IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

OFFICE OF THE DIRECTOR
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5500
FAX 208-334-6558

February 15, 2019

David Meacham
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
M/S RSX-200
701 Fifth Ave., Ste 1600
Seattle, WA 98104

Dear Mr. Meacham:

The State of Idaho is submitting the following Medicaid state plan amendments to add coverage for adults, with incomes at or below 133% of the federal poverty level, effective January 1, 2020:

1. Transmittal #19-0007, modifying the eligibility groups covered by Idaho to add the adult group
2. Transmittal #19-0004, specifying adults in this group, without special health needs, have access to the benefits within Idaho's Basic Plan Alternative Benefit Package
3. Transmittal #19-0005, specifying adults in this group, with special health needs, have access to the benefits within Idaho's Enhanced Plan Alternative Benefit Package
4. Transmittal #19-0006, describing Idaho's eligibility procedures for identification of the adult group for purposes of securing the Federal Medical Assistance Percentage (FMAP) for the adult group

These changes are submitted in accordance with §56-267 of Idaho Code, as established in 2018 by Idaho's Proposition 2, certified by the State Board of Canvassers and Governor Little on November 20, 2018. Governor Little has recommended funding for this coverage in his budget, which is currently being considered by the Idaho Legislature. We will keep you informed as the funding discussion proceeds in the Idaho legislature and let you know when funding is approved.

Tribal solicitation has been completed for these amendments. Please see the attached Tribal Representative Notification Letter. This letter was mailed, e-mailed, and posted to the Medicaid-Tribes website on December 17, 2018. We received multiple comments, which are included as an attachment to this letter.

The State has initiated its public noticing process prior to the submittal of these amendments. A copy of the public notice is attached. We will take any public comments or feedback we receive under consideration and provide them to CMS as we work through the review and approval process.

Idaho appreciates your review of these changes, and anticipates your approval of these amendments. Please direct any questions regarding the SPA's to Matt Wimmer, Administrator for the Division of Medicaid at (208) 364-1804 or matt.wimmer@dhw.idaho.gov.

Sincerely,

DAVE JEPPESEN
Director

Enc:

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- B

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations — ABP1

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

Alternative Benefit Plan Population Name: Basic Alternative Benefit Plan

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

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Parents and Other Caretaker Relatives	Voluntary	X
+	Pregnant Women	Voluntary	X
+	Infants and Children under Age 19	Voluntary	X
+	Former Foster Care Children	Voluntary	X
+	Extended Medicaid due to Spousal Support Collections	Voluntary	X
+	Transitional Medical Assistance	Voluntary	X
+	Deemed Newborns	Voluntary	X
+	Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Voluntary	X
+	Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	Voluntary	X
+	SSI Beneficiaries	Voluntary	X
+	Individuals Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Voluntary	X
+	Certain Individuals Needing Treatment for Breast or Cervical Cancer	Voluntary	X
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). No

Targeting Criteria (select all that apply):

☒ Income Standard.

Income Standard:

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

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

Alternative Benefit Plan

The income standard is as follows:

- ○ A percentage:
- ◉ A specific amount

The standard is as follows:

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

Statewide standard

	Household Size	Income Standard	
+	1	282	X
+	2	355	X
+	3	448	X
+	4	540	X
+	5	633	X
+	6	725	X
+	7	819	X
+	8	911	X
+	9	986	X
+	10	1,061	X

Additional incremental amount?

◉ Yes ○ No

Increment amount $ 75

☐ Disease/Condition/Diagnosis/Disorder.

☒ Other.

Other Targeting Criteria (Describe):

Individuals with healthcare needs that cannot be met with the Standard State Plan
Pregnant individuals within the income limits above are eligible for full Medicaid
Pregnant individuals with incomes greater than those listed above, but below 133% FPL are eligible for pregnancy-related services
Children 0 - 6 in families with income under 142% FPL are eligible for Medicaid
Children 6 - 18 in families with income under 133% FPL are eligible for Medicaid
Deemed Newborns - Automatic Eligibility
Former Foster Care Children under 26 years old, who were in Foster Care at age 18 - Automatic Eligibility

Alternative Benefit Plan

Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care - Automatic Eligibility
Extended Medicaid due to Spousal Support Collections - Continue with previous eligibility

Geographic Area

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

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

PRA Disclosure Statement

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

V.20130724

Alternative Benefit Plan

State Name: Idaho

Attachment 3.1-L- B

OMB Control Number: 0938-1148

Transmittal Number: ID - 19 - 0004

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

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☐ Letter

☐ Email

☒ Other

Alternative Benefit Plan

Describe:

The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that include informing each eligible individual of the available benefit options. Upon identification of an individual who is exempt from mandatory enrollment per 42 CFR 440.315, the Department will inform these individuals that they may choose to enroll in any plan for which they are eligible (Standard, Basic, or Enhanced), and that they may opt out of an ABP at any time and instead access Medicaid benefits under the State plan.

The Department will provide such information at the following opportunities:
• Initial application for assistance;
• Notice of eligibility determination; and
• Selection of primary care case manager.

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

An attachment is submitted.

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

The state informs participants of their benefit plan options when exempt status is determined at the time of enrollment, at redetermination, upon selection of the primary care case manager, and upon request.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

The Department has an "Any Door" policy. The participant can notify their local eligibility office, their regional office, their Healthy Connections provider, or the Medicaid Central Office and obtain information about switching plans and/or initiate the process to opt out of an ABP and instead access Medicaid benefits under the State plan.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

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

☒ In the eligibility system.

☐ In the hard copy of the case record.

☐ Other

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

☒ Copy of correspondence sent to the individual.

☒ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other

Alternative Benefit Plan

☑ The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/ territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

The communication text that is used to inform individuals identified as exempt, as defined under 42 CFR 440.315, about their options for enrollment is as follows:
1. You may choose any benefit plan for which you are eligible—the Standard Benefit Plan, the Basic Alternative Benefit Plan, or the Enhanced Alternative Benefit Plan.
2. You may change your choice of plans at any time by contacting the Department.

PRA Disclosure Statement

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

V.20160722

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-C- B

OMB Expiration date: 10/31/2014

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

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

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

☑ The state/territory must inform the individual they are exempt and the state/territory must comply with all requirements related to voluntary enrollment.

☑ The state/territory assures it will effectively inform individuals who voluntary enroll of the following:

a) Enrollment is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan at any time and regain immediate access to full standard state/territory plan coverage;

c) What the process is for disenrolling.

☑ The state/territory assures it will inform the individual of:

a) The benefits available under the Alternative Benefit Plan; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan differs from the approved Medicaid state/territory plan.

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

☐ Letter

☐ Email

☒ Other:

Describe:

The Department has procedures to take applications, assist applicants, and perform initial processing of applications for Medical Assistance that include informing each eligible individual of the available benefit options. Upon identification of an individual who is exempt from mandatory enrollment per 42 CFR 440.315, the Department will inform these individuals that they may choose to enroll in any plan for which they are eligible (Standard, Basic, or Enhanced), and that they may opt out of an ABP at any time and instead access Medicaid benefits under the State plan.

The Department will provide such information at the following opportunities:
• Initial application for assistance;
• Notice of eligibility determination; and
• Selection of primary care case manager.

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

An attachment is submitted.

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

The state informs participants of their benefit plan options when exempt status is determined at the time of enrollment, at

redetermination, upon selection of the primary care case manager, and upon request.

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

The Department has an "Any Door" policy. The participant can notify their local eligibility office, their regional office, their Healthy Connections provider, or the Medicaid Central Office and obtain information about switching plans and/or initiate the process to opt out of an ABP and instead access Medicaid benefits under the State plan.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Voluntarily and affirmatively chose to enroll in the Alternative Benefit Plan.

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

☒ In the eligibility system.

☐ In the hard copy of the case record.

☐ Other:

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

☒ Copy of correspondence sent to the individual.

☒ Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.

☐ Other:

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

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

The communication text that is used to inform individuals identified as exempt, as defined under 42 CFR 440.315, about voluntary enrollment is as follows:
1. You may choose any benefit plan for which you are eligible—the Standard Benefit Plan, the Basic Alternative Benefit Plan, or the Enhanced Alternative Benefit Plan.
2. You may change your choice of plans at any time by contacting the Department.

PRA Disclosure Statement

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

V.20130807

Alternative Benefit Plan

State Name: Idaho

Attachment 3.1-L- B

OMB Control Number: 0938-1148

Transmittal Number: ID - 19 - 0004

Enrollment Assurances - Mandatory Participants ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☐ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

☐ Self-identification

☒ Other

Describe:

Part of the process of eligibility determination is the collection of eligibility and health status information. Based on that information the state will determine whether an exemption exists and allow selection of a plan voluntarily.

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the “Individuals at or below 133% FPL Age 19 through 64” eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

☐ Review of claims data

☒ Self-identification

☒ Review at the time of eligibility redetermination

☒ Provider identification

☒ Change in eligibility group

☐ Other

Alternative Benefit Plan

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ◉ Annually
- ○ Ad hoc basis
- ○ Other

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

The Department has an "Any Door" policy. The participant can notify their local eligibility office, their regional office, their Healthy Connections provider, or the Medicaid Central Office and obtain information about switching plans and/or initiate the process to opt out of an ABP and instead access Medicaid benefits under the State plan.

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

PRA Disclosure Statement

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

V.20160722

NOTICE OF INTENT TO SUBMIT STATE PLAN AMENDMENTS AND SOLICITATION OF PUBLIC INPUT

The Department of Health and Welfare is giving public notice of an impending change to the Idaho Medicaid State Plan. The Department assures these changes are in compliance with 42 CFR §440.386, 42 CFR§ 440.345 and with the provisions of section 5006(e) of the ARRA of 2009.

Medicaid has solicited input from Idaho's Tribal representatives regarding these changes in compliance with section 5006(e) of the American Recovery and Reinvestment Act of 2009 and its Tribal Consultation Policy. The Department also assures that individuals under twenty-one (21) years of age, pursuant to EPSDT, may receive additional services if determined medically necessary and prior authorized by the Department.

PROPOSED STATE PLAN CHANGES

The Department intends to submit four State Plan Amendments (SPA)'s on or before February 18, 2019, described as follows:

- Modifications to covered eligibility groups under Idaho Medicaid to add the Adult Group
- Adding the Adult Group, as a covered eligibility groups to Idaho's Basic Plan Alternative Benefit Package for adults
- Specifying that adults in this group, with special health needs have access to the benefits within Idaho's Enhanced Plan Alternative Benefit Package
- Adding plan pages describing Idaho's eligibility procedures for identification of the adult group for purposes of securing the Federal Medical Assistance Percentage (FMAP) for the adult group.

The effective date of these changes is January 1, 2020.

No public hearings have been scheduled at this time.

PUBLIC COMMENT

The Department is accepting written comments regarding these SPA's until March 22, 2019 to allow ample time for comment, due to the advanced effective date. Any person wishing to review the changes, call Cindy Brock at (208) 364-1983, or email the request to: cindy.brock@dhw.idaho.gov.

Written comments may also be sent to and reviewed by the public at the following address:

Bureau of Medical Care
Division of Medicaid
Department of Health and Welfare
3232 Elder Street
Boise, Idaho 83705
Phone (208) 364-1983

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

MATT WIMMER - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 17, 2018

Dear Tribal Representative:

In accordance with section 1902(a)(73)(A) of the Social Security Act regarding the solicitation of advice prior to the submission of any Medicaid State Plan Amendment (SPA) or 1915(b) waiver amendment likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations, the Idaho Department of Health and Welfare (Idaho Medicaid) seeks your advice on the following matter.

Purpose

Idaho Medicaid is complying with Idaho Code §56-267, as certified into law on November 20, 2018. This statute directs the Department to add healthcare coverage under the Medicaid State Plan for individuals from the age of nineteen (19) up to the age of sixty-five (65) with Modified Adjusted Gross Income less than or equal to one hundred thirty-three (133%) of the federal poverty level, who are not otherwise eligible for coverage under the Medicaid State Plan, in accordance with section 1902(a)(10)(A)(i)(VIII) and 1902(14) of the Social Security Act.

Idaho Medicaid must submit multiple policy actions to accomplish this work, which will include State Plan and 1915(b) waiver amendments, as required by the Centers for Medicare and Medicaid Services (CMS). Our policy actions will require documents to support:

- Adding the Adult Group as a covered eligibility group within our existing Basic and Enhanced Alternative Benefit Plans (ABP's)
- Adding the Adult Group as a covered eligibility group within our existing 1915(b) managed care waivers for behavioral health and dental services
- Amending existing State Plan pages to add the Adult Group as a covered population
- Amending existing State Plan pages for hospital presumptive eligibility processes and procedures to add the Adult Group
- Adding a new section of State Plan pages to describe operational procedures the State must follow when determining eligibility to secure the 90/10 federal matching rate for the Adult Group
- Other State Plan pages, as determined through consultation with CMS

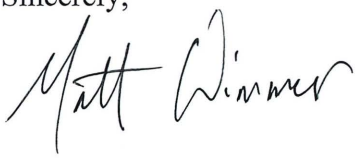
Proposed Effective Date
The Department intends to submit these policy actions to CMS on or before February 19, 2019 with a proposed effective date of January 1, 2020.

Anticipated Impact on Indians/Tribal Health Programs/Urban Indian Organizations (ITU)
We anticipate these policy changes will significantly improve access to Medicaid services for some Idaho resident members of tribes. It will have significant impacts for Tribal Health Programs who serve this population. The Department is dedicated to working in a collaborative effort with the Tribes to address any concerns or questions you may have regarding impacts to your facilities or members.

Comments, Input, and Tribal Concerns
Idaho Medicaid would appreciate any input or concerns that Tribal Representatives wish to share regarding these changes. In order to allow for a timely submission to CMS, please submit any comments for these changes **prior to January 16, 2019** via email to: Cindy.Brock@dhw.idaho.gov.

Idaho Medicaid's development of these policy changes will be shared in more detail and reviewed as part of the Policy Update at the next quarterly Tribal meeting, currently scheduled for February 20, 2019 in Boise, Idaho.

Sincerely,



MATT WIMMER
Administrator

MW/cb

COEUR D'ALENE TRIBE
CHAIRMAN ERNEST L. STENSGAR
P.O. BOX 408
PLUMMER, IDAHO 83851
(208) 686-5803 • Fax (208) 686-8813
chairman@cdatribe-nsn.gov

Sent Via Email

January 16, 2019

Idaho Dept. of Health & Welfare
Division of Medicaid
P.O. Box 83720
Boise, ID 83720

Dear Idaho Department of Health and Welfare:

On behalf of the Coeur d'Alene Tribe, I would like to respectfully express the Tribe's support for the full implementation of the Medicare Expansion Plan, as passed by the Idaho voters this past election.

The Coeur d'Alene Tribe's comments to Idaho Medicaid are as follows:

- The Medicaid expansion will open additional access opportunities for care throughout Idaho.
- The federal government covers 100% of costs for services provided to AIAN Medicaid enrollees through an IHS- or Tribally-operated facility. This 100% matching rate reflects a policy judgment that states should not have to contribute state general funds to the cost of care provided by a federal facility, whether operated by the IHS or on its behalf by a Tribe. In 2016, the Centers for Medicare and Medicaid Services (CMS) released guidance that expands the scope of services considered "received through" an IHS/Tribal facility that may qualify for 100% federal match. Expanding the scope of services that can qualify for 100% federal match provides potential increased savings to states and incentives to increase access to care for AIANs and expand capacity of IHS and Tribal services.
- This expansion will provide additional resources for mental health and substance abuse.
- The Tribe does not support the implementation of additional work requirements, these requirements would impose additional administrative burdens, additional costs, and additional barriers to care. Additionally, many tribal health care facilities have their own work requirements in place.

Respectfully,

Ernest L. Stensgar
Chairman,
Coeur d'Alene Tribe

The SHOSHONE-BANNOCK TRIBES

FORT HALL INDIAN RESERVATION
PHONE (208) 478-3700
FAX # (208) 237-0797

FORT HALL BUSINESS COUNCIL
P.O. BOX 306
FORT HALL, IDAHO 83203

January 16, 2019

Matt Wimmer, Administrator,
Division of Medicaid
Idaho Department of Health and Welfare
P.O. Box 83420
Boise, ID 83703

Attn: George Gutierrez, George.gutierrez@dhw.Idaho.gov

RE: SHOSHONE-BANNOCK TRIBES RESPONSE TO PROPOSED CHANGES TO IDAHO MEDICAID PLAN

On behalf of the Fort Hall Business Council, the governing body of the Shoshone-Bannock Tribes (Tribes), I write to offer formal comments to the Idaho Department of Health and Welfare (Idaho Medicaid) on the proposed changes to the Idaho Medicaid State Plan. The Tribes are pleased that our Idaho constituency passed Proposition 1 with a high majority. With its passage, it allows more Tribal members under age 65 who meet the income requirement to enroll in Medicaid coverage (a federal funding source), in accordance with the Centers for Medicare and Medicaid Services' trust responsibility to American Indians and Alaskan Natives (AIAN).

The health and wellbeing of our people is one of the highest priorities for the Tribes. The Tribes have reserved rights as set forth in the Fort Bridger Treaty of July 3, 1868, between the Shoshone-Bannock Tribes and the United States. Since those reserved treaty rights include health services, it is the responsibility of the Health and Human Services and the Indian Health Service (IHS) to ensure adequate health care is available to American Indians who use our health care facility. With the federal delegation to the State of Idaho, the Tribes must communicate with Idaho Health and Welfare to address Medicaid expansion issues.

The Affordable Care Act and CMS recognizes the unique political status of federal recognized tribes which is based on the tribal treaty rights and the federal trust responsibility held by federal agencies to Indian tribes. States are often unfamiliar with the federal-tribal relationships; therefore the Tribes can provide specific training for Idaho Health and Welfare Departmental staff, if so requested.

The Tribes urge Idaho Medicaid to consult directly with the Fort Hall Business Council and Tribal staff to fully understand and consider our input into the amendments that must be developed and submitted to the Centers for Medicare and Medicaid Services (CMS). There are numerous issues to discuss with Idaho to facilitate expanded health and medical care coverage for AIAN in our community and we look forward to effective consultation discussions and developing plans and strategies to improve our health care needs.

Now that the Proposition 2, the Initiative for Medicaid Expansion has passed, Idaho State Legislators will take up the debate on costs and other requirements that might be imposed, such as work requirements. The Tribes do not support any work requirements for Medicare recipients because it is contrary to, and undermines federal treaties and statues that recognizes the political status of federally recognized Indian tribes. Imposing any work requirements on AINA would be detrimental to the Tribal community because it creates unnecessary barriers for state and tribal administrators and would discourage AIAN from applying for Medicaid.

There are several unique benefits to American Indian patients that are directly resulting from Medicaid expansion.

- It would help eligible Tribal members ensure they are getting the health care and specialty services they need, which are not currently covered by either IHS or tribal Purchased and Referred Care (PRC) funds.
- Since the federal government covers 100% of costs for services provided to AIAN Medicaid enrollees through an IHS- or Tribally-operated facility, there would be no cost to the State of Idaho. This alleviates 100% of Idaho's responsibility to allocate state general funds to meet the cost of care provided to the cost of care at federal health care facilities, operated either by tribes or the Indian Health Service. In 2016, the Centers for Medicare and Medicaid Services (CMS) released guidance that expands the scope of services considered "received through" an IHS/Tribal facility that may qualify for 100% federal match. Expanding the scope of services that can qualify for 100% federal match provides potential increased savings to states and incentives to increase access to care for AINA and expand capacity of IHS and tribal services.
- The approval of Medicaid Expansion will assist in reducing the persistent disparities in health care and medical services for AIAN. Many of our patients rely upon direct care provided by IHS, and the high uninsured rate is a significant barrier to obtaining health care for both physical and behavioral needs.
- As the 2014 statistics indicate, our unemployment rate of 23.8% on the Fort Hall Reservation, this Medicaid expansion would provide more coverage to more AIAN patients. It would help cover health care gaps in employer-provided insurance, which would provide more access to more health care services and providers, beyond what IHS provides, due to limited federal funding. It also provides a key financing source for both IHS and tribal providers.
- There is no cost to eligible Tribal members to enroll in Medicare. Eligible Tribal members do not have to pay premiums or enrollment fees if they are eligible to receive care from our clinic (or an Indian health care provider). In addition, eligible Tribal

members do not have to pay any cost sharing, like deductibles, co-insurance, or copayments for any Medicaid service from any Medicaid provider if they have ever received a service or referral from our clinic (or an Indian Health Care Provider). This expanded funding source would stretch limited funding and provide more efficient use of PRC funds and of our Tribal facilities. The ripple effect extends to increasing revenue to our Tribal clinics because it would cover the costs of eligible patient health care costs, and allows us to allocate PRC funds to provide for additional specialized health care services.

- We have had to prioritize medical care services due to limited funding, but we would be able to go from Priority 1 to Priority 2, or even lower. This would allow for PRC to approve referrals based on medical needs and not based on limited funding. Tribal patients often resort to "seasonal sickness" based on the fiscal year, knowing if referrals are necessary to wait until October when funding is available for non-emergency referrals.
- As we indicated previously, the Tribes would receive more third party revenue, which allows the Tribes to expand health care services to cover new services we have not been able to provide to our community. For example, the Tribes would be able to hire family nurse practitioners to provide direct services to our patients. Turning to see other positive examples of Medicaid expansion in other states and tribes, potential opportunities include: possibly new benefits of non-emergency medical transport, new coverage for long-term care, expansion of pharmacy benefits, expansion of mental health coverage, care coordination services, and expanded provider networks compared to pre-existing programs
- One major misunderstanding at the State level is if services are accessed through IHS or an approved care coordination agreement, the federal government will pay 100% of the billed cost with no fiscal impact to Idaho. Medicaid and its recent expansion provide critical access to a broader array of services and providers.
- To better understand the significance of Medicaid expansion benefits to tribes, we can cite the State of Montana's experience in overcoming their health care disparities for the Montana tribal health care. With Medicaid expansion, a new payment source is available to tribes and IHS to combat mental health and substance use issues on reservations. Prior to Medicaid expansion, the State of Montana's General fund and limited federal dollars was unable to provide adequate services, and Montana tribes suffered tremendously with substance abuse, and a lack of sufficient mental health care. Now, for the first time, Medicaid provides a payment source for care for substance use disorders and mental illness. Medicaid is an important source of health care coverage for American Indians in Montana. Instead, a majority of American Indians receive health care through the IHS.

The Tribes appreciate the efforts to engage in meaningful consultation with the Tribes to improve the healthcare of our Tribal communities and ensure for the safety of our people, both men, women and children. As we identify in this letter, there are many benefits to Medicaid expansion, and we welcome working directly with Idaho to develop amendments that will address AIAN needs in the Idaho Plan amendments to be submitted to CMS. We invite you to come to Fort Hall and talk to Tribal leadership directly to better understand the importance and benefits of Medicaid expansion for our Tribal people and community. For more information,

please contact Ann Jim, Tribal Health and Human Services Director, at Ann.Jim@sb-thhs.com, or call her at 208-478-3744.

Respectfully,

Lalil Edmo (for)

Nathan Small, Chairman
Fort Hall Business Council
Shoshone-Bannock Tribes