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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 21-0001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

August 31, 2021

Matt Wimmer, Administrator
Idaho Department of Health and Welfare
Division of Medicaid
PO Box 83720
Boise, ID 83720-0009

Re: Idaho State Plan Amendment (SPA) 21-0001

Dear Mr. Wimmer:

The Centers for Medicare & Medicaid Services (CMS) completed review of Idaho's State Plan Amendment (SPA) Transmittal Number 21-0001 submitted on June 10, 2021. The purpose of this SPA is to modify the Case Management reimbursement and structure for the Primary Care Case Management Program known as Healthy Connections, and align it with the Healthy Connections Value Care Program.

We conducted our review of this amendment according to statutory requirements of Title XIX of the Social Security Act and implementing Federal regulations. This letter is to inform you that Idaho Medicaid SPA Transmittal Number 21-0001 is approved effective July 1, 2021.

If you have any questions regarding this amendment, please contact Cheryl L. Brimage at 404-562-7116 or via email at cheryl.brimage@cms.hhs.gov.

Sincerely,

/s/

Bill Brooks
Director
Division of Managed Care Operations

cc: Charles Beal
Lynn DelVecchio

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **ID-21-0001**

2. STATE **IDAHO**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07-01-2021

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:
1932(a) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
FFY2020 $ 0.00
FFY2021 $ 0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F pages 2, 3, 9, 11, 12, 13

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
3.1-F pages 2, 3, 9, 11, 12, 13

10. SUBJECT OF AMENDMENT:
Amendment to the State Plan to modify the reimbursement and structure for the Primary Care Case Management Program, known as Connections, and align it with the Healthy Connections Value Care Program.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

/s/

13. TYPED NAME:
MATT WIMMER

14. TITLE:
Administrator

15. DATE SUBMITTED:
06-10-2021

16. RETURN TO:

Matt Wimmer, 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: June 10, 2021

18. DATE APPROVED: August 31, 2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Bill Brooks

22. TITLE: Director, Division of Managed Care Operations

23. REMARKS: Approved with the following changes to block 8 and 9 as authorized by the state on email dated 08/27/21.

Block # 8 changed to read: Attachment 3.1-F pages 1, 2, 3, 6, 7, 8, 9, 10, 11, 12 and 13.

Block # 9 changed to read: Attachment 3.1-F pages 1, 2, 3, 6, 7, 8, 9, 10, 11, 12 and 13.

Citation	Condition or Requirement

HEALTHY CONNECTIONS PATIENT CENTERED MEDICAL HOME

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], primary care case managers [PCCMs], and/or PCCM entities) 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 state wideness (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 described in 42 CFR 438.50(d).

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 a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.

1932(a)(1)(B)(i)

B. Managed Care Delivery System.

1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

42 CFR 438.50(b)(1)-(2)

1. ☐ MCO
   a. ☐ Capitation
   b. ☐ The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.
2. ☒ PCCM (individual practitioners)
   a. ☒ Case management fee
   b. ☐ Other (please explain below)
3. ☐ PCCM entity
   a. ☐ Case management fee
   b. ☐ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
   c. ☐ Other (please explain below)

Citation	Condition or Requirement
	If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services: ☐ Provision of intensive telephonic case management ☐ Provision of face-to-face case management ☐ Operation of a nurse triage advice line ☐ Development of enrollee care plans. ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program ☐ Oversight responsibilities for the activities of FFS providers in the FFS program ☐ Provision of payments to FFS providers on behalf of the State. ☐ Provision of enrollee outreach and education activities. ☐ Operation of a customer service call center. ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement. ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers. ☐ Coordination with behavioral health systems/providers. ☐ Coordination with long-term services and supports systems/providers. ☐ Other (please describe):

Citation	Condition or Requirement
42 CFR 438.50(b)(4)	C. Public Process. Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. (Example: public meeting, advisory groups.) If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110) •The Public and the Tribes of Idaho have had significant ongoing input into the design of the Healthy Connections Program since it was initially implemented as a 1915(b) waiver. •The State has worked collaboratively with multiple stakeholder groups including the Healthy Connections Primary Care Providers, Idaho Primary Care Association , the Idaho Medical Association (IMA), the Idaho Hospital Association (IHA), Idaho Academy of Family Physicians (IAFP), and Independent Doctors of Idaho (IDID) to solicit input and feedback on the re-structuring of the Healthy Connections Patient Centered Medical Home Tier Program. • Ongoing public input will continue to be sought by the State through its website and its routine stakeholder engagement meetings. 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. •Administrative rules, governing program operations and supporting this multi-phase transition, were promulgated and approved by both the 2017 and 2019 Idaho Legislatures.

Citation | Condition or Requirement

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

E. Populations and Geographic Area

2. Included Populations. Please check which eligibility groups are included, if they are enrolled on a Mandatory (M) or Voluntary (V) basis (as defined in 42 CFR 438.54(b)) or Excluded (E), and the geographic scope of enrollment. Under the Geographic Area 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. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the Geographic Area column. Under the Notes column, please note any additional relevant details about the population or enrollment.

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110	X			statewide	
2. Pregnant Women	§435.116	X			statewide	
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	X			statewide	
4. Former Foster Care Youth (up to age 26)	§435.150	X			statewide	
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119	X			statewide	
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X			statewide	
7. Extended Medicaid Due to Spousal Support Collections	§435.115	X			statewide	

Citation Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120	X			statewide	
9. Aged and Disabled Individuals in 209(b) States	§435.121					N/A
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135	X			statewide	
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137					N/A
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138					N/A
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA	X			statewide	
14. Disabled Adult Children	1634(c) of SSA	X			statewide	

B. Optional Eligibility Groups

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220					N/A
2. Optional Targeted Low-Income Children	§435.229					N/A
3. Independent Foster Care Adolescents Under Age 21	§435.226					N/A
4. Individuals Under Age 65 with Income Over 133%	§435.218					N/A
5. Optional Reasonable Classifications of Children Under Age 21	§435.222			X		(state custody and foster care/institutions/ICF-IID/SNF)
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA					N/A

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230					N/A
8. Individuals eligible for Cash except for Institutionalized Status	§435.211					N/A
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217					N/A
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232					N/A
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616 Agreements	§435.234					N/A
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236					N/A
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA					N/A
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA					N/A
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1) of the SSA	**X**			**statewide**	
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA					N/A
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA	**X**			**statewide**	
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA					N/A
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA					N/A
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219					N/A

Citation Condition or Requirement

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214					N/A
22. Individuals with Tuberculosis	§435.215					N/A
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213	X			statewide	

C. Medically Needy

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)					N/A
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)					N/A
3. Medically Needy Children Age 18 through 20	§435.308					N/A
4. Medically Needy Parents and Other Caretaker Relatives	§435.310					N/A
5. Medically Needy Aged	§435.320					N/A
6. Medically Needy Blind	§435.322					N/A
7. Medically Needy Disabled	§435.324					N/A
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330					N/A

2. Voluntary Only or Excluded Populations. Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

Please indicate if any of the following populations are excluded from the program or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		X	statewide	

Citation Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare		**X**		**limited**	***See "Other" population description for more detail.**
American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	**X**		**statewide**	
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120	**X**		**statewide**	
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA	**X**		**statewide**	
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145	**X**		**statewide**	
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227	**X**		**statewide**	
Children with Special Health Care Needs - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.					N/A

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20-year-olds in these Eligibility Groups.

Citation | Condition or Requirement

3. (Optional) Other Exceptions. The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance			N/A
Reside in Nursing Facility or ICF/IID-- Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		X	
Enrolled in Another Managed Care Program-Medicaid beneficiaries who are enrolled in another Medicaid managed care program		X	
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program		X	
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).			N/A
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.		X	
Other (Please define): Dual Medicare Eligibles		X	Dual eligible participants, enrolled in the Medicare Medicaid Coordinated Plan or Idaho Medicaid Plus, are exempt from enrollment in Healthy Connections.

1932(a)(4)
42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For voluntary enrollment: (see 42 CFR 438.54(c))

a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

State with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

Citation	Condition or Requirement

b. ☐ If applicable, please check here to indicate that the state provides an enrollment choice period, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program or will otherwise continue to receive covered services through the fee-for-service delivery system.

i. Please indicate the length of the enrollment choice period:

c. ☐ If applicable, please check here to indicate that the state uses a passive enrollment process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.

i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).

ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:

2. For mandatory enrollment: (see 42 CFR 438.54(d))

a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

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:

- general program information
- provider directory
- information for excluded or exempted populations
- participant rights and responsibilities
- covered benefits including those not provided under HC
- cost sharing
- interpretive services

Enrollees also receive a notice during the annual grace period which contains the required elements, as listed above.

b. ☒If applicable, please check here to indicate that the state provides an enrollment choice period, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan or will otherwise be enrolled in a plan selected by the State's default enrollment process.

i. Please indicate the length of the enrollment choice period:

30_days_____

Citation	Condition or Requirement
	c. ☒ If applicable, please check here to indicate that the state uses a default enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment. i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8). All potential enrollees are asked to identify their PCP at application. Requests for enrollment must be submitted by the participant or an authorized representative, as identified on their eligibility record within the eligibility system. If they do not identify a PCP, after 30 days and up to 90 days, HC staff review claims reports and participant records to determine if the participant has established care, has family relationship PCP status and if none exist, they identify the next PCP on the list that is in close proximity to the enrollee and accepting Medicaid enrollees. The enrollee is notified by mail of the auto-assignment. The enrollee is given the opportunity to contact the HC Team/Regional Staff to exercise their opportunity to change providers if they choose. d. ☐If applicable, please check here to indicate that the state uses a passive enrollment process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment. i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).
1932(a)(4) 42 CFR 438.54	3. State assurances on the enrollment process. Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.
42 CFR 438.52	a.☒ The state assures that, per the choice requirements in 42 CFR 438.52: i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3); ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State; iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.