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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 16-0001

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104



Division of Medicaid & Children's Health Operations

June 21, 2016

Richard Armstrong, Director
Department of Health and Welfare
Towers Building – Tenth Floor
Post Office Box 83720
Boise, ID 83720-0036

RE: Idaho State Plan Amendment (SPA) Transmittal Number 16-0001

Dear Mr. Armstrong:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number 16-0001. This SPA modifies Idaho's Healthy Connections (HC) Primary Care Case Management Program (PCCM) by creating a new tier-based case management fee structure with four (4) distinct payment tiers that vary in amount and increase by tier based upon qualifying criteria.

The enclosed SPA is approved with an effective date of February 1, 2016, as requested by the state. Please be aware that per the federal regulations at 42 CFR §438.3(r), states must submit PCCM entity contracts to CMS for review and approval. Accordingly, please submit Idaho's applicable PCCM entity contracts to the Seattle Regional Office for review and approval.

If you have any questions concerning this SPA or require further assistance, please contact me or have your staff contact Walter Neal at walter.neal@cms.hhs.gov or (206) 615-2330.

Sincerely,

Digitally signed by David L. Meacham -S

A black rectangular box redacting the signature of David L. Meacham.

Date: 2016.06.21 14:54:33 -07'00'

David L. Meacham
Associate Regional Administrator

Enclosure

cc: Matt Wimmer, Administrator

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**1. TRANSMITTAL NUMBER:
16-00012. STATE
IDAHO**FOR: HEALTH CARE FINANCING ADMINISTRATION**3. PROGRAM IDENTIFICATION:
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES4. PROPOSED EFFECTIVE DATE
01 February 2016

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
1902(a)(10)(E), 1905(a)(6), 1905(a)(12), and 2110(a)(24) of the Social Security Act7. FEDERAL BUDGET IMPACT:
Total (\$) Federal Funds
FFY 2016 – \$1,030,008.00
FFY 2017 – \$1,236,009.60

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Pages ~~16-17~~ Pages 13-17 (P&I)
Attachment 3.1-F, Pages ~~2, 8, 9, 12~~ + ~~12a~~ Pages 1-9 (P&I)9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):**Attachment 4.19-B, Pages ~~16-17~~ Pages 13-17 (P&I)**
Attachment 3.1-F, Pages ~~2, 8, 9, 12~~ Pages 1-12 (P&I)

10. SUBJECT OF AMENDMENT:

The proposed changes will modify the primary care physician monthly case management payments for the Healthy Connections program. The new structure will allow primary care physicians to qualify for one of four payment incentive tiers in which to participate. The structure is based on complexity of the participant's healthcare needs and the primary care physician's ability to meet those needs. Primary care case management (PCCM) services are currently offered under the Healthy Connections and Health Homes programs. This state plan changes will assist in transitioning PCCM services from the Health Homes program to the Healthy Connections program and move program operations towards outcome based health care, which is consistent with the implementation of the legislative intent language passed by the 2015 Idaho Legislature and in accordance with Governor Otter's executive orders #2010-15 and #2010-10 to develop a statewide patient-centered medical home model of care.

11. GOVERNOR'S REVIEW (Check One):

☒ **GOVERNOR'S OFFICE REPORTED NO COMMENT**☐ OTHER, AS SPECIFIED:☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
LISA HETTINGER14. TITLE:
Administrator

15. DATE SUBMITTED:

16. RETURN TO:

Lisa Hettinger, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0009**FOR REGIONAL OFFICE USE ONLY**17. DATE RECEIVED:
03/24/1618. DATE APPROVED:
06/21/16

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
02/01/16

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
David L. Meacham22. TITLE:
Associate Regional Administrator

23. REMARKS:

6/21/16 - State authorized P&I change to box 8 and 9.

State: IDAHO

Citation	Condition or Requirement
1932(a)(1)(A)	<p>A. <u>Section 1932(a)(1)(A) of the Social Security Act.</u></p> <p>The State of <u>Idaho</u> 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).</p> <p>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 described in 42 CFR 438.50(d).</p> <p>Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.</p>
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)-(2)	<p>B. <u>Managed Care Delivery System.</u></p> <p>The State will contract with the entity(ies) below and reimburse them as noted under each entity type.</p> <ol style="list-style-type: none"><input type="checkbox"/> MCO<ol style="list-style-type: none"><input type="checkbox"/> Capitation<input checked="" type="checkbox"/> PCCM (individual practitioners)<ol style="list-style-type: none"><input checked="" type="checkbox"/> Case management fee<input type="checkbox"/> Bonus/incentive payments<input type="checkbox"/> Other (please explain below)<input checked="" type="checkbox"/> PCCM (entity based)<ol style="list-style-type: none"><input checked="" type="checkbox"/> Case management fee<input type="checkbox"/> Bonus/incentive payments<input type="checkbox"/> Other (please explain below) <p>For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met all of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).</p> <p><input type="checkbox"/> a. 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.</p> <p><input type="checkbox"/> b. Incentives will be based upon a fixed period of time.</p> <p><input type="checkbox"/> c. Incentives will not be renewed automatically.</p>

State: IDAHO

Citation	Condition or Requirement
	<p><input type="checkbox"/> d. Incentives will be made available to both public and private PCCMs.</p> <p><input type="checkbox"/> e. Incentives will not be conditioned on intergovernmental transfer agreements.</p> <p><input type="checkbox"/> f. Incentives will be based upon specific activities and targets.</p>
CFR 438.50(b)(4)	<p>C. <u>Public Process</u></p> <p>Describe the public process including tribal consultation, if applicable, 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. (<i>Example: public meeting, advisory groups.</i>)</p> <ul style="list-style-type: none">• <i>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 meetings were held throughout the state.</i>• <i>Since program implementation input has been requested and received from providers and enrollees. The State has worked collaboratively with stakeholder groups including the Idaho Medical Home Collaborative, State Healthcare Innovation Plan workgroups, Medical Care Advisory Committee and other organizations to solicit input and feedback on the program structure.</i>• <i>Other opportunities for public input for programmatic changes included public meetings through the administrative rules process in June and October 2015. These meetings provided the public, providers and enrollees an opportunity to provide input on the transformation of Healthy Connections to a patient-centered medical home structure.</i>• <i>New administrative rules governing the program were promulgated and approved by the 2016 Idaho Legislature to support program operations.</i>• <i>Ongoing public input will continue to be sought by the State through its website and the multiple stakeholder groups (including the MCAC). The State will also seek ongoing public input in accordance with the requirements of section 1902(a)(30)(A) of the Social Security Act to ensure access to Medicaid services.</i> <p>D. <u>State Assurances and Compliance with the Statute and Regulations.</u></p> <p>If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.</p> <p>1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)</p> <p>1. <input type="checkbox"/> The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.</p> <p>1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2)</p> <p>2. <input checked="" type="checkbox"/> The state assures that all of the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.</p>

State: IDAHO

Citation	Condition or Requirement
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1902(a)(23)(A)

1932(a)(1)(A)

3. ☒The state assures that all the applicable requirements of section 1932 42 CFR 438.50(c)(3) (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring Beneficiaries to receive their benefits through managed care entities will be met.

1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C)

4. ☒The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)

5. ☒The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).

1932(a)(1)(A)
42 CFR 438
1903(m)

6. ☒The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

1932(a)(1)(A)
42 CFR 438.6(c)
42 CFR 438.50(c)(6)

7. ☐The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

1932(a)(1)(A)
CFR 447.362
42 CFR 438.50(c)(6)

8. ☐The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any non-risk contracts will be met.

45 CFR 92.36

9. ☐The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. **Included Populations.** Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)	X	Statewide			
Section 1931 Adults & Related Populations 1905(a)(ii)	X	Statewide			
Low-Income Adult Group					
Former Foster Care Children under age 21	X	Statewide			
Former Foster Care Children age 21-25	X	Statewide			
Section 1925 Transitional Medicaid age 21 and older	X	Statewide			

State: IDAHO

Citation		Condition or Requirement			
Population	M	Geographic Area	V	Geographic Area	Excluded
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)	X	Statewide			
Poverty Level Pregnant Women – 1905(a)(viii)	X	Statewide			
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)	X	Statewide			
SSI and SSI related Disabled children under age 18	X	Statewide			
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)	X	Statewide			
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)	X	Statewide			
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)	X	Statewide			
Recipients Eligible for Medicare					
American Indian/Alaskan Natives					
Children under 19 who are eligible for SSI					
Children under 19 who are eligible under Section 1902(e)(3)					
Children under 19 in foster care or other in-home placement					
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)					
Other					

2. **Excluded Groups.** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

☐ Other Insurance--Medicaid beneficiaries who have other health insurance.

☐ Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

State: IDAHO

Citation	Condition or Requirement
	<p><input type="checkbox"/>Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program</p> <p><input type="checkbox"/>Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.</p> <p><input type="checkbox"/>Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).</p> <p><input checked="" type="checkbox"/>Retroactive Eligibility--Medicaid beneficiaries for the period of retroactive eligibility.</p> <p><input type="checkbox"/>Other (Please define):</p>
1932(a)(4)	<p>F. <u>Enrollment Process</u></p> <p>1. Definitions.</p> <p>a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary <u>has not had</u> an opportunity to select their health plan.</p> <p>b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary <u>has had</u> an opportunity to select their health plan.</p> <p>2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:</p> <p>a. <input checked="" type="checkbox"/> The applicant is permitted to select a health plan at the time of application.</p> <p>i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e). <i>Potential enrollees are provided information through the Medicaid participant handbook, Medicaid internet website and an enrollment packet for the Healthy Connections (HC) program when determined eligible for Medicaid. These resources include all the required elements including:</i></p> <ul style="list-style-type: none">• <i>general program information</i>• <i>population specific information for excluded or exempted</i>• <i>participant rights and responsibilities</i>• <i>covered benefits including those not provided under HC</i>• <i>cost sharing</i>• <i>interpretive services</i>• <i>transportation services</i>• <i>how to choose, change or disenroll from a provider</i>• <i>participating provider lists including: names, addresses, non-English provider designation, those not accepting new patients</i>• <i>services that require a referral</i>• <i>contact information for their regional HC representative</i>

State: IDAHO

Citation	Condition or Requirement
	<ul style="list-style-type: none">• <i>grievance and fair hearing procedures</i>• <i>services which require a referral or prior authorization</i>• <i>process and procedure for obtaining emergency services</i>• <i>services covered by Idaho Medicaid but not through HC</i>
ii.	<p>What action the state takes if the applicant does not indicate a plan selection on the application.</p> <p><i>The State determines if there has been an existing provider-recipient relationship 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-services experience, or through contact with the recipient.</i></p>
iii.	<p>If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).</p> <p><i>All potential enrollees are requested to identify their primary care provider when determined eligible for Medicaid.</i></p> <p><i>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 they have been seen by a non-HC participating provider, they can be given an enrollment exemption when requested.</i></p> <p><i>Potential enrollees may request an exemption if they are auto-enrolled and have a pre-existing relationship with another PCP by calling the Healthy Connections representative in their area.</i></p>
iv.	<p>The state's process for notifying the beneficiary of the default assignment. (Example: <i>state generated correspondence.</i>)</p> <p><i>Potential enrollees are sent a letter and a list of participating providers and asked to make the choice. If after 30 days the potential enrollee does not respond to the letter, Healthy Connections staff review claims to determine existing relationship with a PCP. If one exists, then the potential enrollee is assigned to a PCP. If the potential enrollee does not establish care or identify their chosen PCP within 90 days, they are auto assigned and notified by mail. In the notification, they are given the opportunity to contact the Regional staff to disenroll and change providers if they choose.</i></p>
b.	<p><input checked="" type="checkbox"/> The beneficiary has an active choice period following the eligibility determination.</p>
i.	<p>How the beneficiary is notified of their initial choice period, including its duration.</p> <p><i>Potential enrollees are sent a letter and a list of participating providers and given 90 days to respond.</i></p>
ii.	<p>How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).</p> <p><i>Potential enrollees are provided information through the Medicaid participant handbook, Medicaid internet website and an enrollment</i></p>

State: IDAHO

Citation	Condition or Requirement
	<i>packet for the Healthy Connections (HC) program when determined eligible for Medicaid.(as specified in F.2.a.i above).</i>
	<p>iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).</p> <p><i>All applicants are asked to identify their PCP at application or re-determination. Potential enrollees are sent a letter and a list of participating providers and asked to make the choice.</i></p> <ul style="list-style-type: none"><i>• If they do not identify a PCP, after 30 days Healthy Connections staff run a report that indicates which providers the participants has seen in the last year (if any).</i><i>• If the participant has seen a HC provider they will be enrolled with that provider.</i><i>• If they have been seen by a non-HC provider, they can be given an enrollment exemption if requested.</i><i>• If the potential enrollee does not establish care or identify their chosen PCP within 90 days, HC staff review for family relationship PCP status. If none exists, they then enroll the participant with the next PCP on the list that is in close proximity to the participant and accepting Medicaid enrollee's. The participant is notified by mail of the auto-assignment. In the notification, they are given the opportunity to contact the Regional staff to disenroll and change providers if they choose.</i> <p>iv. The state's process for notifying the beneficiary of the default assignment.</p> <p><i>Participants are notified by mail (as indicated in F.2.b.iii above).</i></p> <p>c. <input type="checkbox"/> The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.</p> <p>i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).</p> <p>ii. The state's process for notifying the beneficiary of the auto-assignment. <i>(Example: state generated correspondence.)</i></p> <p>iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).</p>
1932(a)(4) 42 CFR 438.50	<p>3. State assurances on the enrollment process.</p> <p>Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.</p> <p>a. <input checked="" type="checkbox"/> The state assures it has an enrollment system that allows Beneficiaries who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.</p>

State: IDAHO

Citation	Condition or Requirement
	<p>b. <input checked="" type="checkbox"/> The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).</p> <p>c. <input checked="" type="checkbox"/> The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties: <i>Areas of the State where a choice of primary care providers does not exist.</i></p> <p>i. <input type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p> <p>d. <input type="checkbox"/> The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.</p> <p>i. <input type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p>
1932(a)(4) 42 CFR 438.56	<p>G. <u>Disenrollment</u></p> <p>1. The state will<input type="checkbox"/> will not <input checked="" type="checkbox"/> limit disenrollment for managed care.</p> <p>2. The disenrollment limitation will apply for Choose an item. months (up to 12 months).</p> <p>3. <input checked="" type="checkbox"/> The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).</p> <p>4. Describe the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. (Examples: state generated correspondence, HMO enrollment packets etc.) <i>Participants can disenroll at anytime and they are advised of that in their enrollment packet.</i></p> <p>5. Describe any additional circumstances of "cause" for disenrollment (if any).</p>
1932(a)(5)(c) 42 CFR 438.50 42 CFR 438.10	<p>H. <u>Information Requirements for Beneficiaries</u></p> <p><input checked="" type="checkbox"/> The state assures that its state plan program is in compliance with 42 CFR 438.10(e) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments.</p>
1932(a)(5)(D)(b) 1903(m) 1905(t)(3)	<p>I. List all benefits for which the MCO is responsible. N/A</p>
1932(a)(5)(D)(b)(4) 42 CFR 438.228	<p>J. <input checked="" type="checkbox"/> The state assures that each managed care organization has established an internal grievance procedure for enrollees.</p>
1932(a)(5)(D)(b)(5)	<p>K. Describe how the state has assured adequate capacity and services.</p>

State: IDAHO

Citation	Condition or Requirement
42 CFR 438.206 42 CFR 438.207	<i>The state does not limit the number of entities it contracts with and assures access by monitoring its primary care provider enrollment and access to care.</i>
1932(a)(5)(D)(c)(1)(A) 42 CFR 438.240	L. <input checked="" type="checkbox"/> The state assures that a quality assessment and improvement strategy has been developed and implemented.
1932(a)(5)(D)(c)(2)(A) 42 CFR 438.350	M. <input type="checkbox"/> The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.
1932 (a)(1)(A)(ii)	N. <u>Selective Contracting Under a 1932 State Plan Option</u> To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will <input type="checkbox"/> /will not <input checked="" type="checkbox"/> intentionally limit the number of entities it contracts under a 1932 state plan option. 2. <input type="checkbox"/> 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. (<i>Example: a limited number of providers and/or enrollees.</i>) <i>The state does not limit the number of entities it contracts with under the primary care case management program.</i> 4. <input checked="" type="checkbox"/> The selective contracting provision is not applicable to this state plan.

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 0938-0933. The time required to complete this information collection is estimated to average 10 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

CMS-10120 (exp. 3/31/2014)

- F. 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 01/01/2011 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 01/01/2011 Medicare rate for all other procedure codes.
- I. Where there is no Medicare equivalent, the payment rate to Medicaid providers will be prescribed by rule.
- II. The fee schedule for these services and any annual/periodic adjustments to the fee schedule are published at: <http://www.healthandwelfare.idaho.gov>
- III. The fee schedule was last updated on 07/01/2011 to be effective for services on or after 07/01/2011.
- G. 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 structure is based on complexity of the participant's healthcare needs and the primary care physician's ability to meet those needs. The case management fee is:
- I. TIER 1 – HEALTHY CONNECTIONS.
- 1) \$2.50 per member per month for all individuals enrolled in the Healthy Connections Basic plan and with the PCCM provider.
- 2) \$3.00 per member per month for all individuals enrolled in the Healthy Connections Enhanced plan and with the PCCM provider.
- II. TIER 2 – HEALTHY CONNECTIONS ACCESS PLUS.
- 1) \$3.00 per member per month for all individuals enrolled in the Healthy Connections Access Plus Basic plan and with the PCCM provider.
- 2) \$3.50 per member per month for all individuals enrolled in the Healthy Connections Access Plus Enhanced plan and with the PCCM provider.
- III. TIER 3 – HEALTHY CONNECTIONS CARE MANAGEMENT.
- 1) \$7.00 per member per month for all individuals enrolled in the Healthy Connections Care Management Basic plan and with the PCCM provider.
- 2) \$7.50 per member per month for all individuals enrolled in the Healthy Connections Care Management Enhanced plan and with the PCCM provider.
- IV. TIER 4 – HEALTHY CONNECTIONS MEDICAL HOME.

- 1) \$9.50 per member per month for all individuals enrolled in the Healthy Connections Care Management Basic plan and with the PCCM provider.
- 2) \$10.00 per member per month for all individuals enrolled in the Healthy Connections Care Management Enhanced plan and with the PCCM provider.

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