department of Health and Human Services pursuant to his authority under section 1937 of the Social Security Act. All references to "the Secretary" mean the Secretary of the US Department of Health and Human Services; all references to "the Act" mean the Social Security Act.)*

All other provisions of the Basic Benchmark Benefit Package are administered by the Department in accordance with statutory authority granted under Chapter 2 of *Title 56, Idaho Code*. The Basic Benchmark Benefit Package as described in this *State Plan Amendment* shall constitute the *State Plan for LOW-Income Children and Working-Age Adults* as set forth in section 56-255, *Idaho Code*.

**1.B POLICY GOALS**

*The broad policy goal for provision of the Basic Benchmark Benefit Package for Low-Income Children and Working-Age Adults is to achieve and maintain wellness by emphasizing prevention and proactively managing health.*

Additional specific goals are:

- To emphasize preventive care and wellness;
- To increase participant ability to make good health choices; and
- To strengthen the employer-based health insurance

BASIC PLAN  
(For Low-Income Children and Working-Age Adults)  
BENCHMARK BENEFIT PACKAGE

system.

1.C GEOGRAPHIC CLASSIFICATION

Unless otherwise indicated in the chart below, the benefits in the Basic Benchmark Benefit Package shall be in effect for all geographic and political subdivisions of the State.

B\_e\_n\_e\_f\_i\_t

C\_r\_a\_p\_h\_i\_c Area

1.D SERVICE DELIVERY SYSTEM

Each individual provided the Basic Benchmark Benefit Package is required to enroll in a Primary Care Case Management program, known as "Healthy Connections" under the authority of section 1937 of Social Security Act.

Certain covered individuals with selected chronic diseases may enroll with a Primary Care Case Management (PCCM) provider who receives an enhanced PCCM fee for measured clinical best practices related to chronic disease management. Enhanced PCCM fees are performance-based incentive payments made for individuals with chronic disease as defined in Attachment 3.1-F, Item B.3.

Except as otherwise indicated in the chart below, beneficiaries may obtain the services available under the plan from any institution, agency, pharmacy, or practitioner qualified to perform such services and participating under the plan, including an organization, which provides such services or arranges for their availability on a pre-payment basis.

Primary Care Case Management System
Inpatient Hospital Services Outpatient Hospital Services (excluding Emergency Services) Ambulatory Surgical Center Services Physician Services

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

Other Practitioner Services (excl. Chiropractors and Podiatrists) Laboratory and Radiological (X-Ray) Services Inpatient Psychiatric Services Outpatient Mental Health Services Home Health Care Physical Therapy Respiratory Care Services Prosthetic Devices Medical and Surgical Services furnished by a dentist Rural Health Clinic Services Federally qualified Health Center Services Independent School District Services EPSDT Pregnancy-Related Services
Managed Care Entity/Selective Contracting
Enhanced PCCM for Chronic Conditions Durable Medical Equipment and Supplies Eyeglasses Other Dental Care Transportation Brokerage

**SECTION 2. COVERED POPULATIONS**

**2.A. COVERED INDIVIDUALS**

The Basic Benchmark Benefit Package is available to the groups specified in this Section.

The conditions of eligibility that must be met are specified in this State Plan.

The following groups will be offered opt-in alternative coverage under the Basic Benchmark Benefit Package covered under this State plan.

**2.A.1 AFDC-Related Individuals**

The Basic Benchmark Benefit Package is available for recipients of AFDC. The approved State AFDC plan includes:

- Families with an unemployed parent for the mandatory 6-month period and an optional extension of 6 months.
- Pregnant women with no other eligible children.
- AFDC children age 18 who are full-time students in a

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

secondary school or in the equivalent level of vocational or technical training.

The following groups were included in the AFDC State plan effective July 16, 1996:

- Pregnant women with no other eligible children.
- AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The Basic Benchmark Benefit Package is available for deemed recipients of AFDC. Deemed recipients of AFDC include:

- Individuals denied a Title IV-A cash payment solely because the amount would be less than \$10.
- Effective October 1, 1990, participants in a work supplementation program under Title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.
- Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
- An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.

The Basic Benchmark Benefit Package is available for families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

The Basic Benchmark Benefit Package is available for families denied AFDC solely because of income and resources deemed to be available from:

- Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;
- Grandparents;

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

- Legal guardians; and
- Individual alien sponsors (who are not spouses of the individual or the individual's parent);

The Basic Benchmark Benefit Package is available for families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

The Basic Benchmark Benefit Package is available for families denied AFDC because the family transferred a resource without receiving adequate compensation.

The Basic Benchmark Benefit Package is available for individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. This includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan). This also includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

The Basic Benchmark Benefit Package is available for qualified pregnant women and children. A qualified pregnant woman is an individual whose pregnancy has been medically verified who:

- Would be eligible for an AFDC cash payment if the child had been born and was living with her;
- Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents Program; or
- Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

The Basic Benchmark Benefit Package is available for children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

The Basic Benchmark Benefit Package is available for caretaker relatives and pregnant women who would be eligible for AFOC as specified in 42 CFR 435.230, but who do not receive cash assistance.

The Basic Benchmark Benefit Package is available for individuals under age 18 who, except for age and school attendance, would be recipients of AFOC.

The Basic Benchmark Benefit Package is available for an incapacitated parent required to accept remedial medical treatment who would be eligible for AFOC if coverage under the State's AFOC plan were as broad as allowed under Title IV-A.

The Basic Benchmark Benefit Package is available for low-income families and children under section 1931 of the Act. Section 402(a)(41) and various provisions at 45 CFR 233.101 (a)(1) and (c)(i)(iii) as in effect prior to the implementation of the Temporary Assistance to Needy Families Program: AFOC Unemployed/Underemployed Parent (UP) Requirements to allow the State to eliminate the one hundred (100) hour rule requirement for the primary wage earner in a two-parent household.

The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

2.A.2 Pregnant Women

The Basic Benchmark Benefit Package is available for pregnant women and infants under one (1) year of age with family incomes up to one hundred thirty three percent (133%) of the Federal poverty level who are described in section 1902(a)(10)(A)(i)(IV) and 1902(1) (1)(A) and (B) of the Act.

The Basic Benchmark Benefit Package is available for pregnant women who are determined by a "qualified provider" (as defined in 51920(b)(2) of the Act) or a "qualified entity" (as defined in 51920A(b)(3) of the Act) based on preliminary information, to meet the applicable income criteria and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with 51920 of the Act.

2.A.3 Low-Income Children

The Basic Benchmark Benefit Package is available for children who have attained one (1) year of age but have not attained six (6) years of age, with family incomes at or below one hundred thirty three percent (133%) of the

BASIC PLAN  
(For Low-Income Children and Working-Age Adults)  
BENCHMARK BENEFIT PACKAGE

Federal poverty levels.

The Basic Benchmark Benefit Package is available for children who have attained six (6) years of age but have not attained nineteen (19) years of age, with family incomes at or below one hundred percent (100%) of the Federal poverty levels.

The Basic Benchmark Benefit Package is available for a child born in the United States to a woman who was eligible for and receiving Medicaid (including coverage of an alien for labor and delivery as emergency medical services) for the date of the child's birth, including retroactively. The child is deemed eligible for one (1) year from birth.

The Basic Benchmark Benefit Package is available for children who would not be eligible for Medicaid under the policies in the State's Medicaid Plan as in effect on April 15, 1997 (other than because of the age expansion provided for in section 1902(1)(2)(0)) and have family income at or below one hundred fifty percent (150%) of the federal poverty level. Medical assistance for these children is provided under the State Children's Health Insurance Program authorized under Title XXI of the Social Security Act, implemented in October 1997 as expanded benefits under the State's Medicaid Plan.

2.B GENERAL CONDITIONS OF ELIGIBILITY

Each individual provided Medical Assistance under this State plan must meet the conditions of eligibility described in this section.

Each individual provided Medical Assistance under this State Plan must meet the applicable non-financial eligibility conditions.

2.0 APPLICATION PROCEDURES

The Department meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medical Assistance.

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 available benefit options. The Department will inform each individual in a covered population that enrollment in the Basic Benchmark Benefit Package is voluntary (i.e. participants may opt-in), and that such individuals may opt-out

7/20/09

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

of the Basic 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.

To ensure that children are provided with the benefit package that will lead most directly to desired health outcomes, and to ensure that these benefits represent the most effective and efficient use of scarce health resources, Idaho Medicaid will incorporate a health risk assessment into Idaho's eligibility determination process and primary care case management (PCCM) program, Healthy Connections.

Applicants for medical assistance will complete an accompanying health questionnaire designed to assess general health status and health behaviors. The questionnaire will also serve as a screening tool to determine whether the applicant has special health needs. The Department will also assess whether the applicant requires special education services or is enrolled in Idaho's Children's Special Health Program, Infant and Toddler Program, Children's Mental Health Program or Adult Mental Health Program.

Eligibility for Idaho's Children's Mental Health Program requires a diagnosis of "serious emotional disturbance (SED). SED in children is defined in Idaho Code 16-2403(13), and further defined in Department rules. Eligibility for Idaho's Adult Mental Health Program requires a "serious and persistent mental illness" (SPMI). SPMI in adults is defined in Department rules.

Children with special health needs will be enrolled in the Enhanced Benchmark Benefit Package. Individuals without such needs will be enrolled in the Basic Benchmark Benefit Package. In addition, the questionnaire will determine whether the applicant is currently under treatment by a physician or has a medical home. If not, the applicant will receive information about Healthy Connections providers and will be asked to select a primary care provider as part of the eligibility determination process.

Failure to complete a health questionnaire will not prohibit an applicant from being determined eligible for medical assistance. However, without a completed health questionnaire, children cannot be immediately provided with

BASIC PLAN  
(For Low-Income Children and Working-Age Adults)  
BENCHMARK BENEFIT PACKAGE

the Enhanced Benchmark Benefit Package.

Subsequent to selection of a Healthy Connections provider, the participant will visit a physician for a comprehensive exam and health education. This assessment will comply with federal requirements for EPSDT for children. If the health risk assessment indicates a previously unknown special health *need*, the participant will be provided with the Enhanced Benchmark Benefit Package. The health risk assessment process will therefore act as both a component of eligibility determination and a safeguard to ensure that benefits address beneficiary health needs by providing access to *needed* services available under the appropriate benefit package.

**SECTION 3. COVERED SERVICES**

3.A GENERAL PROVISIONS

Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, except for Nursing Facility in section 1905(a)(4)(A), is provided as defined in 42 CFR Part 440, Subpart A. For EPSDT services in section 1905(a)(4)(B), the provisions of section 1905(r) and 42 CFR Part 441, Subpart B are met by providing for Medical Assistance to any eligible child under the State plan through the most appropriate benefit options. If a child is eligible for services under EPSDT not covered in the Basic Benchmark Benefit Package, that child will be deemed to have a special health need and be permitted to receive services (Without regard to amount, scope and duration limitations) under an Enhanced Benchmark Benefit Package.

3.B HOSPITAL SERVICES

3.B.1 Inpatient Services

The Basic Benchmark Benefit Package includes Inpatient Hospital Services permitted under sections 1905(a)(1) and 2110(a)(1) of the Social Security Act. These services include semi-private room, intensive and coronary care units, general nursing, drugs, oxygen, blood transfusions, laboratory, imaging service, physical, speech, occupational, heat and inhalation therapy; operating, recovery, birthing, and delivery rooms, routine and intensive care for newborns and other medically necessary benefits and prescribed supplies for treatment of injury or illness are covered;

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

No limitation is placed on the number of inpatient hospital days. However, such inpatient services must be Medically necessary as determined by the Department or its authorized agent.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Inpatient hospital services do not include those services provided in an institution for mental diseases.

Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Payment is limited to semi-private room accommodations unless private accommodations are medically necessary and ordered by the physician.

Excluded Services. The following services are excluded from the Basic Benchmark Benefit Package covered under the State plan.

Elective medical and surgical treatments, except family planning services and medically necessary cosmetic surgery, are excluded from Medicaid payment unless prior approved by the Department or its authorized agent. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program are excluded from Medicaid payment.

Acupuncture, bio-feedback therapy, and laetrile therapy are excluded from Medicaid payment.

Procedures, counseling, and testing for the inducement of fertility are excluded from Medicaid payment.

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

Surgical procedures for the treatment of morbid obesity and panniculectomies are excluded unless prior approved by the Department or its authorized agent.

**3.B.2 Outpatient Services**

The Basic Benchmark Benefit Package includes Outpatient Hospital Services permitted under sections 1905(a)(2) and 2110(a)(2) of the Social Security Act. These services include all benefits described in the inpatient hospital section which are provided on an outpatient basis in a hospital (including, but not limited to, observation beds and partial hospitalization benefits) or ambulatory surgical center; chemotherapy; emergency room benefits for surgery, injury or medical emergency, therapy services; and other services for diagnostic or outpatient treatment of a medical condition, injury or illness are covered.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Limitations. The following service limitations apply to The Basic Benchmark Benefit Package covered under the State plan.

Psychotherapy services are limited to forty-five (45) hours per participant per calendar year.

Psychological evaluation, speech and hearing evaluations, physical therapy evaluation occupational therapy evaluation, and diagnostic services are limited to twelve (12) hours for each eligible participant per calendar year. Services may be provided by:

1. A psychiatrist; or a physician licensed by the Board of Medicine or;
2. Other licensed professionals in accordance with 42 CFR 440.60(a) including:
  - a. Psychologist licensed by the Board of Psychologist Examiners.
  - b. Clinical Social Worker licensed by Board of Social Work Examiners.
  - c. Clinical Professional Counselor licensed by the Professional Counselors and Marriage and Family Therapists Licensing Board
  - d. Marriage and Family Therapist licensed by the Professional Counselors and Marriage and Family Therapists Licensing Board
  - e. Certified psychiatric nurse, Clinical Nurse Specialist or Psychiatric Nurse Practitioner licensed by the Board of Nursing and, at a minimum, have a master's degree.
  - f. Licensed Professional Counselor whose provision of psychotherapy is supervised by one of those listed in 1 and 2(a-f) above and who is licensed by the Professional Counselors and Marriage and Family Therapists Licensing Board.
  - g. Licensed Masters Social Worker whose provision of psychotherapy is supervised by one of those listed in 1 and 2(a-f) above and who is licensed by the board of Social Work Examiners.
  - h. A Psychologist Extender, registered with the Professional Counselors and Marriage and Family Therapists Licensing Board and who is supervised by a Licensed Psychologist.

Diabetic education and training services are limited to twenty-four (24) hours of group counseling and twelve (12) hours of individual counseling through a diabetic education program or by a certified diabetic educator recognized by the American Diabetes Association.

Limitations for Occupational therapy, physical therapy, and speech-language pathology services are listed in Section 3.M, Therapy Services.

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

**3.B.3 Emergency Services**

The Basic Benchmark Benefit Package includes Emergency Hospital Services provided when necessary to prevent death or serious impairment of health and when conditions dictate use of the most accessible hospital available, even if the hospital does not currently meet the conditions for participation under Medicare or the definitions of inpatient or outpatient hospital services included elsewhere in this State plan. All obstetrical deliveries provided to aliens per Section 1903 (v) (3) of the Act.

BASIC PLAN  
(For Low-Income Children and Working-Age Adults)  
BENCHMARK BENEFIT PACKAGE

are designated as emergency services.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Emergency room services are limited to six (6) visits per calendar year. Those services, however, which are followed immediately by admission on an inpatient status will be excluded from the above limitation.

The limit of six (6) emergency room visits will be waived for EPSDT recipients.

3.C. AMBULATORY SURIGCAL CENTER SERVICES

The Basic Benchmark Benefit Package includes Ambulatory Surgical Center Services in addition to services covered as Inpatient and Outpatient Hospital and Physician benefits permitted under sections 1905(a)(9), and 2110(a)(4) of the Social Security Act, including services provided under section 1905(a)(9).

Ambulatory surgical center services are outlined in applicable Department rules and must be prOvided in a facility certified by Medicare as an ASC, and are restricted to those procedures identified by the Medicare program in accordance with 42 CFR 416.65, or identified by the Department as meeting such requirements.

3.0 PHYSICIAN SERVICES

3.0.1 Medical Services

The Basic Benchmark Benefit Package includes Physician Services permitted under sections 1905(a)(5) and 2110(a)(4) of the Social Security Act. These services include office, clinic, outpatient surgery center and hospital treatment by a physician for a medical condition, injury or illness. Physician services are covered whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

The Basic Benchmark Benefit Package includes treatment of medical and surgical conditions by doctors of medicine or

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in applicable Department rules. Medically appropriate second opinions are covered.

Limitations. Limits on psychiatric evaluations and psychotherapy in any twelve (12) month period for Outpatient Mental Health Services shall not apply when such services are provided as Physician Services.

3.0.2 Surgical Services

Surgical Services. The Basic Benchmark Benefit Package includes professional services rendered by a physician, surgeon or doctor of dental surgery.

Abortion Services. A legal abortion is only covered to save the life of the mother or in cases of rape or incest as determined by the courts.

When a pregnancy is life threatening and abortion is provided to save the life of the mother, one licensed physician or osteopath must certify in writing that the woman may die if the fetus is carried to term.

Cases of rape or incest must be determined by a court or documented by a report to law enforcement, except that if the rape or incest was not reported to law enforcement, a licensed physician or osteopath must certify in writing that, in his/her professional opinion, the woman was unable to report the rape or incest to law enforcement for reasons related to her health.

Excluded Services. The following services are excluded from the Basic Benchmark Benefit Package covered under the State plan.

Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21) are excluded from Medicaid payment.

3.E OTHER PRACTITIONER SERVICES

The Basic Benchmark Benefit Package includes Other Practitioner Services specified in sections 1905(a)(6) and 2110(a)(24) of the Social Security Act. These services include medical care and any other type of remedial care recognized

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

**Certified Pediatric or Family Nurse Practitioners' Services.** Certified pediatric or family nurse practitioners' services are those services provided by certified pediatric or family nurse practitioners as *defined* by state and federal law. This coverage has the same exclusions as Physician Services. This coverage specifically includes services by certified pediatric and family nurse practitioners as required by Section 1905(a)(21) of the Act. Services provided by nurse practitioners are limited to Section 54-1402(d) of Idaho Code.

**Physician Assistant Services.** Physician assistant services include those services provided by a physician assistant as defined by state and federal law. This coverage has the same exclusions as Physician Services.

Services provided by physician assistants are limited to Section 54-1803(11) of the Idaho Code.

**Chiropractor Services.** Chiropractic *services are* limited for payment to a total of twenty-four (24) *office* visits during any calendar *year*. The remedial treatment must involve the manipulation of the spine to correct a subluxation condition.

**Podiatrist Services.** Podiatrist Services are limited to treatment of acute foot conditions.

**Optometrist Services.** Optometrist services are limited to providing eye examination and eyeglasses covered under this State Plan unless the optometrist has been issued and maintains certification under the provisions of *Idaho Code* to diagnose and treat injury or diseases of the eye. In these circumstances, payment will be made for diagnosis and treatment services.

**Nurse-Midwife Services.** Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

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**BASIC PLAN**  
(For Low-Income Children and Working-Age Adults)  
**BENCHMARK BENEFIT PACKAGE**

Certified nurse-midwife services are those services provided by certified nurse midwives as defined by state and federal law. This coverage has the same exclusions as Physician Services.

**3.F PRIMARY CARE CASE MANAGEMENT**

The Basic Benchmark Benefit Package includes Primary Care Case Management Services permitted under in sections 1905(a)(2S) and 2110(a)(21) of the Social Security Act. These services are provided by a primary care case manager consistent Section 1937 of the Social Security Act. Participants who opt into the Basic Benchmark Plan must enroll with a PCCM.

**3.G PREVENTION SERVICES**

The Basic Benchmark Benefit Package includes Prevention Services permitted under sections 1905(a)(3), 1905(a)(S), 1905(a)(6), 1905(a)(9), 1905(a)(13), 1905(a)(28), 2110(a)(3), 2110(a)(S), 2100(a)(8), 2100(a)(24) and 2110(a)(28) of the Social Security Act.

Health Risk Assessments. The Basic Benchmark Benefit Package includes a Health Risk Assessment which consists of:

- An initial health questionnaire, and
- A well child screen, or
- An adult physical.

The health questionnaire is designed to assess the general health status and health behaviors of a recipient. This information will be used to provide customized health education. The health questionnaire will be administered at initial program entry and periodic intervals thereafter.

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

**3.G.1 Well Child Screens.**

The Basic Benchmark Benefit Package includes periodic medical screens completed at intervals recommended by the AAP, Committee in Practice and Ambulatory Medicine. Physicians and physician extenders will be required to bill using the appropriate Physician's Current Procedural Terminology (CPT) codes, under section "Preventive Medicine Services".

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

EPSDT RN screeners will be required to bill using codes established by the Department, except when the EPSDT RN screener is an employee of a rural health clinic, Indian Health Clinic, or federally qualified health clinic.

One screen at initial program entry, up to the recipient's twenty-first birthday. The initial screen at program entry should constitute a health risk assessment as specified in applicable Department rules.

One (1) screen at or by age:

- one (1) month,
- two (2) months,
- three (3) months,
- four (4) months,
- six (6) months, and
- nine (9) months.

One (1) screen at or by age:

- twelve (12) months,
- fifteen (15) months,
- eighteen (18) months, and
- twenty-four (24) months.

One (1) screen at or by age:

- three (3) years,
- four (4) years, and
- five (5) years.

One (1) screen at or by age:

- six (6) years,
- eight (8) years,
- ten (10) years,
- twelve (12) years, and
- fourteen (14) years.

One screen at or by age:

- sixteen (16) years,
- eighteen (18) years, and
- twenty (20) years.

Periodic screens and Interperiodic screens should constitute a health risk assessment as specified in applicable Department rules. Interperiodic medical screens are screens that are done at intervals other than those identified in the basic medical periodicity schedule above, and must be performed by physician or physician extender. Interperiodic screens will be required to be billed using the correct Physician's Current Procedural Terminology (CPT) under section "Evaluation and Management". Interperiodic screens will be performed when

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. Interperiodic screening examinations may occur in children who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary.

Developmental screening is considered part of every routine initial and periodic examination. If the screening identifies a developmental problem then a developmental assessment will be ordered by the physician and conducted by qualified professionals. EPSDT RN screeners will routinely refer all clients to primary care providers. EPSDT clients ages two (2) weeks to two (2) years shall receive at least one (1) of their periodic or inter-periodic screens annually from a physician or physician extender unless otherwise medically indicated. A parent or guardian may choose to waive this requirement. EPSDT RN screeners will refer clients for further evaluation, diagnosis and treatment to appropriate services (e.g. physician, registered dietitian, developmental evaluation, speech, hearing and vision evaluation, blood lead level evaluation). Efforts shall be made to assure that routine screening will not be duplicated for children receiving routine medical care by a physician.

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EPSDT Registered Nurse Screener. A licensed professional nurse (RN) who is currently licensed to practice in Idaho, and who meets the following provisions:

- Has completed a Child Assessment training course (or equivalent as approved by the Department) that prepares the RN to identify the difference between screening, diagnosis, and treatment; and prepares the RN to appropriately screen and differentiate between normal and abnormal findings. Training must include at least five (5) days didactic instruction in child health assessment, accompanied by a component of supervised clinical practice; and
- Is employed by a physician, district health department, rural health clinic, Indian Health Clinic, or federally qualified health clinic in order to provide linkage to primary care services. The employers must have a signed Medical Provider Agreement and possess an active Provider Number; or
- Has established and maintains an agreement with a physician or nurse practitioner for consultation on an

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

as-needed basis.

3.G.3 Adult Physicals

The Basic Benchmark Benefit Package includes an annual preventive health visit consisting of procedures recommended by the US Prevention Services Task Force Guide to Clinical Preventive Services. Physicians and physician extenders will be required to bill using the appropriate Physician's Current Procedural Terminology (CPT) codes, under section "Preventive Medicine Services".

3.G.4 Screening Services

**Mammography Services.** The Basic Benchmark Benefit Package screening mammographies performed with certified mammography equipment and staff. Screening mammographies will be limited to one (1) per calendar year for women who are forty (40) or more years of age.

**Diagnostic Screening Clinics.** The Basic Benchmark Benefit Package includes services provided in a diagnostic screening clinic are outlined in applicable Department rules.

**Limitations.** Service limitations are as follows: five (5) hours of medical social services per eligible recipient per state fiscal year is the maximum allowable. Limit of no more than five (5) hours of medical social services per recipient in each state fiscal year will be waived for EPSDT recipients.

3.G.5 Prevention and Health Assistance Benefits

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

Enhanced PHA Benefits are individualized benefits to address targeted health behaviors. Authorizations will be managed by the State Medicaid agency.

PHA benefits made available under the Basic Benchmark Benefit Package will be targeted to individuals who:

- Use tobacco, or
- Are obese.

PHA benefits will be available when individuals complete specified activities in preparation for addressing the targeted

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

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 tobacco cessation and weight reduction/management in accordance with applicable Department rules. These goods and services may include nicotine patches or gum, weight-loss programs, dietary supplements, and other health related benefits.

3.G.6 Nutrition Services

The Basic Benchmark Benefit Package includes intensive nutritional education, counseling, and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetics Association to assure the patient's proper nutrition is allowed. Payment is made at a rate established in accordance with applicable Department rules. Nutrition services must be discovered by the screening services and ordered by the physician; must be medically necessary; and, if over two (2) visits per year are needed, must be authorized by the Department prior to the delivery of additional visits.

limitations. Nutrition services related to obesity, including dietary assessment and individualized nutrition education, shall not be subject to the above limitations when provided as PHA benefits.

Nutrition services in the Basic Benchmark Benefit Package include Diabetes Education and Training Clinics which provide diabetic education and training services outlined in applicable Department rules. Outpatient diabetes education and training services will be covered under the following conditions.

The education and training services are provided through a diabetic management program recognized as meeting the program standards of the American Diabetes Association.

The education and training services are provided through a formal program conducted through a hospital outpatient department or a physician's office by a Certified Diabetic Educator certified by the American Diabetes Association.

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

Only training and education services which are reasonable and necessary for treatment of a current injury or illness will be covered. Covered professional and educational services will address each client's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications.

To receive diabetic counseling, the following conditions apply to each patient:

- the patient must have a written order by his or her primary care physician or physician extender referring the patient to the program; and
- the physician may not use the formally structured program or a Certified Diabetes Educator as a substitute for basic diabetic care and instruction that the physician must furnish to the patient which includes the disease process/pathophysiology of diabetes mellitus and dosage administration of oral hypoglycemic agents.

The medical necessity for diabetic education and training are evidenced by the following:

- a recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetic education; or,
- uncontrolled diabetes manifested by two or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to manifestations, or
- recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or non-healing wounds.
- 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.

Limitations. Diabetes education related to obesity shall not be subject to the above limitations when provided as PHA benefits.

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

**3.H LABORATORY AND RADIOLOGICAL SERVICES**

The Basic Benchmark Benefit Package includes Laboratory and Radiological Services permitted under sections 1905(a)(3) and 2110(a)(8) of the Social Security Act. These services include imaging and laboratory services for diagnostic and therapeutic purposes due to accident, illness or medical condition, as well as X-ray, radium or radioactive isotope therapy.

Laboratory and x-ray services are provided upon and under the direction of a physician or other licensed practitioner.

**Excluded Services.** The following services are excluded from the Basic Benchmark Benefit Package covered under the State plan.

Laboratory and/or x-ray procedures which are associated with excluded Hospital Services and Physician Services are excluded from payment.

**3.1 PRESCRIBED DRUGS**

The Basic Benchmark Benefit Package includes Prescribed Drugs permitted under sections 1905(a)(12), 2110(6) and 2110(a)(7) of the Social Security Act. These services include drugs prescribed by a practitioner acting within the scope of his practice, chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines and prenatal vitamins.

Prescribed drugs are provided for non-institutionalized persons as well as institutionalized patients. Prescriptions for oral contraceptives and diaphragms for women of child bearing age are also eligible for payment. AU drug products requiring, by state or federal law, a licensed practitioner's order for dispensing or administration which are medically necessary are purchasable except for (1) those specifically excluded as ineffective or inappropriate by the Department of Health and Welfare policy, or (2) those drugs not eligible for federal participation. A prescription drug is considered medically necessary for a client if it is reasonably calculated to prevent or treat conditions in the client that endanger life, cause pain or functionally significant deformity or malfunction; and there is no other therapeutically interchangeable prescription drug available or suitable for the client requesting the service which is more conservative or substantially less costly; and the prescription drug meets professionally recognized standards of health care and is substantiated by prescriber's records

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

including evidence of such medical necessity. Those records shall be made available to the Department upon request. The criteria used to determine medical necessity is stated in applicable Department rules.

Additional Covered Drug Products. Additional drug products will be covered as follows:

- Therapeutic Vitamins;
- Injectable Vitamin 812 (cyanocobalamin and analogues);
- Vitamin K and analogues;
- Pediatric vitamin-fluoride preparations;
- Legend prenatal vitamins for pregnant or lactating **women**;
- Legend folic acid;
- Oral legend drugs containing folic acid in combination with Vitamin 812 and/or iron salts, without additional ingredients; and
- Legend Vitamin D and analogues.

Prescriptions for non-legend products will be covered as follows:

- Insulin;
- Disposable insulin syringes and needles;
- Oral iron salts; and
- Permethrin; and
- Federal legend medications that change to non-legend status, as well as their therapeutic equivalents, based on Director approval which is determined by appropriate criteria including safety, effectiveness,

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

clinical outcomes, and the recommendation of the P&T committee.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan. Prior authorization will be required for certain drugs and classes of drugs. The Department utilizes the Idaho State University School of Pharmacy for literature, research, and the state Drug Utilization Review (DUR) Board, and Medicaid's Medical Director and staff pharmacists within the Division of Medicaid, as the Prior Authorization committee. 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. Prescribing physicians, pharmacists, and/or designated representatives may contact the Medicaid Pharmacy Unit for prior authorizations via 1-800 phone and fax lines, or by mail. Responses are issued within 24 hours of the request. Pharmacies are authorized to dispense a 72 hour supply of a prior authorized product in the event of an emergency. The program complies with requirements set forth in section 1927 (d) (5) of the Social Security Act pertaining to prior authorization programs. The following drugs require prior authorization:

- Amphetamines and related CNS stimulants;
- Growth hormones;
- Retinoids;
- Brand name drugs when acceptable generic form is available;
- Medications otherwise covered by the Department for which there is a less costly, therapeutically interchangeable medication covered by the Department;
- Medications prescribed in quantities which exceed the Food and Drug Administration (FDA) dosage guidelines;
- Medications prescribed outside of the FDA approved indications;
- Lipase inhibitors; and
- FDA, 1-A rated single source and innovator multi-source drugs manufactured by companies not participating in the National Rebate Agreement, which have been

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

determined by the Department to be medically necessary.

Non-covered Drugs must be discovered as being medically necessary by the screening services for individuals under twenty-one (21) years of age qualifying under EPSDT; and must be ordered by the physician and must be authorized by the Department or its authorized agent prior to purchase of the drug.

Limitation of Quantities. The Basic Benchmark Benefit Package has a limitation that no more than a thirty-four (34) day supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription. To provide enhanced control over this limitation, the Point of Sale (POS) system has added an early refill edit to identify medication refills provided before at least seventy five percent of the estimated days supply has been utilized. This edit can be overridden by the pharmacy if a change in dosage is ordered. The edit is designed to prevent waste and abuse by preventing unnecessary refills, and identify clients who may be accessing multiple physicians and pharmacies and stockpiling medications. The following medications are the only exceptions to the 34 day supply limitation.

Up to one hundred (100) unit doses or a 100 day supply, whichever is less, of the following medications may be purchased:

- Cardiac glycosides;
  
- Thyroid replacement hormones;
  
- Prenatal vitamins;
  
- Nitroglycerin sublingual and dermal patch products;
  
- Fluoride and vitamin fluoride combination products; and
  
- Nonlegend oral iron salts.

Oral contraceptive products may be purchased in a quantity sufficient for one (1), two (2), or three (3) cycles.

Excluded Drug Products. The following categories and specific

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

products are excluded:

- Legend drugs for which Federal Financial Participation is not available
- Nonprescription items (without the Federal Legend), except permethrin, oral iron salts, disposable insulin syringes and needles.
- Ovulation stimulants and fertility enhancing drugs.
- Medications used for cosmetic purposes.
- Prescription vitamins except injectable B12, vitamin K, legend vitamin D, legend pediatric vitamin and fluoride preparations, legend prenatal vitamins for pregnant or lactating women, and legend folic acid.

Nicotine cessation products, diet supplements and weight loss products are excluded unless provided as PHA benefits.

**3.J FAMILY PLANNING SERVICES**

The Basic Benchmark Benefit Package includes Family Planning Services permitted under sections 1905(a)(4)(C) and 2110(a)(9) of the Social Security Act. These services include pre-pregnancy family planning services and prescribed supplies are covered including birth control contraceptives.

Family planning services and supplies for individuals of child-bearing age include counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. The Basic Benchmark Benefit Package covers diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization.

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

All requirements of 42 CFR Part 441, Subpart F are met.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

BASIC PLAN  
(For Low-Income Children and Working-Age Adults)  
BENCHMARK BENEFIT PACKAGE

Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply.

Sterilization procedures are limited to persons who are at least twenty-one (21) years of **age** or older at the time of **signing** the informed consent form. A person over the **age** of 21 that is incapable of **giving** informed consent will be ineligible to receive Medicaid payment for the sterilization. The person must voluntarily **sign** the informed consent form at least thirty (30) days, but not more than 180 days, prior to the sterilization procedure. Sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ineligible unless ordered by the court of law. Hysterectomies performed solely for sterilization are ineligible for Medicaid payment.

### 3.K MENTAL HEALTH SERVICES

#### 3.K.1 Inpatient Psychiatric Services

In addition to Psychiatric Services covered under Inpatient Hospital Services, the Basic Benchmark Benefit Package Medical Assistance includes services for Certain Individuals in Institutions for Mental Diseases permitted under sections 1905(a)(14) of the Social Security Act.

Inpatient psychiatric facility services for individuals under 22 years of **age** include services provided which meet medical necessity criteria determined by the Department or its authorized agent and provided in a JCAHO accredited hospital.

Limitations. Inpatient mental health services, including Psychiatric Services covered under Inpatient Hospital Services, are limited to ten (10) days per calendar year.

#### 3.K.2 Outpatient Mental Health Services

Mental Health Clinics. MH Clinic services are services that evaluate the need for and provide preventative, therapeutic, rehabilitative treatment to minimize psychiatric symptoms and enhance independent functioning. These services include:

- Evaluation and diagnostics
- Psychotherapy
- Pharmacological management
- Partial care
- Nursing
- Collateral Contact
- Occupational therapy

These services must be furnished by or under the direction of a physician.

**BASIC PLAN  
(For Low-Income Children and Working-Age Adults)  
BENCHMARK BENEFIT PACKAGE**

Provider Qualifications. MH Clinic Services can be provided by Clinics that are under the direction of a physician. Licensed, qualified professionals providing Outpatient Mental Health services must have at a minimum, one of the following qualifications:

- Psychiatrist
- Physician or practitioner of the Healing Arts
- Psychologist or psychologist extender
- Social Worker (Masters, Clinical, Licensed)
- Counselor (Clinical Professional, Professional)
- Marriage and Family Therapist (Associate Marriage and Family Therapist)
- Certified Psychiatric Nurse
- Professional Nurse (RN)
- Occupational Therapist

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan. Mental Health Clinic services are limited to twenty-six (26) services per calendar year including:

Psychotherapy Services. Limited to twenty-four (24) visits per calendar year.

Evaluation and Diagnostic Services. Limited to twelve (12) hours per calendar year in any combination of evaluative or diagnostic services and treatment plan development.

Excluded Services. The following MH Clinic services are excluded from the Basic Benchmark Benefit Package covered under the State Plan.

- Partial care
- Psychosocial rehabilitation

### 3.L HOME HEALTH CARE

The Basic Benchmark Benefit Package includes Home Health Care Services permitted under sections 1905(a)(7) and 1905(a)(8), of the Social Security Act.

The Basic Benchmark Benefit Package includes Home Health Services permitted under sections 1905(a)(7), of the Social Security Act.

These services include intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Services also include home health aide services provided by a home health agency.

Home health services are prOvided in accordance with the requirements of **42 CFR 441.15**.

BASIC PLAN  
(For Low-Income Children and Working-Age Adults)  
BENCHMARK BENEFIT PACKAGE

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Services by a licensed nurse, when no home health agency exists in the area, must be prior approved by the Department as defined in 42 CFR 440.70(b)(l).

Home health visits are limited to one hundred (100) per participant per calendar year provided by any combination of home health agency licensed nurse, home health aide, home health physical therapist, home health occupational therapist, home health speech-language pathologist or licensed nurse.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive in excess of these limited visits per calendar year when the services are prior authorized by the Department.

### 3.M THERAPY SERVICES

The Basic Benchmark Benefit Package includes Therapy Services permitted under sections 1905(a)(11), 1905(a)(13) and 2110(a)(22) of the Social Security Act. These services include physical therapy, occupational therapy, and speech-language pathology services provided by a home health agency, independent therapy provider, hospital outpatient facility, or medical rehabilitation facility.

Therapy services by an independent provider may be furnished by the following providers:

- Physical therapist who in accordance with 42 CFR 440.11 O(a) is licensed by the PT Licensing Board within the Board of Occupational Licensing.
- Occupational Therapist who in accordance with 42 CFR 440.11 O(b) is licensed by the Board of Medicine.
- Speech-Language Pathologist who in accordance with 42 CFR 440.11 O(c), is licensed by the Speech and Hearing Services Licensure Board within the Board of Occupational Licensing.

All therapy services are provided according to a written physician order as a part of a plan of care, and are provided either in the patient's home or in the therapist's office. An office in a nursing home or hospital is not considered an independent therapist's office.

Respiratory care services may be furnished to Individuals under twenty-one (21) years of age qualifying under EPSDT.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Unless additional services are prior authorized, participants are limited to:

- Twenty-five (25) physical therapy visits per calendar year
- Twenty-five (25) occupational therapy visits per calendar year
- Forty (40) speech-language pathology visits per calendar year

Included in this limitation are outpatient hospital facilities, independent

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

providers, outpatient rehabilitation facilities, and developmental disability agencies.

- Home health agency visits by home health aides, nursing services, physical therapists, occupational therapists, and speech-language pathologists in any combination are limited to a total of one-hundred (100) visits per participant per calendar year.

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

**3.N AUDIOLOGY SERVICES**

The Basic Benchmark Benefit Package Audiology Services permitted under sections 1905(a)(6) and 2110(a)(24) of the Social Security Act. These services include services for individuals with hearing disorders provided by an audiologist who is licensed by the Speech and Hearing Services Licensure Board in accordance with {42 CFR 440.11 O(c)}.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive services in addition to those listed in this section (3.N), Audiology services, if those services are determined to be medically necessary and prior authorized by the Department.

Audiology Services include audiometric services and supplies according to applicable Department rules. The Department will provide hearing screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate hearing screen. The guidelines coincide with certain scheduled medical screens; the hearing screen is considered part of the medical screening service.

Hearing Aids. Hearing aids and related services will be covered by the Department.

Augmentative Communication Devices. Augmentative communication devices are covered as specified in applicable Department rules.

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

- The Department will pay for one audiometric examination and testing related to the exam each calendar year when ordered by a physician and provided by a certified audiologist and/or licensed physician. Any hearing test beyond the basic comprehensive audiometry and independent testing must be ordered in writing before the testing is done.
- The Department will purchase one (1) hearing aid per participant with prior approval of the Department. Follow up services are

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

included in the purchase of the hearing aid for the first year. Necessary repairs resulting from normal use after the second year will be covered. Hearing aid batteries will be purchased on a monthly basis. Refitting of hearing aid or additional ear molds will be purchased no more often than forty-eight (48) months from the last fitting.

Individuals under twenty-one (21) years of age qualifying under EPSDT, may receive audiology services and supplies ordered by a licensed physician and supplied by a physician or certified audiologist, with the following exceptions:

- When binaural aids are requested they will be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted; or
- Replacement hearing aids may be authorized if the requirements in applicable Department rules are met.

The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist.

**3.0 MEDICAL EQUIPMENT, SUPPLIES AND DEVICES**

**3.0.1 Medical Equipment and Supplies**

The Basic Benchmark Benefit Package includes Medical Equipment and Supplies permitted under sections 1905(a)(28), 2110(a)(12) and 2110(a)(13) of the Social Security Act. These services include durable medical equipment and other medically-related or remedial devices. These also include medical supplies, equipment, and appliances suitable for use in the home.

Medical equipment and medical supplies must be ordered in writing by a physician. Medical equipment and supplies are provided only on a written order from a physician that includes the medical necessity documentation listed in the Medicare DMERC Supplier manual.

The Department requires recipients to obtain certain services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.

limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State Plan.

Items not specifically listed in applicable Department rules will require prior authorization by the Department or its authorized agent.

**3.0.2 Specialized Medical Equipment and Supplies**

The Basic Benchmark Benefit Package includes Specialized Medical Equipment and Supplies permitted under sections 1905(a)(4)(B) or 1915(c)(4)(B) of the Social Security Act.

Oxygen and related equipment is covered for Individuals under twenty-one (21) years of age qualifying under EPSDT, when the medical need is discovered during a screening service and is physician ordered. PRN oxygen, or oxygen as needed on less than a continual basis, will be authorized for six (6) months following receipt if medical documentation from the attending physician as to an acute or chronic medical condition which requires oxygen support to maintain respiratory status. Medical documentation will include a diagnosis, oxygen flow rate and concentration, and an estimate of the frequency and duration of use. Portable oxygen systems may be ordered to compliment a stationary system if the recipient is respirator dependent, or the attending physician documents the need for a portable oxygen system for use in transportation. Laboratory evidence for hypoxemia is not required under the age of six (6) months.

**3.0.3 Prosthetic Devices**

The Basic Benchmark Benefit Package includes Prosthetic Devices permitted under sections 1905(a)(6), 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include prosthetic and orthotic devices and related services prescribed by a physician and fitted by an individual who is certified or registered by the American Board for Certification in orthotics and/or prosthetics.

The Department will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body.

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Prosthetic and orthotic devices and services will be purchased only if pre-authorized by the Department or its authorized agent. Limit of one refitting, repair or additional parts in a calendar year.

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.

**3.P VISION SERVICES**

The Basic Benchmark Benefit Package includes Vision Services permitted under sections 1905(a)(5), 1905(a)(6), 1905(a)(12) and 2110(a)(24) of the Social Security Act. These services include eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

Vision Screening. The Department will provide vision-screening services according to the recommended guidelines of the American Academy of Pediatrics. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain scheduled medical screens; the vision is considered part of the medical screening service, (Le. eye chart).

The Department will pay for the following vision services and supplies.

- **Eye Examination.** The Department will pay for one (1) eye examination by an ophthalmologist or optometrist during any twelve (12) month period for each eligible participant to determine the need for glasses to correct or treat refractive error. The participant may receive more frequent eye examinations if:
  - o The participant experiences a significant vision change.
  - o There is a medically necessary reason for the exam such as a foreign body in the eye, redness, etc.
- **Eyeglasses.** Eligible participants who have been diagnosed with a visual defect and who need eyeglasses for correction of a refractive error, can receive one (1) pair of single vision or bifocal eyeglasses every four (4) years. Frames or lenses may be provided more frequently when:
  - o There is a major visual change of plus or minus one-half (0.5) diopter of correction, replacement lenses will be provided.
  - o There has been a major change in visual acuity documented by the physician and/or optometrist; and the necessary new lenses cannot be accommodated in the participant's existing frames, new frames will be provided.

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.

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

- e Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of extreme medical conditions as determined by the Department.
- Contact lenses will be covered only when there is documentation showing that the participant has an extreme condition precluding the use of conventional lenses including:
  - o An extreme myopic condition requiring a correction equal to or greater than plus or minus ten ( 10) diopters,
  - o Cataract surgery,
  - o Keratoconus,
  - o Anisometropia, or
  - o Other extreme medical condition precluding the use of conventional lenses.
- Broken, lost, or missing glasses will not be repaired or replaced by the Department for individuals over the age of twenty (20).

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.

Selective Contract. The Department requires recipients to obtain eyeglasses only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services

The State assures it will comply with 42CFR 431.54 as it relates to this fee-for-service selective contracting system.

### 3.Q DENTAL SERVICES

#### 3.Q.1 Medical and Surgical Services

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.

The Basic Benchmark Benefit Package includes Medical and Surgical Services furnished by a dentist permitted under sections 1905(a)(5)(B), and 2110(a)(17) of the Social Security Act (in accordance with section 1905(a)(5)(B) of the Act) are covered for treatment of medical and surgical dental conditions when furnished by a licensed dentist subject to the

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

limitations of practice imposed by state law, and according to applicable Department rules.

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

Limitations. The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Elective medical and surgical dental services are excluded from payment unless prior approved by the Department or its authorized agent.

The following limitations apply to dentures under the Basic Plan:

- Dentures (partial or full) are limited to one set every 6 years
- Pre-existing dentures (partial or full) must be at least 6 year old to qualify for a replacement

Excluded Services. The following dental services are excluded from the Basic Benchmark Benefit Package covered under the State plan.

Non-medically necessary cosmetic services are excluded from payment. Drugs supplied to patients for self-administration other than those allowed by applicable Department rules are excluded from payment.

**3.Q.2 Other Dental Care**

The Basic Benchmark Benefit Package includes Other Dental Care permitted under sections 1905(a)(5)(B) and 1905(a)(6) of the Social Security Act. These services include professional dental services that are provided by a licensed dentist or denturist as described in the contractor's Office Reference Manual. Specific services covered for children are stated in the contractor's Office Reference Manual.

The Department will provide dental services for children through the month of their twenty-first (21 st) birthday including diagnostic, preventative, restorative treatment, endodontics, periodontics, fixed and removable prosthodontics, maxillofacial prosthetics, oral surgery, orthodontics and adjunctive general services.

The Department requires recipients to obtain certain services only from specified providers who undertake to prOvide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

BASIC PLAN  
(For Low-Income Children and Working-Age Adults)  
BENCHMARK BENEFIT PACKAGE

3.R ESSENTIAL PROVIDERS

The Basic Benchmark Benefit Package includes Clinic Services and Rehabilitative Services furnished by **certain** essential providers permitted under sections 1905(a)(9), 1905(a)(13) and 2110(a)(5) of the Social Security Act.

Services from essential providers are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician and which may include those services provided by community health centers.

3.R.1 Rural Health Clinic Services

Rural Health Clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State plan.

3.R.2 Federally Qualified Health Center Services

Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the State plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Federally qualified health centers are provided within the scope, amount, and duration of the State's Medical Assistance Program as described under applicable Department rules.

3.R.3 Indian Health Services Facility Services

Indian Health Service Facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

3.R.4 Independent Schools District Services

Independent School Districts that have entered into a provider agreement with the Department may bill for the following Basic and Enhanced Plan Services when they are identified on the student's Individual Education Plan (IEP). All provider qualification and prior authorization requirements as specified in IDAPA 16.03.09 for these services apply.

Covered Services:

Collateral Contact - Consultation or treatment direction about the student to a significant other in the student's life. Collateral contact may not be reimbursed for general staff training, regularly scheduled parent-teacher conferences, general parent education, or for treatment team meetings.

Developmental Therapy and Evaluation - Instruction in daily living skills the student has not gained at the normal developmental stages in his life, or is not likely to develop without training and therapy beyond age-appropriate learning situations. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the student's disability.

Medical Equipment and Supplies - Medical equipment and supplies as allowed under 440.70 that are covered by Medicaid and are needed for use at school but are too large or unsanitary to transport from home to school. They must be for the student's exclusive use and transfer with the student if the student changes schools.

Nursing Services - Skilled nursing services that must be provided by a licensed nurse. Emergency, first aid or assistance with non-routine medications not identified on the IEP as health related services are not reimbursable.

BASIC PLAN  
(For Low-Income Children and Working-Age Adults)  
BENCHMARK **BENEFIT** PACKAGE

Occupational Therapy and Evaluation - Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation is not covered.

Personal Care Services - School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements while at school.

Physical Therapy and Evaluation

Psychological Evaluation

Psychotherapy

Psychosocial Rehabilitation and Evaluation - Services to assist the student in gaining and utilizing skills necessary to participate in school such as training in behavior control, social skills, and coping skills.

Intensive Behavioral Intervention - Short term, one-on-one comprehensive interventions that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills.

Speech/Audiological Therapy and Evaluation

Social History and Evaluation

Transportation - Student must require special transportation that is ordered by a physician and included on the IEP, and receive another Medicaid reimbursable service on the same day.

Interpretive Services - ~~May~~ only be billed when the student needs the services of an interpreter to receive a Medicaid reimbursable service. Not covered if the person providing the service is able to communicate in the student's primary language.

Limitations:

School Districts are subject to the limitations for covered services. Services provided by schools do not count towards the limitations on covered services for other service providers. Services beyond the scope of service limitation must be identified in an EPSDT screen, found to be medically necessary, and prior authorized.

Excluded Services: Vocational, Educational and Recreational services are not reimbursable under the Benchmark Plans.

### 3.S MEDICAL TRANSPORTATION SERVICES

The Basic Benchmark Benefit Package includes Medical Transportation Services permitted under sections 1905(a)(26), 1905(a)(6) and 2110(a)(17) of the Social Security Act.

These services include transportation services and assistance for eligible persons to medical facilities.

Payment for meals and lodging may be authorized where appropriate. Ambulance services will be covered in emergency situations or when prior authorized by the Department or its designee.

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

The Department operates a Brokered Transportation system. The State assures it has established a non-emergency medical transportation program in order to more cost-effectively provide transportation, and can document, upon the request of CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(f).

The Department will operate the broker system without regard to the freedom of choice requirements of section 1902(a)(23) of the Social Security Act. Recipients are required to use transportation providers with established agreements under the broker system.

Transportation services under the broker system will include:

- Wheelchair van;
- Taxi;
- Stretcher care;
- Bus passes;
- Tickets;
- Secured transportation; and
- Such other non-emergency transportation covered under the State plan.

The Department will assure the provision of necessary transportation of eligible persons to and from providers of Medicaid services.

**Limitations.** The following service limitations apply to the Basic Benchmark Benefit Package covered under the State plan.

Requests for transportation services will be reviewed and authorized by the Department or its designee. Authorization is required prior to the use of transportation services except when the service is emergency in nature. Payment for transportation services will be made, for the least expensive mode available, which is most appropriate to the recipient's medical needs.

**Excluded Services.** Transportation to medical facilities for the performance of medical services or procedures which are excluded under the Basic Benchmark Benefit Package are excluded.

BASIC PLAN  
(For Low-Income Children and Working-Age Adults)  
BENCHMARK BENEFIT PACKAGE

3.U SPECIAL SERVICES FOR CHILDREN/EPSTD

EPSTD Services. The Department meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act with respect to early and periodic screening, and diagnostic, and treatment (EPSTD) services.

The Basic Benchmark Benefit Package includes early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

Services under EPSTD are available to recipients up to and including the month of their twenty-first (21 st) birthday.

EPSTD services include diagnosis and treatment involving medical care within the scope of Medical Assistance, as well as such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in this State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. The Department will set amount, duration and scope for services provided under EPSTD. Needs for services discovered during an EPSTD screening which are outside the coverage provided by applicable Department rules must be shown to be medically necessary and the least costly means of meeting the recipient's medical needs to correct or improve the physical or mental illness discovered by the screening and ordered by the physician, nurse practitioner or physician's assistant. The Department will not cover services for cosmetic, convenience or comfort reasons. Any service requested which is covered under Title XIX of the Social Security Act that is not identified in applicable Department rules specifically as a covered benefit or service will require preauthorization for medical necessity prior to payment for that service. Any service required as a result of an EPSTD screen and which is currently covered under the scope of the Basic Benchmark Benefit Package will be provided to individuals under the State plan without regard to amount, scope, and duration limitations, but will be subject to prior-authorization. The additional service must be documented by the attending physician as medically necessary and that the service requested is the least costly means of meeting the recipient's medical needs. Preauthorization from the Department or its authorized agent will be required prior

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

to payment. Those services required as a result of an EPSDT screen and which are currently covered under the scope of the Basic Benchmark Benefit Package **will** provided under an Enhanced Benchmark Benefit Package, or as wrap-around services to benefits covered under the State plan for children who do not opt-in to an Enhanced Benchmark Benefit Package.

The Basic Benchmark Benefit Package includes Case Management Services permitted under sections 1905(a)(19) and 2110(a)(20) of the Social Security Act.

Case Management (CM) services will be provided for the following target group(s) as permitted in accordance **with** section 1905(a)(19) or section 1915(g) of the Act.

Children Requiring *Case Management Service under* EPSDT.

*Case Management Services* for children under EPSDT require prior authorization and a Service Plan completed by the Department or its authorized agent for the initial Service Plan prior to delivery of case management services. The case manager must review and update the approved service plan for service coordination at least annually. The Department or its authorized agent must approve the Service Plan for continued prior authorization.

The Department requires recipients to obtain case management services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, **quality**, and efficient and economic provision of covered care and services.

The State assures it **will** comply with 42 CFR 431.55(f) as it relates to thiS fee-for-service selective contracting system.

3.V SPECIFIC PREGNANCY-RELATED SERVICES

The Basic Benchmark Benefit Package Pregnancy-related services, including family planning services, and postpartum services for a 60-day period (beginning on the *day* pregnancy ends) and any remaining days in the month in which the 60<sup>th</sup> day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

Pregnancy-related and postpartum services are provided for a 60-day period after the pregnancy ends and any remaining days

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

in the month in which the 60th *day* falls.

The State provides the full range of Medicaid Program services with limitations as elsewhere described in this State plan to eligible pregnant women if such service is related to a medical condition identified by the Department or its authorized agent as pregnancy related (either routine postpartum care, or arising from complications of pregnancy, including delivery).

For presumptively eligible pregnant women, ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under this State plan.

Ambulatory prenatal care for pregnant women is furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

During the presumptive eligibility period, outpatient services related to pregnancy and complications are covered services to pregnant women. Limitations as described elsewhere in this State plan are applicable.

Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that *may* complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a) (10) (A) (i) (IV) and 1902(a) (10) (A) (ii) (IX) of the Act.

Special services related to pregnancy. When ordered by the patient's attending physician, nurse practitioner or nurse midWife, payment of the follOWing services is available after confirmation of pregnancy and extending through the *end* of the month in which the 60th *day* following delivery occurs.

**Risk Reduction Follow-up.** Services to assist the client in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. Payment is available to licensed social workers, registered nurses and physician extenders either in independent practice or as employees of entities which have current provider agreements with the Department. A single payment for each month of service proVided is made.

Individual and Family Medical Social Services. Services directed at helping a patient to overcome social or behavioral

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**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

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.

**Nutrition Services.** Intensive nutritional education, counseling and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/profession requirements in dietetics as approved by the American Dietetic Association to assure the patient's proper nutrition. Payment for two (2) visits during the covered period is available.

**Nursing Services.** Home visits by a registered nurse to assess the client's living situation and provide appropriate education and referral during the covered period. A maximum of two (2) visits in the covered period is provided.

**Maternity Nursing Visit.** Office visits by a registered nurse, acting within the limits of the Nurses Practices Act, for the purpose of checking the progress of the pregnancy. These services must be prior authorized by the Department's care coordinator and can be paid only for women unable to obtain a physician to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized.

**Qualified Provider Risk Assessment and Plan of Care.** When prior authorized by the Department care coordinator, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care.

Deleted Pregnant and Parenting Teen CM

**BASIC PLAN  
(For Low-Income Children and Working-Age Adults)  
BENCHMARK BENEFIT PACKAGE**

management at intake continue to qualify for case management services until the infant is one (1) year of age, so long as the goals of the case management plan have not been met. For purposes of this section, a teen is considered pregnant until 72 hours after delivery. Additionally, any Medicaid eligible teen/infant receiving targeted case management services since October 1, 1993, will be considered part of the target group. Teens and infants must live in Adams, Washington, Payette, Gem, Canyon, or Owyhee counties.

The Department requires recipients to obtain case management services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

The State assures it will comply with 42 CFR 431.55(f) as it relates to this fee-for-service selective contracting system.

BASIC PLAN  
(For Low-Income Children and Work'ing-Age Adults)  
BENCHMARK BENEFIT PACKAGE

3.W SUBSTANCE ABUSE TREATMENT SERVICES

The Basic Benchmark Benefit Package includes Substance Abuse Treatment Services permitted under 1905(a)(9) of the Social Security Act and provided to individuals screened eligible for such services in accordance with applicable Department rules.

Covered Services:

- Assessment: maximum of eight (8) hours per year- includes annual assessment, interviewing and treatment plan building. Each individualized treatment plan is based on a biopsychosocial assessment of the participant's alcohol or substance abuse treatment needs. This assessment must be conducted utilizing a Department-approved standardized assessment tool.
- Drug screening: maximum of three (3) per week. Urinalysis to detect the presence of alcohol or drugs.
- Individual counseling: maximum of twelve (12) hours per week. Service provided to a participant in a one-on-one setting (one participant and one counselor). The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both.
- Group counseling: maximum of twelve (12) hours per week. Service provided to participants in a peer group setting. The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both.
- Service coordination: maximum of four (4) hours per week and fifty five (55) hours per year. Service coordination consists of:
  - o Finding, arranging and assisting the participant to gain access to and maintenance of services, supports and community resources

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

- o Monitoring participant progress- includes verifying that services are received and are satisfactory to the participant, ascertaining that services meet the participant's needs, documenting progress and any revisions in services needed, and making alternative arrangements if services become unavailable to the participant.
- o Planning- community reintegration planning and exit planning

Service coordination is provided on an outpatient basis to participants who are at risk of being institutionalized.

- Family therapy: maximum of two (2) hours per week. Service provided jointly to a participant and the participant's family. The desired outcome is the elimination or reduction of alcohol and drug use and arresting, reversing, or retarding of problems associated with alcohol or drug abuse, or both. Family therapy sessions are for the exclusive benefit of the participant.

Substance abuse treatment services are limited to a five (5)-year period beginning on the date of the initial assessment and regardless of the source of payment for the initial assessment. This lifetime cap only applies to participants twenty-two (22) years of age and older.

Provider qualifications:

Providers of outpatient substance abuse treatment services must maintain a statewide network of approved programs and treatment facilities in accordance with applicable Department rules.

Individuals must provide services through a program with a certificate of approval issued by the state.

Individuals providing services to participants must have a criminal history check.

Assessment: must be conducted by an individual who is:

- Certified in administering the standardized assessment tool being utilized.

And, who has one thousand forty (1,040) hours of supervised experience providing substance abuse treatment and meets one (1) of the following criteria:

- Alcohol and drug counselor certified by the Idaho Board of Alcohol/Drug Counselor's Certification, Inc. (CADC or Advanced CADC).
- Licensed professional counselor or Licensed clinical professional counselor.
- Licensed physician.

**BASIC PLAN**  
**(For Low-Income Children and Working-Age Adults)**  
**BENCHMARK BENEFIT PACKAGE**

- Licensed psychologist.
- Licensed physician assistant, nurse practitioner or clinical nurse specialist.
- Licensed clinical or licensed masters social worker.
- Licensed marriage and family therapist.
- Licensed associate marriage and family therapist.

Drug screening: urinalysis must be conducted in a laboratory that is under the direction of a physician or other licensed provider.

Therapy and counseling services and Service Coordination must be provided by an individual who has one thousand forty (1,040) hours of supervised experience providing substance abuse treatment and meets one (1) of the following criteria:

- Alcohol and drug counselor certified by the Idaho Board of Alcohol/Drug Counselor's Certification, Inc. (CADC or Advanced CADC).
- Licensed professional counselor or Licensed clinical professional counselor.
- Licensed physician.
- Licensed psychologist.
- Licensed physician assistant, nurse practitioner or clinical nurse specialist.
- Licensed clinical or licensed masters social worker.
- Licensed marriage and family therapist.
- Licensed associate marriage and family therapist.

The Department requires participants to obtain outpatient services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality and efficient and economic provision of covered care and services.