

Medicaid Alternative Benefit Plan

Medicaid Alternative Benefit Plan: General Information

State/Territory name: **Idaho**
 Transmittal Number: **14-0014**

General Information:

Submission Title:

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

ID Enhanced ABP- Dental 14-0014

Description:

This amendment revises the Idaho Enhanced Plan to comply with State Legislative direction, and Idaho Code S 56-255(5)(c). Dental services are restored to adults (21 years of age and older) who are on the Enhanced Plan which includes those with disabilities and special health needs, effective 7/1/2014. Services are delivered through the Idaho Smiles program under a managed care structure with a capitated rate provided to Blue Cross of Idaho/DentaQuest.

- 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.*

0

Medicaid Alternative Benefit Plan: File Management Summary

State/Territory name: **Idaho**
 Transmittal Number: **14-0014**

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	3
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: Populations eligible for the Enhanced Alternative Benefit Plan. Uploaded Form Name: Date Uploaded: 02/27/2014
Enhanced ABP1 Populations.pdf

Support Documents

Document
Please provide a short description of this support document: Tribal Notice Uploaded Document Name: Date Uploaded: 02/12/2014
13-269 Tribal letter - EHB & Eligibility (ACA SPAs).pdf
Please provide a short description of this support document: Public Notice Uploaded Document Name: Date Uploaded: 02/12/2014
Legal Notice - ACA Eligibility and EHB 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

Form

Support Documents

Document

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

Form	
Please provide a short description of this ABP2b form:	
<input type="text"/>	
Uploaded Form Name:	Date Uploaded:
Enhanced ABP2b Voluntary enrollment.pdf	

Support Documents

Document	
Please provide a short description of this support document:	
<input type="text"/>	
Uploaded Document Name:	Date Uploaded:
ApplicationForAssistance1.pdf	
Please provide a short description of this support document:	
<input type="text"/>	
Uploaded Document Name:	Date Uploaded:
Idaho Health Plan English.pdf	

Form ABP2c: Enrollment Assurances - Mandatory Participants

ABP2c Forms List

Form

Support Documents

Document

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; width: 100%;"></div>				
<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Uploaded Form Name:</td> <td style="border: none; text-align: right;">Date Uploaded:</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">Enhanced_ABP3_Benchmark_vs_Benchmark_Equivalent.pdf</td> <td style="border: none;"></td> </tr> </table>	Uploaded Form Name:	Date Uploaded:	Enhanced_ABP3_Benchmark_vs_Benchmark_Equivalent.pdf	
Uploaded Form Name:	Date Uploaded:			
Enhanced_ABP3_Benchmark_vs_Benchmark_Equivalent.pdf				

Support Documents

Document

Form ABP4: Alternative Benefit Plan Cost-Sharing

ABP4 Forms List

Form				
Please provide a short description of this ABP4 form: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>				
<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Uploaded Form Name:</td> <td style="border: none; text-align: right;">Date Uploaded: 02/28/2014</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">Enhanced ABP4 Cost Sharing.pdf</td> <td style="border: none;"></td> </tr> </table>	Uploaded Form Name:	Date Uploaded: 02/28/2014	Enhanced ABP4 Cost Sharing.pdf	
Uploaded Form Name:	Date Uploaded: 02/28/2014			
Enhanced ABP4 Cost Sharing.pdf				

Support Documents

Document

Form ABP5: Benefits Description

ABP5 Forms List

Form				
Please provide a short description of this ABP5 form: Supersedes 14-0003				
<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Uploaded Form Name:</td> <td style="border: none; text-align: right;">Date Uploaded:</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">Enhanced_ABP5_Secretary_Approved_8-7-14.pdf</td> <td style="border: none;"></td> </tr> </table>	Uploaded Form Name:	Date Uploaded:	Enhanced_ABP5_Secretary_Approved_8-7-14.pdf	
Uploaded Form Name:	Date Uploaded:			
Enhanced_ABP5_Secretary_Approved_8-7-14.pdf				

Support Documents

Document

Form ABP6: Benchmark-Equivalent Benefit Package

ABP6 Forms List

Form

Support Documents

Document

Form ABP7: Benefits Assurances

ABP7 Forms List

Form				
Please provide a short description of this ABP7 form: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>				
<table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">Uploaded Form Name:</td> <td style="width: 40%; border: none;">Date Uploaded: 02/04/2014</td> </tr> <tr> <td colspan="2" style="border: none;"><div style="border: 1px solid black; padding: 2px;">Enhanced ABP7 Benefits Assurances.pdf</div></td> </tr> </table>	Uploaded Form Name:	Date Uploaded: 02/04/2014	<div style="border: 1px solid black; padding: 2px;">Enhanced ABP7 Benefits Assurances.pdf</div>	
Uploaded Form Name:	Date Uploaded: 02/04/2014			
<div style="border: 1px solid black; padding: 2px;">Enhanced ABP7 Benefits Assurances.pdf</div>				

Support Documents

Document

Form ABP8: Service Delivery Systems

ABP8 Forms List

Form				
Please provide a short description of this ABP8 form: Supersedes 14-0003 <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">Uploaded Form Name:</td> <td style="width: 40%; border: none;">Date Uploaded:</td> </tr> <tr> <td colspan="2" style="border: none;"><div style="border: 1px solid black; padding: 2px;">Enhanced_ABP8_MC_Dental_8-7-14.pdf</div></td> </tr> </table>	Uploaded Form Name:	Date Uploaded:	<div style="border: 1px solid black; padding: 2px;">Enhanced_ABP8_MC_Dental_8-7-14.pdf</div>	
Uploaded Form Name:	Date Uploaded:			
<div style="border: 1px solid black; padding: 2px;">Enhanced_ABP8_MC_Dental_8-7-14.pdf</div>				
Please provide a short description of this ABP8 form: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>				
<table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">Uploaded Form Name:</td> <td style="width: 40%; border: none;">Date Uploaded:</td> </tr> <tr> <td colspan="2" style="border: none;"><div style="border: 1px solid black; padding: 2px;">ABP8_Enhanced_MC-BH_Other_approved_6-4-14.pdf</div></td> </tr> </table>	Uploaded Form Name:	Date Uploaded:	<div style="border: 1px solid black; padding: 2px;">ABP8_Enhanced_MC-BH_Other_approved_6-4-14.pdf</div>	
Uploaded Form Name:	Date Uploaded:			
<div style="border: 1px solid black; padding: 2px;">ABP8_Enhanced_MC-BH_Other_approved_6-4-14.pdf</div>				
Please provide a short description of this ABP8 form: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>				

Form	
Uploaded Form Name:	Date Uploaded:
ABP8_Enhanced_FFS_PCCM_approved_6-4-14.pdf	

Support Documents

Document

Form ABP9: Employer Sponsored Insurance and Payment of Premiums

ABP9 Forms List

Form	
Please provide a short description of this ABP9 form:	
<input type="text"/>	
Uploaded Form Name:	Date Uploaded:
Enhanced_ABP9_Employer_Sponsored.pdf	

Support Documents

Document

Form ABP10: General Assurances

ABP10 Forms List

Form	
Please provide a short description of this ABP10 form:	
<input type="text"/>	
Uploaded Form Name:	Date Uploaded: 12/11/2013
Enhanced ABP10 General Assurances.pdf	

Support Documents

Document

Form ABP11: Payment Methodology

ABP11 Forms List

Form	
Please provide a short description of this ABP11 form:	
<input type="text"/>	

Form	
Payment Methodology: Idaho is making no changes to its already approved methodologies at this time.	
Uploaded Form Name:	Date Uploaded: 09/26/2013
Enhanced ABP11 Payment Methodologies.pdf	

Support Documents

Document	
Please provide a short description of this support document: 4.19-B reimbursement page re-submitted 6/4/14	
Uploaded Document Name:	Date Uploaded:
Attachment 4 19-B_page 50_6-4-14.pdf	

Medicaid Alternative Benefit Plan: Tribal Input

State/Territory name: **Idaho**
 Transmittal Number: **14-0014**

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	
---------------	--
- 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

Document	
Board, who work closely with Idaho tribes as a coordinating agency. Consultation letters are also uploaded onto a website designated specifically for communications between Idaho Medicaid and Idaho Tribes.	
Uploaded Document Name:	Date Uploaded:
14-181 Tribal Notice - Dental Services.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)

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.

Proposed Effective Date

 (mm/dd/yyyy)

Federal Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	<input type="text" value="2014"/>	\$ <input type="text" value="827225.00"/>
Second Year	<input type="text" value="2015"/>	\$ <input type="text" value="3308900.00"/>

Subject of Amendment

Dental benefits are restored for Enhanced Plan participants effective 7/1/2014.

Governor's Office Review

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

Describe:

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

Describe:

Signature of State Agency Official

Submitted By: Rachel Strutton
Last Revision Date: Aug 18, 2014
Submit Date: Aug 18, 2014