

# Medicaid Alternative Benefit Plan

## Medicaid Alternative Benefit Plan: General Information

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State/Territory name: **Idaho**

Transmittal Number: **ID-14-0013**

### General Information:

#### Submission Title:

*short (under 100 characters) label used to identify this submission in the web application*

MMCP - Duals 14-0013

#### Description:

The broad policy goal for the provision of the Medicare/Medicaid Coordinated Benchmark Benefit Package for elders and/or individuals who are dually eligible for Medicare and Medicaid is to finance and deliver cost-effective individualized care.

Additional specific goals are:

- To emphasize preventive care and wellness;
- To improve coordination between Medicaid and Medicare coverage;
- To increase nonpublic financing options for long-term care; and
- To ensure participants dignity and quality of life.

Public notice has been conducted prior to SPA submission pursuant to 42 CFR 440.386.

### ABP Screening Statements to Indicate Required Forms

Select one of the following options for eligibility group coverage:

- The population group for this Alternative Benefit Plan includes only the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2a to indicate agreement to voluntary benefit package selection assurances for the adult group.*
- The population group for this Alternative Benefit Plan includes the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, and also includes other groups.** *If the state selects this option, the state must complete forms ABP2a and ABP2b to indicate agreement to voluntary benefit package selection assurances for the adult group and voluntary enrollment assurances for other eligibility groups.*
- The population for this Alternative Benefit Plan does not include the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.** *If the state selects this option, the state must complete form ABP2b to indicate agreement to voluntary enrollment assurances for these eligibility groups.*

Enrollment is mandatory for some or all participants. *If selected, the state must complete form ABP2c to indicate agreement to mandatory enrollment assurances.*

Specify the number of **benchmark** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP5, and ABP8 for each benchmark benefit package.*

1

Specify the number of **benchmark-equivalent** benefit packages that will be created or amended with this submission. *The state must submit one version of forms ABP3, ABP4, ABP6, and ABP8 for each benchmark-equivalent benefit package.*

## Medicaid Alternative Benefit Plan: File Management Summary

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State/Territory name: **Idaho**

Transmittal Number: **ID-14-0013**

Form Code	Form Name	Uploaded Form Count
ABP1	Alternative Benefit Plan Populations	1
ABP2a	Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	0
ABP2b	Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	1
ABP2c	Enrollment Assurances - Mandatory Participants	0
ABP3	Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package	1
ABP4	Alternative Benefit Plan Cost-Sharing	1
ABP5	Benefits Description	1
ABP6	Benchmark-Equivalent Benefit Package	0
ABP7	Benefits Assurances	1
ABP8	Service Delivery Systems	1
ABP9	Employer Sponsored Insurance and Payment of Premiums	1
ABP10	General Assurances	1
ABP11	Payment Methodology	1

**Medicaid Alternative Benefit Plan: File Management Detail**

**Form ABP1: Alternative Benefit Plan Populations**

**ABP1 Forms List**

Form
Please provide a short description of this ABP1 form: ABP1 Populations <b>Uploaded Form Name:</b> _____ <span style="float: right;"><b>Date Uploaded:</b> 03/27/2014</span>
MMCP ABP1 Populations.pdf

**Support Documents**

Document
Please provide a short description of this support document: Legal Notice <b>Uploaded Document Name:</b> _____ <span style="float: right;"><b>Date Uploaded:</b> _____</span>
Legal Notice - ACA Eligibility and EHB SPAs 8-11-13.pdf
Please provide a short description of this support document: Tribal Solicitation <b>Uploaded Document Name:</b> _____ <span style="float: right;"><b>Date Uploaded:</b> _____</span>
13-269 Tribal letter - EHB and Eligibility - ACA SPAs.pdf

**Form ABP2a: Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act**

**ABP2a Forms List**

<b>Form</b>
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**Support Documents**

<b>Document</b>
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**Form ABP2b: Voluntary Enrollment Assurances for Eligibility Groups other than the Adult Group under Section 1902(a)(10)(A)(i)(VIII) of the Act**

**ABP2b Forms List**

<b>Form</b>
Please provide a short description of this ABP2b form:
<b>Uploaded Form Name:</b>
<b>Date Uploaded: 03/24/2014</b>
MMCP ABP2b Voluntary enrollment.pdf

**Support Documents**

<b>Document</b>
Please provide a short description of this support document:
<b>Uploaded Document Name:</b>
<b>Date Uploaded: 03/24/2014</b>
January 2012 Dual Eligible Letter - BC.pdf

**Form ABP2c: Enrollment Assurances - Mandatory Participants**

**ABP2c Forms List**

<b>Form</b>
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**Support Documents**

<b>Document</b>
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**Form ABP3: Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package**

**ABP3 Forms List**

Form	
Please provide a short description of this ABP3 form:	
<div style="border: 1px solid black; height: 20px;"></div>	
<b>Uploaded Form Name:</b>	<b>Date Uploaded:</b>
<div style="border: 1px solid black; padding: 2px;">MMCP ABP3 Benchmark vs Benchmark Equivalent.pdf</div>	

**Support Documents**

Document
<div style="border: 1px solid black; height: 20px;"></div>

**Form ABP4: Alternative Benefit Plan Cost-Sharing**

**ABP4 Forms List**

Form	
Please provide a short description of this ABP4 form: Cost Sharing ABP4	
<b>Uploaded Form Name:</b>	<b>Date Uploaded:</b>
<div style="border: 1px solid black; padding: 2px;">MMCP ABP4 Cost Sharing 5-13-14.pdf</div>	

**Support Documents**

Document
<div style="border: 1px solid black; height: 20px;"></div>

**Form ABP5: Benefits Description**

**ABP5 Forms List**

Form	
Please provide a short description of this ABP5 form: Supersedes SPA TN 14-0009.	
<b>Uploaded Form Name:</b>	<b>Date Uploaded:</b>
<div style="border: 1px solid black; padding: 2px;">MMCP ABP5 SPA TN 14-0013.pdf</div>	

**Support Documents**

Document
<div style="border: 1px solid black; height: 20px;"></div>

**Form ABP6: Benchmark-Equivalent Benefit Package**

**ABP6 Forms List**

Form
<div style="border: 1px solid black; height: 20px;"></div>

**Support Documents**

<b>Document</b>
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**Form ABP7: Benefits Assurances**

**ABP7 Forms List**

<b>Form</b>	
Please provide a short description of this ABP7 form:	
<b>Uploaded Form Name:</b>	<b>Date Uploaded: 03/20/2014</b>
MMCP ABP7 Benefits Assurances.pdf	

**Support Documents**

<b>Document</b>
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**Form ABP8: Service Delivery Systems**

**ABP8 Forms List**

<b>Form</b>	
Please provide a short description of this ABP8 form: Supersedes SPA TN 14-0009.	
<b>Uploaded Form Name:</b>	<b>Date Uploaded:</b>
MMCP ABP8 SPA TN 14-0013.pdf	

**Support Documents**

<b>Document</b>
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**Form ABP9: Employer Sponsored Insurance and Payment of Premiums**

**ABP9 Forms List**

<b>Form</b>	
Please provide a short description of this ABP9 form:	
<b>Uploaded Form Name:</b>	<b>Date Uploaded: 03/20/2014</b>
MMCP ABP9 Employer Sponsored.pdf	

**Support Documents**

Document

**Form ABP10: General Assurances**

**ABP10 Forms List**

Form				
Please provide a short description of this ABP10 form: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>				
<table style="width: 100%; border: none;"> <tr> <td style="border: none;"><b>Uploaded Form Name:</b></td> <td style="border: none; text-align: right;"><b>Date Uploaded: 03/20/2014</b></td> </tr> <tr> <td colspan="2" style="border: 1px solid black; padding: 2px;">MMCP ABP10 General Assurances.pdf</td> </tr> </table>	<b>Uploaded Form Name:</b>	<b>Date Uploaded: 03/20/2014</b>	MMCP ABP10 General Assurances.pdf	
<b>Uploaded Form Name:</b>	<b>Date Uploaded: 03/20/2014</b>			
MMCP ABP10 General Assurances.pdf				

**Support Documents**

Document

**Form ABP11: Payment Methodology**

**ABP11 Forms List**

Form				
Please provide a short description of this ABP11 form: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>				
<table style="width: 100%; border: none;"> <tr> <td style="border: none;"><b>Uploaded Form Name:</b></td> <td style="border: none; text-align: right;"><b>Date Uploaded: 03/20/2014</b></td> </tr> <tr> <td colspan="2" style="border: 1px solid black; padding: 2px;">MMCP ABP11 Payment Methodologies.pdf</td> </tr> </table>	<b>Uploaded Form Name:</b>	<b>Date Uploaded: 03/20/2014</b>	MMCP ABP11 Payment Methodologies.pdf	
<b>Uploaded Form Name:</b>	<b>Date Uploaded: 03/20/2014</b>			
MMCP ABP11 Payment Methodologies.pdf				

**Support Documents**

Document

**Medicaid Alternative Benefit Plan: Tribal Input**

State/Territory name: **Idaho**  
 Transmittal Number: **ID-14-0013**

- One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State.**
    - This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**
    - The State has solicited advice from Indian Health Programs, Urban Indian Organizations, and/or Tribal governments prior to submission of this State Plan Amendment.**
- Complete the following information regarding any tribal consultation conducted with respect to this submission:*

**Tribal consultation was conducted in the following manner. States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:**

**Indian Tribes**

Indian Tribes	
Name of Indian Tribe:	Federally Recognized Tribes of Idaho
Date of consultation:	01/15/2014 (mm/dd/yyyy)
Method/Location of consultation:	Submitted to tribes in a letter format on 01/15/2014. EHB SPAs were also reviewed during the 8/15/13 Tribal Quarterly meeting. See listing of mailing addresses and e-mail distribution list provided below.

**Indian Health Programs**

Indian Health Programs	

**Urban Indian Organization**

**The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.**

Document	
Please provide a short description of this support document: The Tribal solicitation letter was e-mailed and sent US mail to the federally recognized Idaho Tribes as well as the Northwest Portland Area Indian Health Board, who work closely with Idaho Tribes as a Coordinating agency. Solicitation letters are also uploaded onto a website designed specifically for communication between Idaho Medicaid and Idaho Tribes.	
<b>Uploaded Document Name:</b>	<b>Date Uploaded:</b>
14-016 Tribal Notice Duals - changes to the MMCP.pdf	
Please provide a short description of this support document: A second, revised Tribal solicitation letter was e-mailed and sent US mail to the federally recognized Idaho Tribes as well as the Northwest Portland Area Indian Health Board, who work closely with Idaho Tribes as a Coordinating agency. Solicitation letters are also uploaded onto a website designed specifically for communication between Idaho Medicaid and Idaho Tribes.	
<b>Uploaded Document Name:</b>	<b>Date Uploaded:</b>
14-016 Tribal Notice Duals - changes to the MMCP-revised.pdf	
Please provide a short description of this support document: Current tribal contact information. Hard copy mailing and e-mail distribution lists.	
<b>Uploaded Document Name:</b>	<b>Date Uploaded:</b>
Current Tribal contact information 3-19-14.pdf	

**Indicate the key issues raised in Indian consultative activities:**

**Access**

**Summarize Comments**

**Summarize Response**

**Quality**  
**Summarize Comments**  
  
**Summarize Response**

**Cost**  
**Summarize Comments**  
  
**Summarize Response**

**Payment methodology**  
**Summarize Comments**  
  
**Summarize Response**

**Eligibility**  
**Summarize Comments**  
  
**Summarize Response**

**Benefits**  
**Summarize Comments**  
  
**Summarize Response**

**Service delivery**  
**Summarize Comments**  
  
**Summarize Response**

**Other Issue**

**Medicaid Alternative Benefit Plan: Summary Page (CMS 179)**

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**State/Territory name:** Idaho

**Transmittal Number:**

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

ID-14-0013

**Proposed Effective Date**

07/01/2014 (mm/dd/yyyy)

**Federal Statute/Regulation Citation**

Section 2302 of the Affordable Care Act

**Federal Budget Impact**

	Federal Fiscal Year	Amount
First Year	2014	\$ 0.00
Second Year	2015	\$ 0.00

**Subject of Amendment**

This amendment revises the Medicare/Medicaid Coordinated Plan to reflect the expansion of the plan to include additional benefits and the elimination of fee-for-service components of the delivery system.

**Governor's Office Review**

- Governor's office reported no comment
- Comments of Governor's office received

Describe:

[Empty text box with scroll arrows]

- No reply received within 45 days of submittal
- Other, as specified

Describe:

[Empty text box with scroll arrows]

**Signature of State Agency Official**

Submitted By: Rachel Strutton  
 Last Revision Date: Aug 5, 2014  
 Submit Date: Aug 5, 2014