

## Questions for Idaho about the Standards & Conditions for its Proposed Capitated Financial Alignment Demonstration

### Integration of Benefits

- Please discuss your plan for incorporating the HCBS waivers into the demo.
  - *HCBS waiver services must be offered by the health plans to the same extent they are available to qualifying participants in the waiver program.*
  - *Idaho would retain responsibility for the eligibility assessment for those HCBS waiver participants with incomes above standard Medicaid income limits, who are eligible for Medicaid under 42 CFR §435.217, and whose Medicaid eligibility therefore depends on the results of the assessment. For all other individuals who do meet categorical, income, resource, and other Medicaid eligibility requirements, the health plans would complete the assessment at the time of re-determination (annually) or application.*
  - *Waiver participants contribute to their cost of services if their income is above a certain threshold. The plans would be responsible for determining the mechanism by which a participant's share of cost is deducted by the claim. The assumption that plans would collect a share of cost would be built into the Per Member Per Month (PMPM) payment to health plans.*
  - *For the Aged & Disabled waiver, the Uniform Assessment Instrument (UAI) is used and would be used to determine nursing facility level of care (LOC) and for care planning purposes. Perverse incentives would be avoided because:*
    - 1) *Under Idaho's proposal, plans would receive one PMPM amount for all enrollees. Therefore, assessing an individual at a higher level of need would not result in greater reimbursement to the plan.*
    - 2) *Plans would be required to use the UAI in the same way it is currently used.*
    - 3) *Assessing participants for a lower need for HCBS services may ultimately result in higher costs to the plan, as a person might be forced into more expensive institutional care without the proper HCBS supports.*
  - *For participants with an Aged and Disabled waiver or a Developmental Disabilities waiver, the same assessment tools currently in place must continue to be used to determine the quantity and types of waiver services a participant may receive.*
  - *Health plan staff conducting the LOC assessments would be required to meet the HCBS waiver qualifications. Idaho would require the plans to submit qualifications of each assessor. Standard instructions on completing the assessments would be distributed to the plans, and the plans would be required to attest that all its assessors have been trained in accordance with the instructions. Idaho would confirm the qualifications were met through its HCBS quality reviews.*
- Please describe how the State would encourage integration of behavioral health services (e.g., co-location)?
  - *Under this initiative, Health Plans will be required to provide for, either directly or through subcontract(s), Medicare and Medicaid-covered services, and will be encouraged to provide as well as supplemental items and services, under a capitated model of financing. CMS, IDHW, and the Health Plans will ensure that beneficiaries have access to an adequate network of medical, behavioral health, and supportive services.*

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- *A managed care program for behavioral health services is under development and is expected to be implemented on July 1, 2013. The health plans would be required to make available the covered benefits required under the behavioral health managed care program. The health plans must build their provider network to offer the required covered benefits or they may contract with the behavioral health managed care entity. If the health plans contract with the behavioral health managed care entity, they must describe how they would collaborate with the managed care entity so that the behavioral health services are coordinated with other services and are effectively integrated into the care plan.*
- The Proposal refers to a “Specialty Mental Health Plan” on page 14. Please provide additional information about which benefits would be covered by this plan, specifically whether non-mental health behavioral health services, such as substance abuse counseling, would be covered.
  - *Benefits covered by this plan include: Community-Based Outpatient Behavioral Health Services, Screening, Evaluation and Diagnostic Assessments, Treatment Planning, Psychological and Neuropsychological Testing, Psychotherapy (Individual, Group and Family), Family Psychotherapy, Pharmacologic Management, Partial Care Treatment, Behavioral Health Nursing, Occupational Therapy, Drug Screening, Community-Based Rehabilitation and Substance use Disorder Treatment Services, and Case Management. Substance abuse counseling would be covered under the “Specialty Mental Health Plan.”*
- Is the State still on track to implement the new managed behavioral health program by July 2013? Does the State anticipate any problems with transitioning Medicare-Medicaid beneficiaries from the behavioral health plan into the demonstration within six months?
  - *Idaho remains on track to implement the new managed behavioral health program by July 2013. Idaho recognizes that the timing of the transition is not ideal, but it does not anticipate major problems. As indicated above, the plans must describe how they would interact with the behavioral health managed care entity to ensure an effective transition.*

### **Care Model**

- Please clarify whether individuals would be re-evaluated for 1915(c) waiver services upon transition to managed care. If so, please describe that process, including responsible parties and timeframes.
  - *The health plans are responsible for conducting assessments only for participants whose Medicaid eligibility is not tied to the results of the Level of Care (LOC) assessment. For those waiver participants, the waivers have established timeframes for assessment (an initial assessment and an annual assessment within 364 days of the prior assessment are required). The Department would continue to evaluate participants whose Medicaid eligibility depends upon their waiver eligibility.*
- Would individuals continue to have a case manager and an individual team as described in the current 1915(c) waiver programs or would those services and teams be eliminated and replaced by the network care coordinator and multi-disciplinary team?
  - *Service coordination activities required in the Developmental Disabilities (DD) waiver must be incorporated into the new model of care. The care team for participants with a DD waiver must include a Qualified Intellectual Disabilities Professional (QIDP). The transition plan would allow the participant to access all current providers for ninety (90) days after enrollment into the health plan. The Aged and Disabled waiver does not offer case management as a waiver service.*

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- For the financial alignment demonstration, how would the State determine the caseload for care coordinators? Would plans propose care coordinator ratios as part of the RFP? Would the State require or allow plans to stratify beneficiaries?
  - *Idaho does not intend to determine care coordinator caseloads, but the requirements of the model of care, as listed, must be fulfilled. Idaho will not propose care coordinator ratios. Plans must stratify beneficiaries to determine the extent of care planning needed for each enrollee.*
- Please clarify who would be developing the care plan and how development would be coordinated with the HCBS case managers.
  - *The interdisciplinary care team, led by the primary care provider (PCP) and care coordinator, would partner with the beneficiary to develop the plan of care.*
  - *The health plans would be responsible for ensuring that applicable case management functions are incorporated into the model of care.*
- The demonstration target population is a heterogeneous group. Please describe the modifications that you anticipate to the care model to accommodate the different sub-populations served by the demonstration (e.g., people with developmental disabilities, people with serious and persistent mental illness).
  - *The extent of the care planning required will depend on the complexity of the individual's health and functional needs. Therefore, the health plans are required to stratify participants in accordance with the individual's health and/or functional needs, which determine the extent of care planning needed.*
  - *The assurances and performance measures currently in place for both waivers would remain in place. Additionally, the health plans would be required to offer all services available under the Idaho's behavioral health managed care program, which is expected to be implemented effective July 1, 2013. The RFP will require that plans meet network adequacy standards.*
- Please provide additional information on how the model of care will include mechanisms for improving care transitions and maximizing continuity of care, particularly for enrollees currently eligible for HCBS waiver services.
  - *The readiness review would ensure that plans have sufficient provider networks in place to deliver HCBS waiver services. Further, there would be a ninety (90) day transition period after a participant's initial enrollment during which enrollees may continue to obtain services from providers in the previous provider network.*

### **Stakeholder Engagement**

- Please provide additional information on how stakeholders would be engaged throughout the demonstration.
  - *A website is available to facilitate communication with stakeholders at <http://www.MedicaidLTCManagedCare.dhw.idaho.gov>. Website features include a summary of the history and status of the initiative, a survey through which suggestions can be offered, a feedback form which takes suggestions and questions, a brief of the proposal, links to panelist presentations at a Statewide stakeholder videoconference, information regarding upcoming events, and a number of helpful links.*
  - *Input from stakeholders will continue to be encouraged and facilitated throughout the demonstration. Stakeholders will continue to have an opportunity to discuss issues related to*

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*the demonstration through the quarterly Personal Assistance Oversight Committee (PAO) meetings, the quarterly Medical Care Advisory Committee (MCAC) meetings, and the Nursing Facility Prospective Payment System meetings. The demonstration to integrate care for dual eligibles is a standing agenda item at the PAO and MCAC meetings.*

- *Stakeholders will continue to be able to submit feedback by email to [LTCmanagedcare@dhw.idaho.gov](mailto:LTCmanagedcare@dhw.idaho.gov).*
- *Idaho would require health plans to operate an advisory committee which would meet in person a minimum of two times a year. The committee would be composed of providers, participants, and participants' representatives.*
- *Idaho will continue to engage with and incorporate feedback from stakeholders during the implementation and operational phases of the Demonstration. This will be accomplished through an ongoing process of public meetings, monitoring individual and provider experiences through a variety of means, including surveys, website updates and data analysis. In addition, Idaho would require that Health Plans develop meaningful beneficiary input processes as part of their ongoing operations, as well as systems for measuring and monitoring the quality of service and care delivered to eligible individuals. Idaho would also develop consumer notices and related materials about the Medicare-Medicaid Coordinated Program that are easily understood by persons with limited English proficiency, and would translate materials into prevalent languages as determined by CMS and Idaho.*
- Please provide information on the requirements the State would establish to ensure ongoing, meaningful beneficiary input, both at the plan level and the State level.
  - *A website is available to facilitate communication with beneficiaries at <http://www.MedicaidLTCManagedCare.dhw.idaho.gov>.*
  - *Beneficiaries will continue to be able to submit feedback by email to [LTCmanagedcare@dhw.idaho.gov](mailto:LTCmanagedcare@dhw.idaho.gov).*
  - *Idaho would require health plans to operate an advisory committee which would meet in person a minimum of two times a year. The committee would be composed of providers, participants, and participants' representatives.*
  - *Idaho will continue to engage with and incorporate feedback from beneficiaries during the implementation and operational phases of the Demonstration. This will be accomplished through an ongoing process of public meetings, monitoring individual and provider experiences through a variety of means, including surveys, website updates and data analysis. In addition, Idaho would require that plans develop meaningful beneficiary input processes as part of their ongoing operations, as well as systems for measuring and monitoring the quality of service and care delivered to eligible individuals. Idaho would also develop consumer notices and related materials about the program that are easily understood by persons with limited English proficiency, and would translate materials into prevalent languages as determined by CMS and Idaho.*

### **Beneficiary protections**

- Please discuss the details around a proposed transition policy.
  - *There would be a ninety (90) day transition period after a participant's initial enrollment, and each time a participant enrolls in a new plan. A participant may change plans at the start of any month, with or without cause. During the transition period, the health plans*

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*must reimburse the providers in the participant's previous provider network no less than the FFS rate for the service at the time the service was rendered.*

- The Demonstration requires that beneficiaries have the ability to opt out of the Medicare-Medicaid Plan (MMP) for any reason on a monthly basis. Please clarify if this policy is for beneficiaries who opt-out of the demonstration, and thus will be mandated into a Medicaid MCO under the proposed §1915(b)/§1915(c) authority.
  - *Idaho now intends to allow beneficiaries to change plans on a monthly basis for any reasons, regardless of whether a participant decided to opt out of the demonstration.*
- The Standards and Conditions require that States develop, in conjunction with CMS, uniform/integrated enrollee materials that are accessible and understandable to the beneficiaries who would be enrolled in the plans, including those with disabilities, speech and vision limitations, and limited English proficiency. Please provide additional details on how the State would ensure all required materials would be accessible to all enrollees.
  - *Enrollee and prospective Enrollee materials, in all forms, require prior approval by CMS and Idaho (unless either entity authorizes the other to review and approve certain documents on its own). CMS and Idaho would also work to develop pre-approved documents that may be used, under certain circumstances, without additional CMS or Idaho approval. All materials must be integrated and must be accessible and understandable to the beneficiaries that would be enrolled in the plans, and their caregivers. This includes individuals with disabilities, including, but not limited to, those with cognitive and functional limitations, and those with limited English proficiency, in accordance with current Federal guidelines for Medicare and Medicaid. Where Medicare and Medicaid standards differ, the standard providing the greatest access to individuals with disabilities or limited English proficiency would apply.*
- The Standards and Conditions require that the States ensure that all care meets the beneficiary's needs, allows for involvement of caregivers, and is in an appropriate setting, including in the home and community. The proposal states that “two home and community based waivers, the Aged and Disabled waiver and the Developmentally Disabled waiver, offer services in addition to the Basic Plan services and Enhanced Plan services that waiver participants may also receive. These include a variety of home and community-based services which help people to live in the community and avoid institutionalization.” Please describe how the State would ensure that enrollees not eligible for these waivers would also be encouraged and provided support to live in the community. Please also describe how the State would ensure that caregivers are involved in care planning processes.
  - *Services must be delivered in a care setting appropriate to their needs, with a preference for the home and the community over institutions. Plans must ensure that medically necessary covered services are provided to beneficiaries, in the least restrictive community setting, and in accordance with the Enrollee's wishes and Individualized Care Plan.*
  - *Within one year from the time of an individual's enrollment, the health plan would evaluate that person's suitability for the Idaho Home Choice program, which helps individuals to transition from institutions into the community.*
  - *As members of the ICT, the providers of waiver services assist in the development in the plan of care.*
  - *Services available through the Medicaid Enhanced Plan, such as personal care services, home health care, developmental therapy, and mental health services, would assist individuals who are not eligible for the waivers in avoiding institutionalization.*

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- The Standards and Conditions require that the States ensure access to all services in a manner that is sensitive to the beneficiary's language and culture, including customer service representatives that are able to answer enrollee questions and respond to complaints/concerns appropriately. Please describe how you would meet this standard.
  - *Health plans must demonstrate that their enrollee services departments:*
    - *Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by enrollees, including American Sign Language (ASL);*
    - *Maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for deaf and hard of hearing enrollees;*
    - *Maintain employment standards and requirements (e.g., education, training, and experience) for enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and*
  - *The health plan must employ enrollee services representatives (ESRs) who:*
    - *Are trained to answer enrollee inquiries, complaints, and concerns from enrollees and prospective enrollees;*
    - *Are trained in the use of TTY, video relay services, remote interpreting services, how to provide accessible PDF materials, and other alternative formats;*
    - *Are capable of speaking directly with, or arranging for someone else to speak with, enrollees in their primary language, including American Sign Language, or through an alternative language device or telephone translation service;*
    - *Are knowledgeable about Idaho Medicaid, Medicare, and all terms of the contract, including the covered services;*
    - *Are available to enrollees to discuss and provide assistance with resolving enrollee complaints; and*
    - *Have access to the health plan's enrollee database and an electronic provider directory.*
  - *The health plans must ensure that ESRs make available to enrollees and potential enrollees, upon request, information concerning the following:*
    - *The identity, locations, qualifications, and availability of providers;*
    - *Enrollees' rights and responsibilities;*
    - *The procedures available to an enrollee and provider(s) to challenge or appeal the failure of the health plan to provide a covered service and to appeal any adverse actions (denials);*
    - *How to access oral interpretation services and written materials in prevalent languages and alternative formats;*
    - *Information on all covered services and other available services or resources(e.g., State agency services) either directly or through referral or authorization;*
    - *The procedures for an enrollee to change plans or to opt out of the Medicare component of the demonstration; and*
    - *Additional information that may be required by enrollees and potential enrollees to understand the requirements and benefits of the health plan.*

### **Network Adequacy**

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- Please describe the specific network adequacy requirements for long term services and supports.
  - *Proposal currently states:*
    - *Contractor shall maintain a network of appropriate providers sufficient to provide adequate access to all services covered under the contract, and Contractor shall comply with federal requirements in 42 CFR §422.112 regarding access to services.*
      1. *Medical and pharmacy network adequacy requirements would be based on Medicare requirements.*
      2. *The State's network adequacy requirements would be used for Medicaid-only services.*
      3. *For services covered by Medicare and Medicaid, CMS and the State would collaborate to develop network adequacy standards.*
  - *Additional Requirement:*
    - *As will be stipulated in the MOU, Idaho would require plans to meet all network adequacy standards identified by CMS in the readiness review, including standards for Long Term Services and Supports (LTSS).*
- Would the State require the health plans to meet a minimum number of waiver providers by service type?
  - *As will be stipulated in the MOU, Idaho would require plans to meet all network adequacy standards identified by CMS in the readiness review, including standards for Long Term Services and Supports (LTSS).*
- Please provide additional information on the monitoring of the network and standards, including mechanisms for assessing network adequacy beyond the minimum standards above (e.g., monitoring service utilization, survey results, beneficiary complaints or appeals, etc.).
  - *As will be stipulated in the MOU, Idaho would review network adequacy by service area in the readiness review and on an ongoing basis. Plans must submit their appeals and complaints data to Idaho, and this information would be reviewed to determine if there are problems with enrollees' ability to access providers as needed.*
- How would the demonstration plans coordinate with existing ADRC, AAA, and case managers/care coordinator programs in the State to provide care coordination services?
  - *The Idaho Commission on Aging is developing a grant application for options counseling. The tentative plan is for the Area Agencies on Aging and/or Idaho Centers for Independent Living to provide in-person options counseling for dual eligibles upon request. The plans would be required to work with the Area Agencies on Aging and/or Idaho Centers for Independent Living to provide them with all information they may need to share with and explain to beneficiaries.*

### **Measurement/Reporting**

- Please provide additional detail around how the State would monitor the health plans to ensure that they are meeting HCBS waiver requirements. As part of your response to this question, please provide examples of the reporting requirements of the plans related to the HCBS waivers.
  - *Idaho would meet all the waiver assurances and require the plans to specify how they would report on all of the HCBS waiver performance measures and requirements. For instance, the Aged and Disabled has the following performance measures, among others, and the health plans would be required to report their results to the Department:*

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- *Number and percent of participants who received annual eligibility redetermination (redet) within 364 days of prior waiver eligibility assessment. a. Numerator: # of participants who received annual eligibility redet within 364 days of prior assessment. b. Denominator: # of participants who should have received annual redet of eligibility within 364 days of prior assessment.*
  - *Number and percent of participants who reported they were given a choice when selecting waiver service providers. a. Numerator: Number of participants reviewed in a random sample of records that reported that they were given a choice when selecting wavier service providers. b. Denominator: Number of participants reviewed in a random sample of records.*
- Please provide a list of proposed quality measures participating plans would be required to report on for this initiative, including LTSS-focused quality measures applied at the plan level.
  - *In addition to the quality measures required by CMS in the Massachusetts MOU, plans would also be required to report on all applicable 1915(c) waiver quality measures (“performance measures”).*
- Please describe how the state would assure and report on the consistent administration of the LOC assessment for the general Medicaid population and the population that is only made eligible through the HCBS waiver.
  - *The same assessment is used for general and waiver populations to determine level of care and level of service. Idaho would monitor changes in the results of the assessments and review any significant changes.*

### **Data**

- Please provide written confirmation that the State would provide to CMS any required beneficiary-level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models.
  - *Idaho would provide to CMS any required beneficiary-level expenditure data and covered benefits for most recently available three years, including available encounter data in capitated models*
- Please provide written confirmation that the State would provide to CMS data on State supplemental payments to providers (e.g., DSH, UPL) during the three year period.
  - *Idaho would provide to CMS data on Idaho's supplemental payments to providers (e.g., DSH, UPL) during the three year period.*

### **Enrollment**

- In today's Medicare Advantage program, beneficiaries with ESRD can stay in an MA plan in which they are already enrolled, but cannot otherwise join an MA plan. Do you intend to follow this type of enrollment policy? If not, would passive enrollment processes apply to beneficiaries with ESRD? If so, what types of special approaches are you proposing to meet the unique needs of the population?
  - *Idaho intends to fully include participants with ESRD in this program, which means that they would be passively enrolled in the program. If participants with ESRD are already enrolled in a MA plan which participates in the demonstration, they would remain enrolled with that plan. Plans must describe their approaches to meeting the unique needs of the ESRD population.*

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- Would the State allow for individuals who have opted out to re-enroll in the demonstration at a later date? How would this process work?
  - *Idaho would allow individuals who have opted out to re-enroll in the demonstration at a later date. Participants would apply for enrollment. Re-enrollment would be effective the first date of the month following the application. Please note that Idaho intends to require mandatory enrollment in Medicaid managed care for all dual eligibles who qualify for the demonstration, regardless of whether they elect to opt out of the demo.*
- CMS encourages the use of an intelligent auto-assignment process in which beneficiaries are assigned to a plan that best meets his or her needs. How would Idaho propose to assign beneficiaries to each of the selected health plans? What factors would the State's auto-assignment algorithm take into account?
  - *Idaho would first auto-enroll beneficiaries in their current Medicare-Medicaid Coordinated Plan, if they are already enrolled in such a plan. For participants already enrolled in a Medicare Advantage plan that is responsible only for Medicare coverage, Idaho may elect to auto-enroll beneficiaries in the coordinated plan run by the same company. For all other beneficiaries, enrollees would be assigned to plans that qualify for passive enrollment in the service area on a rotating basis, with one enrollee to each plan in a set order that would repeat as often as needed.*
- CMS is increasingly focused on policies to promote a smooth implementation process without overwhelming the ability of States or plans to manage the intake of individuals with complex needs. How would the State ensure that plans have the capacity to accept passive enrollment? Would the State consider a plan to phase-in enrollment on a monthly or quarterly basis? Would the State consider starting with a period of only opt-in enrollment before passive enrollment begins?
  - *Each plan's capacity to accept passive enrollment would be determined in the readiness review. Idaho is open to phase-in approaches, such as not enrolling all enrollees in all service areas immediately. Idaho does not intend to start with a period of opt-in enrollment.*
- Idaho currently operates a 1937(a) State Plan Amendment. What is Idaho's anticipated process for breaking down the Medicare-Medicaid Coordinated (MMC) benchmark plan and ensuring a smooth transition from the MMC plan into the demonstration? How and at what timeframes, would beneficiaries be notified of this change? What are the State's plans to ensure continuity of care for these beneficiaries?
  - *Idaho is planning to transition from 1937(a) authority to concurrent 1915(b)/1915(c) authority. Eligible participants would be notified by mail before the open enrollment period about the program, their choices of plans, how to enroll, and who to contact to obtain help in making a decision. Eligible participants would always be given a minimum of 60 days' notice, during which they may select a plan, before they would be passively enrolled.*
  - *Idaho would require plans to allow enrollees to obtain services from providers in the enrollees' previous provider networks for a minimum of ninety days.*

### **Public Notice**

- Please confirm that the State would provide/has provided appropriate tribal consultation.
  - *Idaho confirms that tribal consultation notices were sent on April 3, 2012 and September 19, 2012.*
  - *Updates are provided quarterly during tribal consultation meetings, most recently on November 7, 2012.*

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- *In addition, tribes receive notification via stakeholder communication.*

**Implementation**

- Does the state intend to submit a Health Homes SPA? If so, how does this affect the rest of the timeline?
  - *The Health Home SPA was approved on November 21, 2012, with an effective date of January 1, 2013.*
- The goal of this demonstration is to have all of the beneficiary's services integrated by the plan, at the time of enrollment. Please provide an update on the State's consideration to phase-in the services for people with developmental disabilities, as discussed on page 17.
  - *Idaho does not plan to phase-in the services for people with developmental disabilities, as previously discussed. Idaho plans to have all of the beneficiary's services integrated by the plan, at the time of enrollment.*

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