Citation	Condition or Requirement

1932(a)(1)(A) A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Idaho enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans – see D.2.ii below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. – vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i) 1. The State will contract with an

1932(a)(1)(B)(ii) __i. MCO
42 CFR 438.50(b)(1) X ii. PCCM (including capitated PCCMs that qualify as PAHPs)
__iii. Both

42 CFR 438.50(b)(2) 2. The payment method to the contracting entity will be:
42 CFR 438.50(b)(3) X i. fee for service;
__ii. Capitation;
X iii. A case management fee;
__iv. A bonus/incentive payment;
__v. a supplement payment, or
__vi. Other. (Please provide a description below).

1905(t) 3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted
42 CFR 440.168 as an enhancement to the PCCMs case management fee, if certain conditions are met.
42 CFR 438.6(c)(5)(iv)

Citation	Condition or Requirement

Place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

_X_ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

_X_ ii Incentives will be based upon specific activities and targets.

_X_ iii. Incentives will be based upon a fixed period of time.

_X_ iv. Incentives will not be renewed automatically.

_X_ v. Incentives will be made available to both public and private PCCMs.

_X_ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (*Example: public meeting, advisory groups.)*

- The Public had significant input into the design of the Healthy Connections Program when it was initially implemented as a 1915(b) waiver. Provider and recipient meeting were held throughout the state.
- Since implementation input has been received from providers and enrollees through a regular survey process and through feedback requested regarding information regarding program changes on the Department Website.
- Upon approval of the State Plan Amendment, new rules governing the program will be promulgated with public input.
- Ongoing public input will continue to be sought via the existing Healthy Connections client and provider survey processes, and Medical Care Advisory Committee.

1932(a)(1)(A) 5. The state plan program will __/will not X implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory enrollment will be implemented in the following

Citation	Condition or Requirement
	1. Medicaid participants who will have less than three months of Medicaid eligibility remaining upon enrollment into a program 2. Medicaid participants for the period of retroactive eligibility 3. Medicaid participants who have a pre-existing relationship with a primary care provider who participates in Idaho Medicaid but does not participate in the Healthy Connections program 4. PW who choose a OB/GYN and there are no HC participating OB/GYNs in the participants geographic location 5. Medicaid participants who reside in a NF or ICF/ID
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis N/A
1932(a)(4) 42 CFR 438.50	H. Enrollment process. 1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: i. the existing provider-recipient relationship (as defined in H.1.i). All applicants are requested to identify their primary care provider on their application for Medicaid and re – determination information. If the individual does not identify a PCP and is currently on Medicaid, the HC enrollment staff runs a report that indicates which providers the participant has seen in the last year (if any). If the participant has seen a HC provider they will be enrolled with that provider. If they have been by a non-HC participating provider, they can be given an enrollment exemption if requested.

Citation	Condition or Requirement
42 CFR 438.50 42 CFR 438.10	438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM) Enrollees are eligible for the following services without a referral from their PCP: Family Planning Emergency Care Dental Services Podiatry Audiology Optical Chiropractic Pharmacy Nursing Facility ICF/ID Immunizations Diagnosis and Treatment for Sexually Transmitted Diseases Mammogram (1 per year for women over 40) Indian Health Clinics Personal Care Services Pregnancy related services provided by OB/GYN providers not enrolled as a PCP Servicesprovided in a school as part of an IEP Laboratory services Anesthesiology services Radiology services Services provided by an Urgent Care Clinic after the Primary Care Provider's office has closed.
1932 (a)(1)(A)(ii)	M. Selective contracting under a 1932 state plan option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will____/will not _X_ intentionally limit the number of entities it contracts under a 1932 state plan option. 2. _NA_ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services. 3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* Not applicable

system.

1.C GEOGRAPHIC CLASSIFICATION

Unless otherwise indicated in the chart below, the benefits in the Basic Benchmark Benefit Package shall be in effect for all geographic and political subdivisions of the State.

Benefit	Geographic Area

1.D SERVICE DELIVERY SYSTEM

Each individual provided the Basic Benchmark Benefit Package is required to enroll in a Primary Care Case Management program, known as "Healthy Connections" under the authority of section 1937 of Social Security Act.

Except as otherwise indicated in the chart below, beneficiaries may obtain the services available under the plan from any institution, agency, pharmacy, or practitioner qualified to perform such services and participating under the plan, including an organization, which provides such services or arranges for their availability on a pre-payment basis.

Primary Care Case Management System
Inpatient Hospital Services Outpatient Hospital Services (excluding Emergency Services) Ambulatory Surgical Center Services Physician Services

persons with disabilities; and

- To provide and to promote family-centered, community-based, coordinated care for children with special health care needs.

1.C GEOGRAPHIC CLASSIFICATION

Unless otherwise indicated, in the chart below, the benefits in the Enhanced Benchmark Benefit Package shall be in effect for all geographic and political subdivisions of the State.

Benefit	Geographic Area

1.D SERVICE DELIVERY SYSTEM

Each individual provided the Enhanced Benchmark Benefit Package under the State plan is required to enroll in a Primary Care Case Management program, known as "Healthy Connections" as specified pursuant to a waiver program authorized under section of section 1937 of Social Security Act.

Unless otherwise indicated in the chart below, benefits may be obtained from any institution, agency, pharmacy, or practitioner qualified to perform such services and participating under the plan, including an organization, which provides such services or arranges for their availability on a pre-payment basis.

Primary Care Case Management System
Inpatient Hospital Services

2. c. iv.

f. For newly qualified FQHCs after Federal fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.

g. In the case of any FQHC that contracts with a managed care organization, supplemental payments will be made quarterly to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system.

h. The Medicaid payment for case management under the Healthy Connections program, and for presumptive eligibility screenings shall be included in the encounter rate calculation, however shall be reimbursed separately from the encounter.

i. **Medicare-Medicaid Coordinated Plan or a Dental Services Contractor**
For services provided at an FQHC to participants enrolled with a managed care contractor for the Medicare-Medicaid Coordinated Plan or a contractor for dental services , the State will be conducting quarterly reconciliations to ensure compliance with Section 1902(bb)(5)(A) of the SSA.

To ensure that the appropriate amounts are being paid to each FQHC, the Idaho Medicaid will perform quarterly reconciliations and verify that the wrap-around payments made in the prior quarter were in compliance with Section 1902(bb)(5)(A). The reconciliation for the first quarter of 2013 will start in the second quarter of 2013. Thereafter, each quarter's reconciliation will start in the following quarter. This process will apply to all FQHCs. The quarterly reconciliation will be done as follows:

Prospective Payment System (PPS): (managed care encounters X PPS encounter rate) less (fee for service equivalent) = State's payment amount

J. **Non-Medicare-Medicaid Coordinated Plan**
For participants enrolled with a managed care contractor that is not a contractor for the Medicare-Medicaid Coordinated Plan, the State will pay the FQHC a supplemental payment in addition to the amount paid by the managed care contractor. The supplemental payments, called wrap-around payments, will be paid in amounts necessary to ensure compliance with Section 1902(bb)(5)(A) of the SSA. The State will pay the enhancements every four months on a per-member-per-month basis.

To ensure that the appropriate amounts are being paid to each center, the State will perform an annual reconciliation and verify that the wrap-around payments made in the previous year were in compliance with Section 1902(bb)(5)(A). The reconciliation for calendar year 2013 will start in calendar year 2014. Thereafter, each year's reconciliation will start in the following calendar year. This process will apply to all FQHCs. The annual reconciliation will be done as follows:

PPS: (managed care encounters X PPS encounter rate) less (fee-for-service equivalent) = State's payment amount

5. a.

vii. Pursuant to Idaho Code, Chapter 2, Title 56, Section 265 (version effective as of July 1, 2011) Where there is an equivalent the payment to a Medicaid provider will not exceed 100% of the 01/1/2011 Medicare rate for primary care procedure codes as defined by the centers for Medicare and Medicaid service; and will be ninety percent (90%) of the 01/1/2011 Medicare rate for all other procedure codes. Where there is no Medicare equivalent, the payment rate to Medicaid providers will be prescribed by rule.

The fee schedule for these services and any annual/periodic adjustments to the fee schedule are published at the following web site:

http://www.healthandwelfare.idaho.gov

The fee schedule will be effective for services on or after 7/1/2011.

viii. The Medicaid payment for primary care case management under Idaho's Primary Care Case Management program is paid in addition to FFS to physicians and mid-level providers who are enrolled as providers in the PCCM program. The case management fee is:

- $2.50 per member per month for all individuals enrolled in the Basic Benchmark Benefit Plan and with the PCCM provider;
- $3.00 per member per month for all individuals enrolled in the Enhanced Benchmark Benefit Plan and with the PCCM provider; and
- The case management fee is increased by $0.50 per member per month if the PCCM provider offers extended office hours of 46 hours per week or more to its' enrollees.