IDAHO DEPARTMENT OF
HEALTH & WELFARE

Draft Complex Medical Needs Waiver Application for Comment

November 7, 2017

Draft Complex Medical Needs Waiver Application

Contents

Executive Summary

Today Idahoans afflicted with a complex life-threatening medical condition rely on a mix of federally subsidized insurance, catastrophic health care fund coverage, and charity care to meet their needs. Accessing these variable methods of coverage results in an additional burden for Idahoans and their families at a time when they have the most difficulty in effectively managing the daily challenges of life related to their condition.

The Idaho Department of Health and Welfare (IDHW) and the Idaho Department of Insurance (DOI) are proposing a unique approach, which consists of a dual waiver, as part of the Idaho solution to address consistent, comprehensive coverage for this population which promotes accountability and responsible usage of taxpayer dollars. As part of this approach, the IDHW is seeking approval of a Section 1115(d) Demonstration Waiver through the Centers for Medicare and Medicaid Services to provide Medicaid coverage to Idahoans with Complex Medical Needs who have household incomes up to 400% of the Federal Poverty Level (FPL).

The Department of Insurance's component is an application for a Section 1332 Waiver to extend Advanced Premium Tax Credits (APTC) to working citizens who file federal tax returns with income below 100% of the FPL. DOI has also implemented changes to the Idaho Individual High-Risk Pool with the goal of lowering overall APTC costs within the State based exchange.

The Complex Medical Needs (CMN) waiver, as part of a sustainable solution for Idaho, will provide a reliable and comprehensive source of coverage, allow for better outcomes and reduce the negative impacts of unpredictable costs for these consumers and for the healthcare marketplace.

Section I - Program Description

This section should contain information describing the goals and objectives of the Demonstration, as well as the hypotheses that the Demonstration will test. In accordance with 42 CFR 431.412(a)(i), (v) and (vii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act). (This summary will also be posted on Medicaid.gov after the application is submitted. If additional space is needed, please supplement your answer with a Word attachment);

The Idaho Department of Health and Welfare proposes a Section 1115 demonstration to expand eligibility to children and adults with medically complex healthcare needs, whose household income is less than 400% FPL. Individuals with genetic conditions requiring ongoing complex medical support such as hemophilia, cystic fibrosis and those with end of life needs will be covered under the Complex Medical Needs (CMN) Demonstration Waiver. The CMN waiver will allow Idaho to ensure its high-needs individuals have consistent access to comprehensive healthcare coverage through the Medicaid program.

The demonstration will establish consistent and reliable coverage, where none currently exists, for individuals with medically complex conditions whose income is less than 100% of the Federal Poverty Level (FPL). These individuals either have no healthcare coverage at all or are subject to extremely limited, inefficient, and variable levels of healthcare services provided through charity care and the Idaho Catastrophic Health Care Fund. This new mode of coverage will achieve the objectives of title XIX by increasing overall Medicaid coverage and improving health outcomes for low-income individuals.

The demonstration will also achieve title XIX objectives for individuals with medically complex conditions and incomes between 100 – 400% of FPL by improving efficiency and quality of care through the provision of more comprehensive coverage at a lower cost than is available through existing methods of support.

Both groups will receive better end of life care consistent with patient desires. All individuals covered by this demonstration will have access to coverage for advance care planning which is not consistently available to them in the current system of care. This will promote better quality, end-of-life care and a better care experience in alignment with title XIX objectives.

2) Include the rationale for the demonstration (if additional space is needed, please supplement your answer with a Word attachment);

The coverage groups described above present specific challenges for coverage under commercial plans operating in Idaho. The demonstration will improve health outcomes, patient care experiences, and reduce the overall cost of care in the Idaho healthcare system by shifting their coverage to a Medicaid plan that is better able to meet their needs.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them (if additional space is needed, please supplement your answer with a Word attachment);

See the attached Appendix - E.

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate (if additional space is needed, please supplement your answer with a Word attachment);

The demonstration will operate statewide.

5) Include the proposed timeframe for the Demonstration (if additional space is needed, please supplement your answer with a Word attachment); and

Idaho is requesting a 5-year period for the waiver with an effective date of July 1, 2018.

CMS approval is requested by March 2018, to allow sufficient time for planning and enrollment activities. See the attached Appendix - A for a detailed project timeline.

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems (if additional space is needed, please supplement your answer with a Word attachment).

Idaho is currently conducting an analysis of the coverage of advance planning services utilizing Medicare's guidelines. Our systemic improvement plans for both Medicaid and CHIP include enhancing our existing services by aligning with Medicare. Our targeted implementation date for this alignment is January 2018.

We will continue to align with Medicare's coverage of these services in the context of this demonstration. Idaho will leverage our primary care providers, oncologists, and other specialists within our network to provide these services and to effectively conduct outreach for the demonstration when they identify potentially eligible individuals.

Section II – Demonstration Eligibility

This section should include information on the populations that will participate in the Demonstration, including income level. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included). Please refer to Medicaid Eligibility Groups: http://www.medicaid.gov/Medicaid-CHIP-Program- Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf when describing Medicaid State plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

Optional State Plan/Expansion Group

Eligibility Group Name	Eligibility Criteria	Income Level
Medically Complex Individuals	• Children and adults up through age 64 • Not otherwise eligible for the Medicaid program • Do not have access to an affordable employer-sponsored plan as defined in 26 CFR 1.36 • Diagnosis of a targeted medically complex condition as listed in the table below	• Up to 400% FPL

Diagnoses from the following hierarchical condition categories (HCC) will be included in the Demonstration:

HCC	HCC Label
66	Hemophilia
8	Metastatic Cancer
G07	Diseases of the Blood (Hemolytic anemia, sickle cell anemia, thalassemia major, etc)
159	Cystic Fibrosis
9	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
118	Multiple Sclerosis
G06	Disorders of Bone Marrow (Myelodysplastic syndromes, Myelofibrosis, Aplastic Anemia)

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan (if additional space is needed, please supplement your answer with a Word attachment);

The State will:

- Leverage qualified health plans, in conjunction with the Idaho Department of Insurance, to engage and conduct outreach to potentially eligible participants and refer potential eligibles to the state based on diagnoses contained in their claims data

- Leverage its existing Medicaid provider network of primary care providers, hospitals and specialty physicians to identify potentially eligible participants based on diagnosis and engage them to conduct outreach and refer potential eligibles to the state based on diagnosis.

- Utilize the modified adjusted gross income (MAGI) methodology, currently in effect under its State Plan, to determine income eligibility for the population targeted by this demonstration. Methodology changes will not be required for any population currently covered by the Idaho State plan.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment);

The State does not seek to cap or limit enrollment for the population covered by this demonstration.

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e.,
Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs (if additional space is needed, please supplement your answer with a Word attachment);

The State projects an initial enrollment of 1,500 participants based on carrier data provided by the Idaho Department of Insurance and an estimation of the number of individuals under 100% FPL that will gain Medicaid eligibility through this demonstration project.

State Fiscal Year	Demonstration Year	Projected Enrollment
2019	1	1,500
2020	2	1,575
2021	3	1,654
2022	4	1,736
2023	5	1,823

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State) (if additional space is needed, please supplement your answer with a Word attachment);

Demonstration participants who meet institutional level of care requirements will also be eligible for benefits described in Idaho's 1915(c) HCBS waivers as listed below. Demonstration participants who meet needs based eligibility criteria for 1915(i) benefits described in the Idaho State plan will have access to those benefits. Demonstration financial eligibility will be solely based on MAGI standards.

Idaho currently operates the HCBS waivers listed below:

HCBS Waiver #	Description
ID.1076.R06.00	Adult Developmental Disabilities
ID.0859.R01.02	Children's Developmental Disabilities
ID. 0887.R01.02	Children's Act Early
ID.1076.R06.00	Aged and Disabled

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for individuals or express lane eligibility for children after 2013) (if additional space is needed, please supplement your answer with a Word attachment)

Not Applicable

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014 (if additional space is needed, please supplement your answer with a Word attachment).

Not Applicable

Section III – Demonstration Benefits and Cost Sharing Requirements

This section should include information on the benefits provided under the Demonstration as well as any cost sharing requirements. In accordance with 42 CFR 431.412(a)(ii), the information identified in this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

☐ No ☒ Yes (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

☐ No ☒ Yes (if no, please skip questions 8 - 11)

Premiums for the demonstration population will be assessed based on a sliding fee schedule and a percentage of household income up to the maximum allowed by federal law.

Demonstration participants with countable incomes at or above 150%FPL will be subject to a monthly premium based on their countable household income. Participants with countable household income between 150%FPL up to 200%FPL will be subject to a premium up to 3% of their income. Those participants with household incomes between 200%FPL and 400%FPL will be subject to a premium up to 5% of their household income.

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

Not Applicable

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

Federal Employees Health Benefit Package

☐

☐ State Employee Coverage

☐ Commercial Health Maintenance Organization

■ Secretary Approved

Plan from largest small group product, preferred provider organization

(Blue Cross of Idaho Preferred Blue PPO)

**Please note that, in accordance with section 1937(a)(2)(B) of the Act, the following populations are exempt from benchmark equivalent benefit packages: mandatory pregnant women, blind or disabled individuals, dual eligibles, terminally ill hospice individuals, individuals eligible on basis of institutionalization, medically frail and special medical needs individuals, beneficiaries qualifying for long-term care services, children in foster care or receiving adoption assistance, mandatory section 1931 parents, and women in the breast or cervical cancer program. Also, please note that children must be provided full EPSDT benefits in benchmark coverage.

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

Not applicable

Please refer to List of Medicaid and CHIP Benefits: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Medicaid-andCHIP-Benefits.pdf, when completing this chart.

6) Indicate whether Long Term Services and Supports will be provided.

■ Yes (if yes, please check the services that are being offered) ☐ No

In addition, please complete the: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf, and the: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf.

x	Homemaker	x	Home Health Aide
x	Case Management (DD only)	x	Personal Care Services
x	Adult Day Health Services	x	Habilitation – Residential Habilitation
x	Habilitation – Supported Employment		Habilitation – Pre-Vocational
x	Habilitation – Day Habilitation		Habilitation – Education (non-IDEA Services)
x	Habilitation – Other Habilitative	x	Day Treatment (mental health service)
x	Respite		Clinic Services
	Psychosocial Rehabilitation		Vehicle Modifications
x	Environmental Modifications (Home Accessibility Adaptations)	x	Special Medical Equipment (minor assistive devices)
x	Non-Medical Transportation	x	Assistive Technology
x	Home Delivered Meals	x	Nursing Services
x	Personal Emergency Response	x	Adult Foster Care
	Community Transition Services	x	Supported Employment
	Day Supports (non-habilitative)	x	Private Duty Nursing (for children only)
x	Supported Living Arrangements	x	Adult Companion Services
x	Assisted Living	x	Supports for Consumer Direction/Participant Directed Goods and Services (for DD only)
x	Other (please describe)		

All demonstration participants will have access to support services available under the State Plan. Idaho covers all beneficiaries under one of three alternative benefit plans: Basic, Enhanced (for individuals with special health needs) and Coordinated (for duals). We plan to cover all demonstration participants under our Enhanced ABP which includes skilled nursing facility (and ICF) coverage. Participants will also have access to support services identical to those provided through our HCBS waivers. These services will be provided under 1115 authority. Idaho currently operates the following HCBS waivers:

HCBS Waiver #	**Description**
ID.1076.R06.00	Adult Developmental Disabilities
ID.0859.R01.02	Children's Developmental Disabilities
ID. 0887.R01.02	Children's Act Early
ID.1076.R06.00	Aged and Disabled

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

☐ Yes (if yes, please address the questions below)

☒ No (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program (if additional space is needed, please supplement your answer with a Word attachment);

b) Include the minimum employer contribution amount (if additional space is needed, please supplement your answer with a Word attachment);

c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing (if additional space is needed, please supplement your answer with a Word attachment); and

d) Indicate how the cost-effectiveness test will be met (if additional space is needed, please supplement your answer with a Word attachment).

8) If different from the State plan, provide the premium amounts by eligibility group and income level (if additional space is needed, please supplement your answer with a Word attachment).

Demonstration participants with countable incomes at or above 150%FPL will be subject to a monthly premium based on their countable household income. Participants with countable household income between 150%FPL up to 200%FPL will be subject to a premium up to 3% of their income. Those participants with household incomes between 200% and 400%FPL will be subject to a premium up to 5% of their household income.

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

If the state is proposing to impose cost sharing in the nature of deductions, copayments or similar charges beyond what is permitted under the law, the state should also address in its application, in accordance with section 1916(f) of the Act, that its waiver request:

a) will test a unique and previously untested use of copayments;
b) is limited to a period of not more than two years;

c) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients;
d) is based on a reasonable hypothesis which the Demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area; and
e) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

Please refer to Information on Cost Sharing http://www.medicaid.gov/Medicaid-CHIP- Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Information-on- Cost-Sharing-Requirements.pdf requirements for further information on statutory exemptions and limitations applicable to certain populations and services.

Not applicable

10) Indicate if there are any exemptions from the proposed cost sharing (if additional space is needed, please supplement your answer with a Word attachment).

Premiums will be waivable in part or in whole for those who are not able to pay due to their health condition or if payment of the premium would compromise the individual's ability to pay for reasonable, basic living expenses such as housing, food or utilities. All mandatory exempt populations, as specified in the Social Security Act, will be exempt from premiums.

Attestation of hardship based on income, housing and utility cost will be verified on a case by case basis. This will be based upon attestation by the enrollee and verified by the state's contractor.

Section IV – Delivery System and Payment Rates for Services

This section should include information on the means by which benefits will be provided to Demonstration participants. In accordance with 42 CFR 431.412(a)(ii), a description of the proposed healthcare delivery system must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

☒ Yes

☐ No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

Idaho benefits are provided entirely through alternative benefit plans (ABP's). The Idaho standard plan meets minimal requirements for Medicaid coverage and has an enrollment of zero individuals because of selection of more beneficial ABP enrollment options by participants. The demonstration will leverage existing Idaho ABP coverage as described below.

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms (if additional space is needed, please supplement your answer with a Word attachment);

Delivery system reforms are being explored outside of this waiver application within our integrated care model planning. These reforms are independent of this waiver authority and will promote better care through accountable care and patient centered medical home shared savings options for Idaho providers.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- ■ Managed care
  - ☐ Managed Care Organization (MCO),
  - ☐ Prepaid Inpatient Health Plans (PIHP)
  - ■ Prepaid Ambulatory Health Plans (PAHP)
- ■ Fee-for-service (including Integrated Care Models)
- ■ Primary Care Case Management (PCCM)
- ☐ Health Homes
- ☐ Other (please describe)

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:

Idaho Medicaid is a mixed delivery system of fee-for-service (FFS) and managed care. The service delivery for the Demonstration population will utilize the current provider networks and existing waiver authorities. Managed care benefits are authorized as follows:

Authority	**Service(s)**
1932(a)	Primary Care Case Management
1915(b)	Dental Services
1915(b)	Behavioral Health Services

5) If the Demonstration will utilize a managed care delivery system:

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations (if additional space is needed, please supplement your answer with a Word attachment)?

Enrollment for our managed care benefits is mandatory except for populations specifically exempted by federal law.

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state (if additional space is needed, please supplement your answer with a Word attachment);

Idaho's managed care benefits are operated on a statewide basis.

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state. If additional space is needed, please supplement your answer with a Word attachment);

The full Idaho Medicaid managed care network will be available to the demonstration population at implementation. There will not be a phased-in rollout for managed care.

d) Describe how will the state assure choice of MCOs, access to care and provider network adequacy (if additional space is needed, please supplement your answer with a Word attachment);

The State will leverage its existing contracts, waivers and State Plan assurances to ensure access to care and adequacy of our provider network.

e) Describe how the managed care providers will be selected/procured (if additional space is needed, please supplement your answer with a Word attachment).

The managed care provider networks currently in place will be utilized for this population. Additional recruitment will not be required.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion (if additional space is needed, please supplement your answer with a Word attachment);

All services currently available in the Idaho Medicaid State Plan will be available to the demonstration population.

7) If the Demonstration will provide personal care and/or long-term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration (if additional space is needed, please supplement your answer with a Word attachment).

☐ Yes ☒ No

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology (if additional space is needed, please supplement your answer with a Word attachment);

The State will utilize the existing State Plan reimbursement methodologies which consist of a mixed delivery system for our fee-for-service and managed care network.

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438 (if additional space is needed, please supplement your answer with a Word attachment); and

The State will leverage actuarially sound methods consistent with 42 CFR 438 requirements to adjust rates for the new population, if necessary. All services will be provided under our fee-for-service network except the following services which are authorized under our managed care program:

Authority	**Service(s)**
1932(a)	Primary Care Case Management
1915(b)	Dental Services
1915(b)	Behavioral Health Services

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected (if additional space is needed, please supplement your answer with a Word attachment).

Not Applicable

Section V – Implementation of Demonstration

This section should include the anticipated implementation date, as well as the approach that the State will use to implement the Demonstration. Specifically, this section should:

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone (if additional space is needed, please supplement your answer with a Word attachment);

Idaho is requesting a five-year Demonstration with the eligibility expansion to be effective July 2018. The determination of eligibility, delivery of services and state wideness is not based on a phased in approach. See the attached Appendix - A for the project timeline.

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration (if additional space is needed, please supplement your answer with a Word attachment); and

Enrollment will take place through two pathways; identification via qualified health plan carriers and enrollment through the Single State Agency based on physician verification of a qualifying diagnosis.

The Idaho Department of Insurance will share carrier data identifying participants with qualifying diagnoses based on QHP claims history on a monthly basis. These individuals will be enrolled into the Medicaid program and notified as described below.

The Department of Health and Welfare will conduct outreach activities to primary care and specialty providers informing them of enrollment processes for their patients with qualifying diagnoses. Enrollment and diagnosis certification forms will be completed by the participant and signed by their physician. IDHW staff will verify eligibility based on condition and financial standards through existing enrollment processes. The state will then issue a Notice of Decision to notify the participant of their eligibility for Medicaid and Medicaid benefit information.

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action (if additional space is needed, please supplement your answer with a Word attachment).

Idaho will amend its existing managed care contracts for behavioral health services, dental services and its transportation brokerage to include the demonstration population and leverage our annual actuarial review process to incorporate the demonstration population. Procurement actions will not be required as the State's existing managed care contracts specify a fixed capitated amount for an unlimited number of eligible participants.

Section VI – Demonstration Financing and Budget Neutrality

This section should include a narrative of how the Demonstration will be financed as well as the expenditure data that accompanies this application. The State must include 5 years of historical data, as well as projections on member month enrollment. In accordance with 42 CFR
431.412(a)(iii) and (iv), historical and projected expenditures as well as projected enrollment for the proposed demonstration project must be included in a state's application in order to be determined complete. The additional information requested will be needed before the application can be acted upon.

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: http://www.medicaid.gov/Medicaid- CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf includes a set of standard financing questions typically raised in new section
1115 demonstrations; not all will be applicable to every demonstration application. The Budget
Neutrality form and spreadsheet: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

All funding for demonstration participants will be provided by federal and state funds at the standard Idaho Medicaid title XIX federal financial participation rate. There is no historical data available, so the projected enrollment and spend numbers are based on Medicaid historical spend for the same conditions and carrier data for people with the same complex medical needs. See table below.

State Fiscal Year	Insurance Carrier Data Individuals	Anticipated Cost
SFY 2019	1,500	$42,000,000
SFY 2020	1,575	$44,000,000
SFY 2021	1,654	$46,000,000
SFY 2022	1,736	$49,000,000
SFY 2023	1,823	$51,000,000

Section VII – List of Proposed Waivers and Expenditure Authorities

This section should include a preliminary list of waivers and expenditures authorities related to title XIX and XXI authority that the State believes it will need to operate its Demonstration. In accordance with 42 CFR 431.412(a)(vi), this section must be included in a state's application in order to be determined complete. Specifically, this section should:

1) Provide a list of proposed waivers and expenditure authorities; and

The State requests federal authority to receive Federal Financial Participation (FFP) for individuals with medically complex health needs whose household incomes are less than 400 percent of the FPL (i.e. hemophilia, cystic fibrosis and those with end of life needs),

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

The State is requesting this waiver to provide consistent, comprehensive coverage to this population which is not currently available to them through Medicaid or employer sponsored insurance. Eligibility determination for this population is based on MAGI eligibility methods in addition to diagnosis with a CMN and countable income up to 400% FPL. This population will be subject to the requirements in our managed care network unless otherwise exempted in federal law.

Social Security Act Citation	**Description**
1902(a)(23)(A)	Freedom of Choice as based on our existing managed care waivers
1915(b)(4)	Mandate to single PIHP or PAHP managed care
1902(a)(4)	State wideness for managed care plans
1902(a)(10)(B)	Comparability of Services under managed care

Please refer to the list of title XIX and XXI waivers and expenditure authorities: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115 /Downloads/List-of-Waivers-and-Expenditure-Authorities.pdf that the state can reference to help complete this section. CMS will work with the State during the review process to determine the appropriate waivers and expenditures needed to ensure proper administration of the Demonstration.

Section VIII – Public Notice

This section should include information on how the state solicited public comment during the development of the application in accordance with the requirements under 42 CFR 431.408. For specific information regarding the provision of state public notice and comment process, please click on the following link to view the section 1115 Transparency final rule and corresponding
State Health Official Letter: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html

Please include the following elements as provided for in 42 CFR 431.408 when developing this section:

1) Start and end dates of the state's public comment period (if additional space is needed, please supplement your answer with a Word attachment);

   November 1, 2017 – December 15, 2017

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS (if additional space is needed, please supplement your answer with a Word attachment);

   Full public notice of the application was posted on the state's website on November 1, 2017, (located at www.cmnwaiver@dhw.idaho.gov).

   The full public notice was also published in the newspapers with the widest circulation in the state on or between November 1st and November 5, 2017. Those publications are: The Idaho Statesman, The Idaho Press Tribune, Idaho State Journal, Poster Register and the Coeur d'Alene Press.

   An abbreviated public notice was posted in the state's Administrative Bulletin (December edition) published on December 6, 2017 and is located at: https://adminrules.idaho.gov/bulletin/. This notice was also published in our Medicaid provider newsletter, the MedicAide on November 3rd and December 1st.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted (if additional space is needed, please supplement your answer with a Word attachment);

   The State will conduct three public hearings in the regional hubs to solicit public comments. The hearings are scheduled in Boise on December 7, 2017; Pocatello on

December 8, 2017 and in Coeur d'Alene on December 12th. Specific details on the hearings are listed in Appendix - B and Appendix - C of this application.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used. If additional space is needed, please supplement your answer with a Word attachment);

See the attached Appendix - B.

5) Comments received by the state during the 30-day public notice period (if additional space is needed, please supplement your answer with a Word attachment);

The State received comments from pertinent stakeholders regarding the Demonstration application. A summary of those comments, the state's response and any modifications of the application based on those comments is summarized in the attached Appendix - C.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application (if additional space is needed, please supplement your answer with a Word attachment);

See the attached Appendix - C.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation (if additional space is needed, please supplement your answer with a Word attachment).

See the attached Appendix - B.

If this application is an emergency application in which a public health emergency or a natural disaster has been declared, the State may be exempt from public comment and tribal consultation requirements as outlined in 42 CFR 431.416(g). If this situation is applicable, please explain the basis for the proposed emergency classification and public comment/tribal consultation exemption (if additional space is needed, please supplement your answer with a Word attachment).

Not applicable

Section IX – Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

Name and Title: Matt Wimmer, Administrator, Division of Medicaid, Idaho Department of Health and Welfare
Telephone Number: 208.364.1804
Email Address: matt.wimmer@dhw.idaho.gov

Appendix A _ Project Timeline

Phase I – Pre-Application Submittal

September 2017 – November 2017

- Legislation content developed
- Identification of project resources
- Development of the waiver application
- Development of the public notice, tribal notice and the abbreviated public notice
- Development of application communications plan
- Logistics development for public notice and comment process

Phase II – Public Notice and Comment

November 1, 2017 – December15, 2017

- *See Appendix B for detailed information*

Phase III – Application Submittal and Legislation

January 2018 – April 1, 2018

- Submittal of application to CMS and completeness review begins
  The Demonstration application will be submitted to CMS the week of January 1st – 8th, 2018. Idaho is requesting CMS's approval of the waiver by April 1, 2018 with implementation date of July 1, 2018
- Proposed legislation for two statutes changes will proceed through the legislative process. The Medicaid statutory change is to seek the authority for the 1115 demonstration and its companion statutory change, facilitated by the Idaho Department of Insurance, is to seek authority for a 1332 waiver. The request is for the legislation to be effective July 1, 2018.
- Design of automated system changes
- Development of outreach and enrollment strategy
- Development of program operations and monitoring strategy
- Drafting of policy components (Administrative rules process)

Phase –IV Pre-Program Launch Post Application Approval

April 1, 2018 – June 30, 2018

- Implementation of automated system project
- Implementation of outreach, notification and enrollment activities

Phase V – Delivery of Services

July 1, 2018 – March 30, 2023

- Implementation of operations for delivery, monitoring and reporting

Phase VI – Development of Amendment #1

July 1, 2018 – April 1, 2018

- 2nd phase of Automated System Design
  Modifications to operations and policy

Phase VII _ Evaluation of the Program

January 1, 2020 _ April 30, 2020

Evaluation of the demonstration
Submittal of the evaluation to CMS

Phase VIII _ Renewal of the Demonstration

January 1, 2021 - March 30, 2023

Renewal activities begin

Appendix B _ Public Engagement Documentation

Public and Tribal Notice

Idaho posted and published public and tribal notices and implemented a website to publicize the demonstration application to offer opportunity for public comment commencing November 1, 2017. Tribal notification will occur during our regularly scheduled quarterly Tribal meeting on November 8, 2017. Engagement with our Medical Care Advisory Committee will occur via electronic email during the first week of
November. We will also leverage an abbreviated notice in the December addition of our Administrative Bulletin (publication date of December 6, 2017) and our November and December edition of our Medicaid provider newsletter, the MedicAide, to solicit public comment and to publicize the logistics of the public hearings.

Public Hearings

Idaho will conduct three public hearings in distinctly different geographic areas of the state. Our regional hubs in eastern, southern and northern Idaho will serve as the venues. Hearings will be held on December 7th, 8th and 12th 2017 and will include statewide access via teleconference.

Public Comment

Public comment will be compiled, analyzed and recommendations for modifications will be considered and any changes incorporated into the demonstration application. A summary report of the public comments will be included in Appendix – C of the waiver package.

Electronic Mailing List Certification

The State certifies that it notified tribal communities, the Idaho Primary Care Association,
Idaho Hospital Association, the Idaho Medicaid Medical Care Advisory Committee, Idaho
Medical Association, the Idaho Medicaid Pharmacy & Therapeutics Committee, Idaho Osteopathic Physicians Association, the Idaho Health Care Association, Idaho Chapter of the American Academy of Pediatrics and the Idaho Academy of Family Physicians of the submittal of the demonstration application and the opportunity for public comment. Notification was made via email distribution and included information regarding where the public notice, tribal notice and demonstration application was viewable on the State's website and detailed information on the public hearing and the opportunity for public comment

Tribal Notification Certification

The state certifies it is in the process of conducting tribal notification according to its formal process. Idaho's formal tribal notice, which included information on the public hearings and the demonstration application, was provided to the tribes via email, USPS mail and posted to the tribal website on November 1, 2017. The state will seek additional discussion with the tribes regarding the application during the quarterly tribal meeting to be held in Lapwai, ID on November 8, 2017.

Public Notice

Idaho Department of Health and Welfare Demonstration Waiver for Complex Medical Needs

Notice of Public Hearing and Public Comment Period

Pursuant to 42 CFR §431.408, §440.386 and §440.345 and in compliance with the provisions of section 5006(e) of the ARRA of 2009, the Idaho Department of Health and Welfare (IDHW), gives notice of its intent to apply for a demonstration waiver to the Centers for Medicare and Medicaid Services (CMS), The waiver is requested under the authority provided in §1115(d) of the Social Security Act. The waiver application will be submitted on or after January 1, 2018. The proposed effective date for the waiver is July 1, 2018.

Description and Goal of the Waiver

The Department intends to submit an application to the Centers for Medicare and Medicaid Services (CMS) for a demonstration waiver. The purpose of the waiver is to provide Medicaid coverage to children and adults with a complex medical condition with the goal of improving improve access to consistent and comprehensive coverage which fully meets their needs.

Today Idahoans afflicted with a complex life-threatening medical condition rely on a mix of federally subsidized insurance, catastrophic health care fund coverage, and charity care to meet their needs. Accessing these variable methods of coverage results in an additional burden for Idahoans and their families at a time when they have the most difficulty in effectively managing the daily challenges of life related to their condition. By providing a reliable and comprehensive source of coverage, the CMN waiver will allow for better outcomes for this population while reducing the negative impacts of unpredictable costs for these consumers and for the healthcare marketplace.

The waiver application is available for review on our website at www.cmnwaiver@dhw.idaho.gov . The Department is seeking public comment through the website, public hearings, via email, through the website or USPS mail through the contact provided at the end of this notice.

Evaluation of the Demonstration

The Department will conduct an evaluation to determine if the needs of those with complex medical needs had their medical needs more effectively met prior to or after coverage by Medicaid and to determine if their outcomes and experience of care improved, stayed the same or declined.

The Department will leverage available data resources to conduct the evaluation which will include obtaining information regarding experience of care and services prior to the waiver, Medicaid claims data and standardized survey tools to measure quality, outcomes and care

experiences after the implementation and on an annual basis. This will provide a baseline and an ongoing assessment of the waivers status.

Eligibility Requirements

Participants must meet the following requirements:

- Children and adults, up through age 64, with household income between 0 - 400% of the Federal Poverty Level (FPL)
- Not otherwise eligible for Medicaid
- Do not have access to an affordable employer-sponsored plan as defined in 26 CFR 1.36
- Diagnosis of a targeted medically complex health care condition as listed in the table below:

HCC	HCC Label
66	Hemophilia
8	Metastatic Cancer
G07	Diseases of the Blood (Hemolytic anemia, sickle cell anemia, thalassemia major, etc)
159	Cystic Fibrosis
9	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
118	Multiple Sclerosis
G06	Disorders of Bone Marrow (Myelodysplastic syndromes, Myelofibrosis, Aplastic Anemia)

Services and Delivery System

Participants eligible for the demonstration will have access to all inpatient, outpatient, primary care, physician specialty care, surgical, diagnostic, rehabilitative, hospice, dental, transportation, long-term supports, prescription drug and behavioral health services currently approved in the Idaho Medicaid State Plan. Services are currently delivered under a delivery system of both feefor-service and managed care provider networks.

Cost-Sharing

Consistent with other Idaho Medicaid programs, participants of CNM will be subject to the assessment of a premium based on household income and not to exceed the maximums set forth in federal law and regulations for the Medicaid program. The Department will establish a premium fee schedule and publish it on its website. Eligible individuals will be notified of their eligibility for Medicaid and cost-sharing requirements.

Financing and Enrollment

The projected fiscal impact for State Fiscal Year 2019 is estimated at a federal cost of ~$53,200,000-$69,300,000 and a State General Fund estimated between $22,500,000-$29,700,000 for a total estimated fiscal impact of $76,000,000-$99,000,000. Final numbers for the fiscal impact will be determined once the cost effectiveness calculations have been

completed. The Department projects enrollment during the first year of the demonstration will be approximately 1,400-2,000 participants. Enrollment in years two through five will be approximately 1,500-2,200 participants based on disease prevalence data for the covered conditions as monitored by the Centers for Disease Control and Prevention and commercial coverage data provided by the Idaho Department of Insurance.

Public Hearings

Pursuant to CFR 431.408(C)(iv), Idaho Medicaid will hold public hearings to provide an opportunity for stakeholders to provide comment on the waiver application. Interested stakeholders are afforded three opportunities to attend in person or by teleconference.

Boise Public Hearing	**Pocatello Public Hearing**	**Coeur d'Alene Public Hearing**
Location: Pete T. Cenarrusa Bldg.	Location: DHW Region VI	Location: DHW Region I
7th Floor, Conference Rm. 7A	Suite #230	Large Conference Rm.
450 W. State St.	1070 Hiline Rd.	1120 Ironwood Dr.
Date: December 7, 2017	Date: December 8, 2017	Date: December 12, 2017
Time: 11:00AM - 1:00 PM	Time: 11:00AM - 1:00PM	Time: 10:00AM - 12:00PM PDT

Conference line for all dates and locations:
Call: 1-877-820-7831
Guest Code: 701700

Tribal Notification Process

The Department has implemented its Medicaid Tribal Notification Process regarding this waiver application. The process includes providing a written notice to the Tribes (via USPS mail) sixty (60) days prior to the submission of the waiver application, posting of the notice on the Tribal website and engaging Tribal representatives during our routine quarterly meeting on November 8, 2017 in Lapwai, ID.

Public Review and Comment Opportunities

Copies of all notices regarding the waiver application and the waiver application itself are available for viewing at any Idaho Department of Health and Welfare office or on our website at www.cmnwaiver@dhw.idaho.gov**.** Interested parties may also request hard copies of the waiver application or submit comments via email or traditional USPS mail to:

Attention: Cindy Brock Alternative Care Coordinator Division of
Medicaid P.O. Box 83720; Boise, Idaho 83720-0009
E-mail to: cmnwaiver@dhw.idaho.gov

Public comments will be accepted until December 15, 2017.

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

November 1, 2017

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 waiver 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

The Department intends to submit an application to the Centers for Medicare and Medicaid Services (CMS) for a demonstration waiver. The purpose of the waiver is to provide Medicaid coverage to children and adults with a complex medical condition with the goal of improving access to consistent and comprehensive coverage which fully meets their needs.

Today Idahoans afflicted with a complex life-threatening medical condition rely on a mix of federally subsidized insurance, catastrophic health care fund coverage, and charity care to meet their needs. Accessing these variable methods of coverage results in an additional burden for Idahoans and their families at a time when they have the most difficulty in effectively managing the daily challenges of life related to their condition. By providing a reliable and comprehensive source of coverage, the CMN waiver will allow for better outcomes for this population while reducing the negative impacts of unpredictable costs for these consumers and for the healthcare marketplace.

The waiver application is available for review on our website at cmnwaiver.dhw.idaho.gov . The Department is seeking public comment through the website, public hearings, via email or USPS mail through the contact provided at the end of this notice. You are afforded three opportunities to attend a hearing in person or by teleconference on the days and times listed below:

Boise Public Hearing	**Pocatello Public Hearing**	**Coeur d'Alene Public Hearing**
Location: Pete T. Cenarrusa Bldg.	Location: DHW Region VI	Location: DHW Region I
7th Floor, Conference Rm. 7A	Suite #230	Large Conference Rm.
450 W. State St.	1070 Hiline Rd.	1120 Ironwood Dr.
Date: December 7, 2017	Date: December 8, 2017	Date: December 12, 2017
Time: 11:00AM - 1:00 PM	Time: 11:00AM - 1:00PM	Time: 10:00AM - 12:00PM PDT

Conference line for all dates and locations:
Call: 1-877-820-7831
Guest Code: 701700

Anticipated Impact on Indians/Tribal Health Programs/Urban Indian Organizations (ITU)

While this waiver will provide access to Medicaid services for this population, no significant impact to ITU providers is anticipated. Some Idaho resident members of tribes in Idaho may be provided greater access to coverage than is currently available.

Comments, Input, and Tribal Concerns

Idaho Medicaid would appreciate any input or concerns that Tribal Representatives wish to share regarding this waiver application. In order to allow for a timely submission to CMS, this solicitation is being made under expedited circumstances. Please submit any comments prior to December 15, 2017, to Cindy Brock, Alternative Care Coordinator at cmnwaiver@dhw.idaho.gov.

Sincerely,

MATT WIMMER
Administrator

MW/cb

Idaho Department of Health and Welfare Demonstration Waiver for Complex Medical Needs
Notice of Public Hearing and Public Comment Period

The Idaho Department of Welfare gives notice of intent to apply to the Centers for Medicare and Medicaid Services (CMS) for an 1115(d) demonstration waiver on or about January 5, 2018. The purpose of the Complex Medical Needs (CMN) waiver is to provide Medicaid coverage to children and adults who have a complex medical condition(s). The waiver will provide access to consistent and comprehensive coverage which fully meets the needs of this population. The proposed effective date for the waiver is July 1, 2018.

Today, Idahoans living with complex, life-threatening medical conditions rely on a mix of federally subsidized insurance, catastrophic health care fund coverage, and charity care to meet their needs. This variable coverage results in challenges for people who are trying to manage their complex condition at a time when they have the most difficulty in managing those challenges effectively due to their condition. By providing a reliable and comprehensive source of coverage, the CMN waiver will allow for better outcomes for this population while reducing the negative impacts of unpredictable costs for these consumers and for the healthcare marketplace.

The Department's comprehensive public notice, tribal notice and the waiver application are available on our website at www. complexmedicalneeds.dhw.idaho.gov. The Department is seeking public comment through public hearings, the interactive form available on the website, via email or traditional mail as indicated below. Public hearings will be held at the following locations:

Boise Public Hearing	**Pocatello Public Hearing**	**Coeur d'Alene Public Hearing**
Location: Pete T. Cenarrusa Bldg. Region I	Location: DHW Region VI	Location: DHW
7th Floor, Conference Rm. 7A Rm.	Suite #230	Large Conference
450 W. State St.	1070 Hiline Rd.	1120 Ironwood Dr.
Date: December 7, 2017	Date: December 8, 2017	Date: December 12, 2017
Time: 11:00AM - 1:00 PM PDT	Time: 11:00AM - 1:00PM	Time: 10:00AM - 12:00PM

Conference line for all dates and locations:
Call: 1-877-820-7831
Guest Code: 701700

Interested parties may also request hard copies of the waiver packet or submit comments via email or traditional USPS mail to:

Attention: Cindy Brock
Alternative Care Coordinator
Division of Medicaid
P.O. Box 83720; Boise, Idaho 83720-0009
E-mail to: CMNwaiver @dhw.idaho.gov
Public comments will be accepted until December 15, 2017.

Appendix C – Public Comments Summary

PLACEHOLDER PUBLIC COMMENTS SUMMARY

PLACEHOLDER PUBLIC COMMENTS SUMMARY

Appendix D – Demonstration Financing Form

Demonstration Financing Form

Please complete this form to accompany Section VI of the application in order to describe the financing of the Demonstration.

The State proposes to finance the non-federal share of expenditures under the Demonstration using the following (please check all that are applicable):

☒ State General Funds

☐ Voluntary intergovernmental transfers from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

☐ Voluntary certified public expenditures from governmental entities. (Please specify and provide a funding diagram in the narrative section – Section VI of the application).

☐ Provider taxes. (Provide description the narrative section – Section VI of the application).

☐ Other (If the State is interested in other funding or financing arrangements, please describe. Some examples could include, but are not limited to, safety net care pools, designated state health programs, Accountable Care Organization-like structures, bundled payments, etc.)

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking States to confirm to CMS that providers retain 100 per cent of the payments for services rendered or coverage provided.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

☒ Yes ☐ No

If no, provide an explanation of the provider payment arrangement.

Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of payments are returned to the State, local governmental entity, or other intermediary organizations?

☐ Yes ☒ No

If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount of percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.). Please indicate the period that the following data is from.

Section 1902(a) (2) provides that the lack of adequate funds from other sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global, supplemental, enhanced payments, capitation payments, other) is funded.

Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment. Please indicate the period that the following data is from:

If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

For any payment funded by CPEs or IGTs, please provide the following, and indicate the period that the data is from:

Name of Entity Transferring/ Certifying Funds	Type of Entity (State, County, City)	Amount Transferred or Certified	Does the entity have taxing authority?	Did the entity receive appropriations?	Amount of appropriations

Section 1902(a) (30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) and 2105(a)(1) provide for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type, and indicate the time period that that the data is from.

Provider Type	Supplemental or Enhance Payment Amount

Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global, supplemental, enhanced, and other) that, in the aggregate, exceed its reasonable costs of providing services?

☐ Yes ■ No

If yes, provide an explanation.

In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

☐ Yes ■ No ☐ Not Applicable

If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

☐ Yes ■ No

Use of other Federal Funds

Are other federal funds, from CMS or another federal agency, being used for the Demonstration program? ☐ Yes ■ No

If yes, provide a list below of grants the State is receiving from CMS or other federal agencies. CMS must ensure these funds are not being used as a source of the non-federal share, unless such use is permitted under federal law. In addition, this will help to identify potential areas of duplicative efforts and highlight that this demonstration is building off of an existing grant or program.

Source of Federal Funds	Amount of Federal Funds	Period of Funding

Appendix E – Evaluation of the Demonstration

EVALUATION

Idaho will carry out an evaluation that tests the following hypotheses about the 1115 demonstration waiver:

1. Medicaid coverage will meet the needs of medically complex individuals with incomes from 100% to 400% of FPL more effectively than qualified health plan (QHP) coverage.
2. Medicaid coverage for medically complex individuals with incomes less than 100% of FPL will result in better health outcomes and care experiences.

To test these hypotheses, the evaluation will collect survey data on health care access, quality, and patient experience from Idahoans who become Medicaid eligible under the waiver, and evaluate changes in these outcomes using statistical models. An initial wave of surveys will capture the experience of newly eligible Medicaid members in the year before the waiver. Subsequent survey rounds will track members' experience with Medicaid coverage, providing the basis for evaluation of the waiver's effects.

To more rigorously test Hypothesis 1, the evaluation will also attempt to obtain administrative claims data from QHP carriers for the pre-waiver study period, along with Medicaid claims for the post-waiver period. These data will provide a more extensive set of access and quality measures for assessment. In addition, claims data will allow comparison of changes in access and quality among former QHP members who become Medicaid eligible with changes among an out-of-state population not affected by the waiver, providing more rigorous evidence of the waiver's effects.

Populations and Data

Three primary groups of Idahoans with medically complex conditions may gain Medicaid coverage under the 1115 demonstration waiver:

- QHP members with income from 100% to 400% FPL who were previously eligible for advance premium tax credits (APTCs)
- Idahoans with incomes less than 100% FPL who were not eligible for APTCs, and who received health care through the Idaho Catastrophic Health Care Fund or charity care
- Uninsured Idahoans with incomes less than 400% FPL who were not enrolled in a QHP and who did not receive services through the Catastrophic Health Care Fund or charity care

Ideally, detailed data from periods before and after the waiver would be available to evaluate changes in access, quality, and patient experience. Unfortunately, such data are not currently available for the pre-waiver period. The Idaho Department of Health and Welfare (DHW) can provide detailed data on health care services use of newly eligible Medicaid members after they

enroll in Medicaid; however, publicly available data from QHPs and the Catastrophic Health Care Fund are insufficiently detailed to create useful outcome measures, and no statewide data source captures services used by the uninsured. In addition, no publicly available data source on patient experience—for example, "perceived ease of getting care" or "satisfaction with care overall"—includes information needed to identify and report on these populations.

The evaluation will use two potential data sources—a retrospective survey and claims data from QHP carriers—to fill the gap in existing data sources.

Retrospective Survey

To capture data on access, quality, and patient experience for all populations, the evaluation will survey Idahoans who gain Medicaid coverage under the 1115 waiver upon their enrollment, resurveying them annually until the waiver ends or they dis-enroll. The survey will ask about their experience over the previous 12 months, enabling the evaluation to establish baseline outcomes before the members gained Medicaid coverage (i.e., when they were still enrolled in QHPs, receiving care through the Catastrophic Health Care Fund or charity care, or uninsured).
The survey will include items from tested and validated survey instruments, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the National Health Insurance Survey (NHIS), enabling the evaluators to calculate a variety of self-reported outcome measures. For example:

- Percentage of people who said they had a doctor's office visit, specialty visit, ED visit, or inpatient stay
- Percentage of people who said it was always easy to get needed care, tests, or treatment
- Percentage of people who rated their overall health good, very good, or excellent
- Percentage of people who said they didn't get care because they couldn't afford it

In addition, the evaluators will identify or develop survey items to determine whether enrollees had advance planning for end-of-life care. The survey will also capture basic demographic information for use in regression analysis. Attachment 1 lists potential survey items that may be drawn from existing instruments.\

The evaluators will use regression analysis to assess changes in outcomes before and after the waiver, controlling for the effect of population characteristics on outcomes. Results will be reported by population and other demographic categories of interest if a sufficiently large sample is available (see Dependencies below). Analysis of survey data will be used to test both Hypotheses 1 and 2.

Data from the retrospective survey will have several limitations. First, retrospective survey data are subject to recall bias—differences in the accuracy or completeness of the reported information among respondents—and are generally considered less reliable than claims or other administrative records. Recall bias may be especially large among patients with complex medical needs given the high volume of services they are likely to have received. Second, retrospective survey data allow only a comparison of outcomes before and after the waiver, and cannot be used to account for unobservable factors that may be driving change independently of the waiver. Comparing change in outcomes among newly eligible Idahoans with change among a similar out-of-state group not affected by the waiver could help account for such factors; however, the evaluation will not be able to identify such a group in existing survey datasets because people with medically complex conditions cannot be identified in these datasets. To overcome these limitations, the evaluation will attempt to obtain and analyze claims from QHP carriers.

Claims Data from QHP Carriers

Obtaining claims data from QHP carriers will enable the evaluation to include claims-based measures of health care access and quality that have been tested and validated by national measure stewards and compare changes in these measures among former QHP members before and after the waiver to changes among an out-of-state population. Attachment 2 provides examples of claims-based measure that could be used for the evaluation. These include overall measures of access and quality, such as Adults' Access to Preventive-Ambulatory Services and Potentially Avoidable ED Visits, and quality-of-care measures for specific conditions, such as
30-day Unplanned Readmission Rate for Cancer Patients and Statin Therapy for Patients with Cardiovascular Disease. The ability to reliably calculate quality-of-care measures for specific conditions will depend on having data for a sufficiently large number of members with those conditions in the overall population (see Dependencies below).

At least 12 months of pre-waiver claims data will be requested to establish a baseline. Claims data will also be requested from the period following waiver implementation in order to track outcomes for any members that remain in QHPs. The request will cover a limited set of data elements needed to create outcome measures appropriate for the target population (see Attachment 3). Results will not be reported by QHP carrier.

Claims data will enable the evaluation to test Hypothesis 1 more rigorously than survey data alone: They will allow evaluators to calculate an expanded set of access and quality measures for former QHP members. In addition, they may allow evaluators to compare changes among former QHP enrollees with changes among a similar out-of-state group. This would help account for the effect of secular trends that affect health care use by low-income people with complex medical conditions across the region or nation. Possible comparison groups include Medicaid members in the neighboring states of Oregon or Washington, and QHP members in Oregon, which operates an all-payer claims database that includes data from commercial

insurance members. Evaluators in other states have used out-of-state comparison groups to evaluate Medicaid waivers.[1,2]

Claims data from QHP carriers would increase the rigor of the evaluation, adding high-quality evidence about the waiver's effects. However, the effort involved in working with QHP carriers to obtain complete and accurate claims data, clean the data, and assign patient identifiers across QHP and Medicaid datasets (described below) would add to the complexity and cost of the evaluation.

Dependencies

The methods described above will depend on timely administration of a retrospective survey, cooperation from QHP carriers, and obtaining data for a sufficient number of members through surveys or claims:

- For both survey and claims data analysis, a sufficiently large sample of members would be needed to confidently establish that the waiver was associated with changes in outcomes. The State estimates that the number of people moving from QHPs to Medicaid would be relatively small (about 1,500). If too few people respond to surveys; if too few carriers contribute data; or if too few people meet access and quality measure inclusion criteria, it will be challenging to establish that the waiver was associated with changes in outcomes at conventional levels of statistical certainty.
- A retrospective survey will need to be administered to newly-eligible Medicaid members as soon as possible after enrollment in Medicaid in order to minimize recall bias, and to ensure the same data collection methods apply to each member.
- Carriers would need to submit uniform and complete claims data from members who gained Medicaid eligibility. There were five QHP carriers participating in Idaho's exchange marketplace in 2017, suggesting that it would be feasible to work with them on obtaining data. However, obtaining and reconciling carrier data would require substantial effort, as carriers often use different systems for data management.
- To identify and track Idahoans who moved from QHPs to Medicaid, and to calculate quality measures for those who moved among QHPs in the pre-waiver period, the evaluation would require direct patient identifiers from carriers. Substantial analytic effort may be needed to match patients across QHP and Medicaid datasets.

[1] McConnell KJ, Renfro S, Chan BKS, et al. Early Performance in Medicaid Accountable Care Organizations: A Comparison of Oregon and Colorado. *JAMA Intern Med*. February 2017. doi:10.1001/jamainternmed.2016.9098. [2] McConnell KJ, Renfro S, Lindrooth RC, Cohen DJ, Wallace NT, Chernew ME. Oregon's Medicaid Reform And Transition To Global Budgets Were Associated With Reductions In Expenditures. *Health Aff (Millwood)*. 2017;36(3):451-459. doi:10.1377/hlthaff.2016.1298.

ATTACHMENT 1: POTENTIAL SURVEY ITEMS FROM EXISTING INSTRUMENTS*

DOMAIN	SURVEY ITEM
Access	In the last 12 months, how many days did you usually have to wait for an appointment when you needed care right away?
	In the last 12 months, how often were you able to get the care you needed from a doctor's office or clinic during evenings, weekends, or holidays?
	In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?
Services use	In the last 12 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?
	In the last 12 months, how many times have you gone to a hospital or emergency room to get care for yourself?
	In the last 12 months, how many times were you a patient in a hospital overnight or longer?
Experience	Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?
	Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?
Health status	In general, how would you rate your overall health?
	In general, how would you rate your overall mental or emotional health?
Affordability	In the last 12 months, was there any time when you needed any of the following, but didn't get it because you couldn't afford it? (prescription medicines, to see a specialist, mental health care or counseling, followup care, dental care)

*All items are from the CAHPS Commercial Health Plan Survey except for affordability items, which are from the National Health Insurance Survey.

ATTACHMENT 2: POTENTIAL CLAIMS-BASED MEASURES OF ACCESS AND QUALITY FOR PEOPLE WITH MEDICALLY COMPLEX CONDITIONS*

CONDITION	ESTIMATED ID LIVES†	MEASURE	STEWARD‡
Overall quality of care	NA	Adults' Access to Preventive-Ambulatory Services	NCQA
		Outpatient Visits and ED Utilization	NCQA
		Potentially Avoidable ED Visits	Medi-Cal
		Follow-Up After Emergency Department Visit for People With High-Risk Multiple Chronic Conditions	NCQA
		Inpatient Hospital Utilization	NCQA
		Plan All-Cause Readmissions	NCQA
Metastatic cancer	656	30-day unplanned readmission rate for cancer patients	Alliance of Dedicated Cancer Centers
Lung, brain, and other severe cancers	251	Diagnostic flexible bronchoscopy: proportion of adults with suspected lung malignancy having computed tomography scans reported prior to bronchoscopy	British Thoracic Society
Hemophilia	8	Under development	
Multiple Sclerosis	475	Under development	
Cystic Fibrosis	30	Under development	
Disorders of bone marrow	28	Myelodysplastic syndromes (MDS): percentage of higher-risk MDS patients receiving azacitidine or decitabine	American Society of Hematology
Diseases of the Blood	52	Under development	

ATTACHMENT 3: ANTICIPATED DATA ELEMENTS TO REQUEST FROM QHP CARRIERS

FIELD	NOTES
Carrier ID	Needed for data management; results will not be reported by carrier
Carrier submission date or batch identifier	Needed for data management
Claim ID	Needed for claim version control
Claim status	Example: reversal, adjustment (and dependent claim ID)
MemberID	Needed for data management
Member age	
Member birthdate	Needed to accurately calculate some quality measures
Member gender	
Member zip code of residence	
Enrollment start date	Needed for all enrollment segments if there is discontinuity
Enrollment end date	Needed for all enrollment segments if there is discontinuity
Payer/type of business	Example: QHP, Medicare, Catastrophic plan, Dual eligible
First date of service	Or admit date for inpatient visits
Last date of service	Or discharge date for inpatient visits
Claim type code	Example: inpatient, outpatient, ED, professional
BETOS code	
ICD-9 diagnosis level 1	Could accept ICD-10 if that is what is available
ICD-9 diagnosis level 2	Could accept ICD-10 if that is what is available
ICD-9 diagnosis level 3	Could accept ICD-10 if that is what is available
ICD-9 diagnosis level 4	Could accept ICD-10 if that is what is available
ICD-9 procedure level 1	Could accept ICD-10 if that is what is available
ICD-9 procedure level 2	Could accept ICD-10 if that is what is available
ICD-9 procedure level 3	Could accept ICD-10 if that is what is available
CPT or HCPCS	
CPT modifier	
Place of service code	Per CMS standards
Claim source inpatient admission code	Per CMS standards
UB revenue code	Per CMS standards
Patient discharge status code	Per CMS standards
Type of bill	Per CMS standards
NDC	Needed for drug-based quality measures
Quantity dispensed	Needed for drug-based quality measures
Days' supply	Needed for drug-based quality measures
Date dispensed	Needed for drug-based quality measures