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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 19-0003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106-2898

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

July 12, 2020

Mr. Matt Wimmer, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
P.O. Box 83720
Boise, ID 83720-0009

Dear Mr. Wimmer:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Idaho's State Plan Amendment (SPA) #19-0003, which was submitted on September 30, 2019. The purpose of SPA #19-0003 is to impose a premium as a condition of eligibility to the optional group described at section 1902(a)(10)(A)(ii)(XXII) of the Social Security Act ("Act"). CMS approved this SPA on June 15, 2020, with an effective date of July 1, 2019, subject to the limitation detailed below.

In response to the coronavirus pandemic, the Families First Coronavirus Response Act (FFCRA) was signed into law (Pub. L. 116-127). The FFCRA authorizes a temporary 6.2 percentage point increase to each qualifying state Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Social Security Act. States may claim this enhanced FMAP for expenditures beginning January 1, 2020, and extending through the last day of the calendar quarter in which the public health emergency is declared by the Secretary of Health and Human Services. However, in order to qualify for the enhanced FMAP, states need to meet certain requirements in section 6008 of the FFCRA. Under section 6008(b)(1) of the FFCRA, states cannot impose stricter eligibility and enrollment requirements during this public health emergency, including imposing new premiums.

Because the purpose of SPA #19-0003 is to impose a new premium to an already existing eligibility group, this premium would be a new condition of eligibility being imposed during the public health emergency period and would violate the maintenance of effort requirement in section 6008(b)(1) of the FFCRA. Therefore, in order for the state to comply with the maintenance of effort requirement and claim the enhanced FMAP, the state must wait until the Secretary of Health and Human Services declares that the public health emergency has ended before assessing this premium.

If you have any questions about this letter or require any further assistance, please contact Laura D'Angelo at (816) 426-6425, or Laura.DAngelo1@cms.hhs.gov.

Sincerely,

Ruth A. Hughes

Digitally signed by Ruth A. Hughes
Date: 2020.07.12 18:25:42 -05'00'

Ruth A. Hughes, Acting Director
Division of Program Operations

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106-2898

Medicaid and CHIP Operations Group

July 12, 2020

Mr. Matt Wimmer, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
P.O. Box 83720
Boise, ID 83720-0009

Dear Mr. Wimmer:

This letter is being sent with the Centers for Medicare and Medicaid Services' (CMS) approval of Idaho's State Plan Amendment (SPA) #19-0003, consistent with the State Medicaid Director letter (SMD) #10-020 published on October 1, 2010 (relating to SPA review process), to address concerns with cost sharing and premium policies. Idaho's SPA #19-0003 proposes 1) to elect a new premium for individuals enrolled through section 1902(a)(10)(ii)(XXII) and 2) to migrate cost sharing policies from the old paper pages to the newer state plan pages in the Medicaid Model Data Lab (MMDL).

During its review of SPA #19-0003, CMS identified several cost sharing and premium policies that were not consistent with federal requirements at sections 1916, 1916A and 1902 of the Social Security Act ("Act"). Specifically:

1. Premium Comparability – Sections 1916 and 1916A of the Act permit states to impose premiums to certain non-exempt individuals provided that the state applies the premium uniformly to similarly situated beneficiaries. In the description of the state's premiums imposed on families of children enrolled in the eligibility group under section 1902(e)(3) of the Act ("Katie Beckett" group) in Attachment 4.18-F, the state describes a policy that reduces premiums by 25 percent if families have other health insurance coverage. On February 21, 2020, CMS informed the state that this policy is inconsistent with the comparability requirements in sections 1902(a)(10)(B) and 1902(a)(17) of the Act because it allows a set of individuals within the Katie Beckett group to have a lower premium than others in the same eligibility group. CMS requests that the state stop applying this reduction in premiums and that the state remove the reference to the premium reduction in Attachment 4.18-F. If the state wishes to continue this policy, the state will need to seek the appropriate pathway (section 1115 or 1915(c)) to waive comparability of this premium.

2. Notices - Sections 1916A(a)(2)(B), (b)(1)(B)(ii) and (b)(2)(A) of the Act, as implemented at 42 CFR §447.56(f), set an aggregate limit on the total premiums and cost sharing charged to a given beneficiary (or, in the case of a family with multiple beneficiaries, all beneficiaries in the household) to five percent of the beneficiary's family income on a quarterly or

monthly basis. As specified in 42 §§447.56(f)(3) and 447.57(b)(1), states are required to inform beneficiaries of the following information: when they are subject to cost sharing and premiums, the amount of the beneficiary's aggregate limit, and when a beneficiary has reached his/her aggregate household limit. In reviewing the state's notices, CMS determined that the state's notices failed to inform beneficiaries of his/her aggregate limit. On a call held on February 21, 2020, the state agreed to revise its notices to include this required information. While there is no follow up specifically needed, CMS is including this item in this letter to memorialize that agreement.

3. American Indian/Alaska Native exemption - Sections 1916(j), 1916A(b)(3)(A)(vii), and 1916A(b)(3)(B)(x) of the Act, as implemented at §447.56(a)(1)(x), require that American Indian/Alaska Native (AI/AN) individuals who *have ever received or are currently receiving an item or service* from an Indian health care provider are exempt from cost sharing and individuals who have *received or are eligible to receive an item or service* from an Indian health care provider are exempt from premiums. The state currently applies the exemption to individuals either when there is a claim in the MMIS claims system for an item or service received from an Indian health care provider or based on race/ethnicity data. Using race/ethnicity data to apply the exemption is not permissible as it exceeds the scope of the statutory authority. On a call held on April 22, 2020, the state proposed to include questions concerning the receipt of services from Indian health care providers to its single streamlined application and use the application to identify individuals eligible for this exemption. The state agreed to amend its application by no later than June 12, 2021. Until the revised application is available, the state agreed to follow up directly with beneficiaries and new applicants to ask these receipt of services questions to help identify individuals eligible for the exemption. CMS is including this item in this letter to memorialize that agreement.

During a phone call on April 22, 2020, CMS reiterated the need for the state to implement cost sharing and premium policies that are consistent with statutory and regulatory requirements. The items identified during the review of the state's submission are not integral to the purpose of SPA #19-0003. In accordance with SMD #10-020, CMS explained to the state that it has the option to resolve this issue separately from the approval of the SPA. The state informed CMS that it would like to address the steps needed to comply with federal policy governing cost sharing and premiums separately. This letter initiates that separate process.

Please respond within 90-days of receipt of this letter by submitting a premium SPA to address compliance with reduction of premiums for certain beneficiaries in the Katie Beckett group. During this 90-day period, CMS welcomes the opportunity to work with you and your staff. Should you or your staff have any questions, please contact Stephanie Kaminsky, Director, Division of Medicaid Eligibility and Policy at Stephanie.Kaminsky@cms.hhs.gov.

Sincerely,

Ruth A. Hughes Digitally signed by Ruth A. Hughes Date: 2020.07.12 18:21:34 -05'00'

Ruth A. Hughes, Acting Director
Division of Program Operations

Medicaid Premiums and Cost Sharing: 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.

ID-19-0003

Proposed Effective Date

07/01/2019 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 447.52; 42 CFR 447.55

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2019	$ 0.00
Second Year	2020	$ 0.00

Subject of Amendment

1) Delete all cost-sharing information from state plan attachments and move it onto PDF forms; 2) Document premiums information for all eligibility groups subject to premiums in Attachment 4.18-F; 3) Delete/supersede existing pages in state plan where cost-sharing information has been documented in the wrong locations.

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:	**Robin Butrick**
Last Revision Date:	**May 20, 2020**
Submit Date:	**Sep 30, 2019**

Medicaid Premiums and Cost Sharing

State Name: Idaho

OMB Control Number: 0938-1148

Transmittal Number: ID - 19 - 0003

Cost Sharing Requirements — G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☒ The state includes an indicator in the Medicaid Management Information System (MMIS)

☒ The state includes an indicator in the Eligibility and Enrollment System

☐ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;

■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

☒ Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and

☒ Provide a referral to coordinate scheduling for treatment by the alternative provider.

☑ The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

Hospitals are required to comply with federal requirements to screen for and provide services to individuals who visit the emergency department and request emergency care, and the hospital may bill the patient in the event the visit is determined to be a non-emergency.

The hospital may choose to waive payment of any co-pay. Since co-pays are limited to $3.65 per visit, hospitals do not generally elect to impose a co-pay under these circumstances.

The state assures that hospitals comply with the notice requirements described in 42 CFR 447.54(d).

Cost Sharing for Drugs

The state charges cost sharing for drugs. No

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

The state published the required public schedule containing the content required at 42 CFR 447.57, making it available via a link on the Idaho Medicaid home page, found here: https://healthandwelfare.idaho.gov/Default.aspx?TabId=123. The state also published public notices in the following newspapers: Post Register, Idaho Statesman, Coeur d'Alene Press, Idaho State Journal, and Idaho Press Tribune.

Medicaid Premiums and Cost Sharing

State Name: Idaho

OMB Control Number: 0938-1148

Transmittal Number: ID - 19 - 0003

Cost Sharing Amounts - Categorically Needy Individuals — G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add						Remove

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item: Accessing Hospital Emergency Department for Non-Emergency Medical Conditions — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL	No limit	3.65	$	Visit		Remove

Service or Item: Accessing Emergency Transportation Services for Non-Emergency Medical Conditions — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL	No limit	3.65	$	Trip		Remove

Service or Item: Chiropractic Services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL	No limit	3.65	$	Visit	Provider charge must exceed $36.50, or a copayment may not be charged.	Remove

Service or Item: Occupational Therapy — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL	No limit	3.65	$	Visit	Provider charge must exceed $36.50, or a copayment may not be charged.	Remove

Service or Item: Optometric Services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL	No limit	3.65	$	Visit	Provider charge must exceed $36.50, or a copayment may not be charged.	Remove

Service or Item: Outpatient Hospital Services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL	No limit	3.65	$	Visit	Provider charge must exceed $36.50, or a copayment may not be charged.	Remove

Service or Item: Physical Therapy — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL	No limit	3.65	$	Visit	Provider charge must exceed $36.50, or a copayment may not be charged.	Remove

Service or Item: Podiatry Services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL	No limit	3.65	$	Visit	Provider charge must exceed $36.50, or a copayment may not be charged.	Remove

Service or Item: Physician Office Visit — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL	No limit	3.65	$	Visit	A co-payment may not be charged when the visit is for a preventive wellness exam, immunizations, or family planning, or when the visit is for urgent care provided at a clinic billing as an urgent care facility.	Remove

Service or Item: Speech Therapy — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL	No limit	3.65	$	Visit	Provider charge must exceed $36.50, or a copayment may not be charged.	Remove

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.	

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.	No

PRA Disclosure Statement

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Idaho

OMB Control Number: 0938-1148

Transmittal Number: ID - 19 - 0003

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Idaho

OMB Control Number: 0938-1148

Transmittal Number: ID - 19 - 0003

Cost Sharing Amounts - Targeting G2c

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals. Yes

Population Name (optional):

Eligibility Group(s) Included:

Incomes Greater than TO Incomes Less than or Equal to

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add						Remove

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. Yes

Providers may require payment of cost sharing as a condition for receiving all items or services listed above. Yes

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Add Population

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: Idaho

OMB Control Number: 0938-1148

Transmittal Number: ID - 19 - 0003

Cost Sharing Limitations — G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).

■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:

- ■ 133% FPL; and
- ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.

■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:

- ■ SSI Beneficiaries (42 CFR 435.120).
- ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
- ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).

■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).

■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.

■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

■ An individual receiving hospice care, as defined in section 1905(o) of the Act.

■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over.	No
The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs.	Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☒ The state accepts self-attestation
  - ☒ The state runs periodic claims reviews
  - ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☒ The Eligibility and Enrollment and MMIS systems flag exempt recipients
  - ☐ Other procedure

Additional description of procedures used is provided below (optional):

Idaho Medicaid will review historical claims data and identify any American Indian/Alaskan Native (AI/AN) Medicaid participants who have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x). Additionally, the state will use Appendix B of the single streamlined application to identify individuals who have received, are receiving, or are eligible to receive services furnished by an Indian health care provider or through referral under contract health services.

■ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☒ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☐ The Eligibility Verification System notifies providers when a beneficiary is exempt

☐ Other procedure

Additional description of procedures used is provided below (optional):

Providers are instructed to check each participant's eligibility prior to rendering services. The co-pay field of the eligibility response indicates whether the participant is subject to co-pay or is exempt.

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

◉ 5%

○ 4%

○ 3%

○ 2%

○ 1%

○ Other: ____ %

■ The state calculates family income for the purpose of the aggregate limit on the following basis:

○ Quarterly

◉ Monthly

Medicaid Premiums and Cost Sharing

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. **Yes**

☑ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☒ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☐ Managed care organization(s) track each family's incurred cost sharing, as follows:

☐ Other process:

☑ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

Idaho monitors co-payments and premiums on at least a monthly basis and tracks the amount paid compared with family income. When the State identifies that co-pays and premiums assessed have reached 95% or more of the maximum amount for the eligibility period, a letter is sent to the family informing them that they are approaching their limit and that they will be exempted for the remainder of the period. The status of the beneficiary is changed to co-pay exempt in the information system at that point for the remainder of the eligibility period.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **No**

☑ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The participant may bring documentation to the Medicaid agency to demonstrate payment of cost-sharing in excess of the aggregate limit for the month. The Medicaid agency will review the documentation and will direct providers to reimburse participants for any amounts paid after the 5% aggregate limit was exceeded.

☑ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

At any time, participants may notify the Medicaid agency of a change in income or other circumstances that might affect the current aggregate cost-sharing limit. Once a participant notifies the Medicaid agency of such a change, the Medicaid agency will review the updated information and change aggregate limits, if necessary.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). **No**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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