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## General Information and Requirements for Providers

The General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, is applicable to all provider types, and must be followed except where otherwise stated for a specific provider type. Should the handbook ever appear to contradict relevant provisions of Idaho or federal rules and regulations, the rules and regulations prevail. Any paper or digital copy of these documents is considered out of date except the version appearing on Gainwell Technologies' [Idaho Medicaid](#) website.

Providers must follow their provider type or service specific handbook as located in the [Provider Guidelines](#). Handbooks in addition to this one which always apply to providers include:

- [General Billing Instructions](#); and
- [Glossary](#).

Handbooks can only be used properly in context. Providers must be familiar with the handbooks that affect them and their services. The numbering in handbooks is also important to make note of as subsections rely on the content of the sections above them.

### Example

Section 1.2.3(a) The Answer requires the reader to have also read Section 1, Section 1.2 and Section 1.2.3 to be able to properly apply Section 1.2.3(a).

References are included throughout the handbook for provider and staff convenience. Not all applicable references have been incorporated into the handbook. Not all references provided are equal in weight.

- **Case Law:** Includes references to court cases that established interpretations of law that states and providers would be required to follow.
- **CMS Guidance:** These references reflect various Centers for Medicare and Medicaid Services (CMS) publications that Idaho Medicaid reviewed in the formulation of their policy. The publications themselves are not required to be followed for Idaho Medicaid services.
- **Federal Regulations:** These references are regulations from the federal level that affected policy development. Usually these include the Code of Federal Regulations, the Social Security Act and other statutes. They are required to be followed.
- **Idaho Medicaid Publications:** These are communications from Idaho Medicaid to providers that were required to be followed when published. These are included in the handbook for historical reference. The provider handbook supersedes other communications unless the documents are listed in the Department's [Rules, Statutes, and Policies](#) webpage under policies in Medicaid's [department library](#).
- **Idaho State Plan:** The State Plan is the agreement between the State of Idaho and the Centers for Medicare and Medicaid Services on how the State will administer its medical assistance program.
- **Professional Organizations:** These references reflect various publications of professional organizations that Idaho Medicaid reviewed in the formulation of their policy. Providers may or may not be required to follow these references, depending on the individual reference and its application to a provider's licensure and scope of practice.
- **Scholarly Work:** These references are publications that Idaho Medicaid reviewed in the formulation of their policy. The publications themselves are not required to be followed for Idaho Medicaid services.

- State Regulations: These references are regulations from the state level that affected policy development. They usually include statute and IDAPA. They are required to be followed.



## 1. Provider Responsibilities

Providers are required to adhere to all applicable provisions of federal law including, but not limited to, the following as amended:

- Title VI of the Civil Rights Act of 1964;
- Title IX of the Education Amendments of 1972 regarding education programs and activities;
- The Age Discrimination Act of 1975;
- Section 504 of the Rehabilitation Act of 1973;
- The Americans with Disabilities Act of 1990;
- Section 1557 of the Patient Protection and Affordable Care Act;
- Health Insurance Portability and Accountability Act (HIPAA);
- Sections 262 and 264 of Public Law 104-191;
- 42 USC Section 1320d;
- 45 CFR Subchapter C Administrative Data Standards and Related Requirements;
- False Claims Act (31USC 3729-3733);
- Section 12006(a) of the 21<sup>st</sup> Century Cures Act; and
- 42 CFR §455 Subpart B Disclosure of Information by Providers and Fiscal Agents.

Providers have the following, but not limited to, ongoing responsibilities:

- To review and abide by the contents of all [Idaho Medicaid rules](#) governing items and services under Medicaid;
- To abide by their provider agreement;
- To review and abide by the [Idaho Medicaid Provider Handbook](#);
- To review and abide by periodic provider [Information Releases](#) and other program notification issued by Medicaid such as the [MedicAide Newsletter](#);
- To make records available to Medicaid upon request per the [Documentation](#) subsection;
- To abide by [Provider Enrollment](#) requirements including, but not limited to:
- Being licensed, certified, or registered with the appropriate state authority and to provide items and services in accordance with professionally recognized standards;
- To comply with the disclosure of [Ownership and Controlling Interests](#);
- To keep Medicaid and Gainwell Technologies advised of the provider's current address and telephone number per the [Maintenance of Contact Information](#) subsection;
- To sign every claim form submitted for payment or complete a signature-on-file form (including electronic signatures). See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for more information;
- To acknowledge when Medicaid is a secondary payer and agree to seek payment from other sources. See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for more information about third party liability;
- To accept Medicaid payment for any item or service as payment in full and to make no additional charge to participants or other parties for the difference. See the [Participant Financial Responsibility](#) section for more information;
- To not bill a Medicaid participant unless the item or service is non-covered or excluded by Medicaid, and the provider complies with the [Participant Financial Responsibility](#) section. See [Non-Covered and Excluded Services](#), which includes a list of excluded services, for more information; and
- Medicaid participants cannot be billed for "no-show" or missed appointments nor can they enter into an agreement to be responsible for any resulting fees.

## **1.1. Employees and Contractors**

Providers are responsible for the recruiting, hiring, firing, training, supervision, scheduling, and payroll for their employees, subcontractors, or agents. The Provider shall maintain general liability insurance coverage, worker's compensation, and unemployment insurance, and shall pay all FICA taxes and state and federal tax withholding for its employees. The Provider agrees to bill only for service providers who have the qualifications required for the type of service that is being delivered.

Furthermore, providers assume sole responsibility for the actions of their employees and contractors on their behalf. This includes the accuracy of claims submitted as specified in the [Idaho Medicaid Provider Agreement](#). The provider shall immediately repay the Department for any items or services determined to be improperly provided, documented, or claimed. In cases of suspected fraud, the Department may refer individual employees to the Medicaid Fraud Control Unit for further investigation and possible prosecution. Providers may also contact local law enforcement or take independent civil action against employees to recover losses caused by the employee.

### **1.1.1. References: Employees and Contractors**

#### ***a) Idaho Medicaid Publications***

**"Medicaid Program Integrity Unit: Provider Responsibilities Regarding Overpayments."**  
*MedicAide Newsletter*, January 2014,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/January%202014%20MedicAide.pdf>.

## **1.2. Documentation**

Providers are required to generate records at the time the service is delivered and maintain all records necessary to fully document the extent of services submitted for Medicaid reimbursement. Services which have not been sufficiently documented are not reimbursable. The person delivering the services and any supervising providers must ensure all documentation is legible, complete, dated, time-stamped, and includes a written or electronic dated signature to attest that the records are a true and accurate account of the services delivered.

### **1.2.1. Additional Documentation**

Additional documentation requirements may vary by provider or service type and are listed in the appropriate sections of the Idaho Medicaid Provider Handbook. Providers should consult the applicable sections or chapter of the Provider Handbook prior to delivering or billing for services.

### **1.2.2. Amendments or Corrections**

Any records requiring amendment or corrections must be clearly and permanently identified as such while leaving the original contents of the document legible. Amendments and corrections are intended to provide clarification and cannot be used to add new services for billing or retroactively establish medical necessity. Amendments and corrections separately require the author to be clearly identified with their credentials, a signature and the date of the changes.

### **1.2.3. Signatures**

Handwritten or electronic signatures (including those captured by Electronic Visit Verification software certified by the Department) are acceptable. All signatures must be dated. Electronic signatures must meet the requirements in the [Electronic Signatures](#) subsection. For handwritten signatures, stamped and typed signatures are only allowed for providers with proof of a physical disability that prevents their signing.

Records should be signed shortly after the service is provided with time allowed for transcription by a scribe. Signatures cannot be added to documents beyond that time frame, and scribes do not need to sign documents.

If the Department determines a handwritten signature is illegible, a provider may submit a signature log or attestation with requested records to support the identity of the signer. A signature log must include a typed list of provider names, titles and credentials followed by the corresponding handwritten signature. Signature attestations must be signed and dated by the author of the illegible signature. Attestations must include a statement of the document's validity, the name and credentials of the author, the date of service being attested to and the participant's name and Medicaid Identification Number (MID). Attestations can also be used as documentation for missing signatures.

### **1.2.4. Electronic Signatures**

Idaho Medicaid will accept dated electronic signatures for provider orders and records to meet the requirements for documentation. The individual whose name is on the electronic signature and the provider bear the responsibility for authenticity. Each provider must develop written policies and procedures to assure complete, accurate, and authenticated records and at a minimum include:

- Security provisions to protect against the use of an electronic signature by anyone other than the person to which the electronic signature belongs;
- How the privacy and integrity of the record is protected;
- A list of which records will be maintained and signed electronically;
- How an e-signature code is assigned;
- How passwords are assigned and the frequency for which they are changed in provider software;
- Clarification on whether a digital signature, a digitized signature, or an electronic signature is being used, and the details of the signing process involved; and
- Access standards to the records for participants, the Department and others who are authorized by law.

The following are not considered acceptable electronic signatures and may not be accepted by Idaho Medicaid: (a) created by, (b) received by/for, (c) generated by/for, (d) administratively signed by, (e) dictated but not signed, (f) electronically signed to expedite delivery, or (g) proxy signature (signed via approval letter or statement).

Providers are encouraged to review and apply HIPAA guidance on the U.S. Health & Human Services site: <https://www.hhs.gov/hipaa/index.html>. As required by HIPAA-covered entities, the provider must ensure that the software program used is set up so that the signer cannot deny having signed the document in the future, the signer's identity is guaranteed at the time the signature was generated, and that the document has not been altered since it was signed. Providers using Electronic Visit Verification (EVV) software to verify service delivery automatically meet these requirements as long as the EVV software used is certified by the Department or its contractor.

### **1.2.5. Retention of Records**

Providers are required to retain records of documented services submitted for Medicaid reimbursement for at least five (5) years from the date of service. Upon request from the Department, Centers for Medicare and Medicaid Services (CMS), or any Department or CMS contractor, providers must immediately provide documentation sufficient to substantiate the amount, duration, scope, and medical necessity of billed services. Documentation to support claims for services includes, but is not limited to, medical records, treatment plans, medical necessity justification, assessments, appointment sheets, patient accounts, financial records, or other records regardless of its form or media. Medicaid may recoup the payment and apply a penalty if proper documentation cannot be produced by the provider.

Documentation created after a Department records request is made will not be accepted. Intentional deception or misrepresentation made with the knowledge that the deception could result in an unauthorized benefit constitutes fraud, and offending individuals will be referred for prosecution.

### **1.2.6. References: Documentation**

#### **a) CMS Guidance**

"Chapter 3 – Verifying Potential Errors and Taking Corrective Actions." *Medicare Program Integrity Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>.

“Electronic Visit Verification (EVV).” Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicaid.gov/medicaid/home-community-based-services/guidance/electronic-visit-verification-evv/index.html>.

“Medical Documentation Signature Requirements. Noridian Healthcare Solutions, 4 April 2022, <https://med.noridianmedicare.com/web/jfb/cert-reviews/signature-requirements>.

“Signature Guidelines for Medical Review Purposes” CMS Medicare Learning Network (MLN) Matters (MM)6698, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm6698.pdf>.

### **b) Federal Regulations**

“Criminal Penalties for Act Involving Federal Health Care Programs.” Social Security Act, Sec. 1128B (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title11/1128B.htm](https://www.ssa.gov/OP_Home/ssact/title11/1128B.htm).

Failure to Grant Immediate Access, 42 CFR 1001.1301 (1992). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol5/pdf/CFR-2018-title42-vol5-sec1001-1301.pdf>.

The Rehabilitation Act. H.R. 8070 (1973). U.S. 93<sup>rd</sup> Congress, <https://www.congress.gov/bill/93rd-congress/house-bill/8070>.

“State Plans for Medical Assistance.” Social Security Act, Sec. 1902(a)(27) (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1905.htm](https://www.ssa.gov/OP_Home/ssact/title19/1905.htm).

### **c) Idaho Medicaid Publications**

“Documentation of Services Provided – Signature Required.” *MedicAide Newsletter*, October 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202018%20MedicAide.pdf>.

“If it is not documented, it has not been done, CMS.gov.” *MedicAide Newsletter*, October 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202018%20MedicAide.pdf>.

“Medicaid Program Integrity Unit: Documentation Requirements for Personal Care Services.” *MedicAide Newsletter*, August 2022, <https://www.idmedicaid.com/MedicAide%20Newsletters/August%202022%20MedicAide.pdf>.

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“Medicaid Program Integrity Unit: Documentation Requirements.” *MedicAide Newsletter*, February 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/February%202019%20MedicAide.pdf>.

"Medicaid Program Integrity Unit: Medical Record Entries." *MedicAide Newsletter*, October 2013,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/October%202013%20MedicAide.pdf>.

"Signatures on Documentation." *MedicAide Newsletter*, May 2023,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf>.

### **d) State Regulations**

Administrative Remedies, Idaho Code 56-209h (1998). Idaho State Legislature,  
<https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-209h>.

"Documentation of Services and Access to Records." *IDAPA 16.05.07*, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct," Sec. 101. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160507.pdf>.

Failure to Retain Records, Idaho Code 56-209o (2007). Idaho State Legislature,  
<https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-209o/>.

Legal Recognition of Electronic Records, Electronic Signatures and Electronic Contracts – Electronic Transmittal in Lieu of Certified Mail, Idaho Code 28-50-107 (2003). Idaho State Legislature,  
<https://legislature.idaho.gov/statutesrules/idstat/title28/t28ch50/sect28-50-107/>.

### 1.3. Ordering, Referring and Prescribing Providers

As a condition of payment provider's claims designated in the [Provider Types and Specialties](#), Idaho Medicaid Provider Handbook, require inclusion of an enrolled ordering, referring or prescribing (ORP) provider's name and NPI. If the claims are submitted without an enrolled provider's name and NPI, they will deny. Claims that come directly from Medicare to Idaho Medicaid will not require an enrolled ORP, but if the provider has to submit a claim manually it will deny without one.

Based on the State of Idaho's medical licensing structure and statutes, the following individual provider types may order, refer, or prescribe healthcare services or supplies for participants of the Idaho Medicaid program. These services or supplies must be requested in accordance with the provider's scope of practice and their licensure, which includes any certifications or credentials they possess. Eligible healthcare professionals are:

- Dentists;
- Licensed midwives;
- Nurse practitioners;
- Optometrists;
- Pharmacists;
- Physicians including residents, licensed bridge year physicians and licensed international medical graduates;
- Physician assistants;
- Podiatrists; and
- Psychologists (except school-based psychologists, who are exempt).

ORP providers must:

- Enroll with Idaho Medicaid as a billing provider, a non-billing ORP, or a crossover provider;
- Complete enrollment application;
- Complete Idaho Medicaid Provider Agreement; and
- Retain all documentation to support services ordered including the establishment of medical necessity for the services, equipment or supplies.

Billing providers must:

- Ensure all ORP providers are enrolled with Idaho Medicaid;
- Obtain the name and the NPI of the ORP provider and include it on claims; and
- Retain all documentation to support services billed

Interns and students (except first-year physician residents) are not eligible to enroll as ORP providers. The teaching, admitting or supervising eligible healthcare professional, however, can review their documentation and perform the order or referral on their behalf.

**Note:** Pharmacists enrolled as an ORP will be able to prescribe and provide medical services within the specifications allowed under the Idaho Pharmacy Act. Actual billing for Idaho Medicaid payable drugs, medical supplies and services will continue to be billed under the enrolled Medicaid pharmacy or other associated business provider number.

### **1.3.1. References: Ordering, Referring and Prescribing Providers**

#### **a) CMS Guidance**

"1.5.1.B. Ordering or Referring Physicians or Other Professionals (ORP)." *Medicaid Provider Enrollment Compendium (MPEC)*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicaid.gov/sites/default/files/2019-12/mpec-7242018.pdf>

"1.5.2. When Screening is Required." *Medicaid Provider Enrollment Compendium (MPEC)*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf>.

#### **b) Federal Regulations**

Enrollment and Screening of Providers, 42 CFR 455.410 (2011). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf>.

#### **c) Idaho Medicaid Publications**

"Edits Will Change from Warn to Deny on October 1, 2017." *MedicAide Newsletter*, September 2017, <https://www.idmedicaid.com/MedicAide%20Newsletters/September%202017%20MedicAide.pdf>.

"Policy Update: Ordering, Referring, and Prescribing (ORP) Providers." *MedicAide Newsletter*, April 2023, <https://www.idmedicaid.com/MedicAide%20Newsletters/April%202023%20MedicAide.pdf>.

#### **d) State Regulations**

"Ordering, Prescribing, and Referring Providers." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 210.06. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.



## 1.4. Prohibition on Gifts to Participants

Providers are prohibited from offering gifts or incentives to participants and may be liable for a civil monetary penalty up to \$10,000 per occurrence as well as exclusion from Federal programs for a period not to exceed ten (10) years. This includes waivers of co-payments and the transfer of items or services for free or below the fair market value. There are some allowances such as:

- Nominal gifts other than cash with a value up to \$15 per item, but not more than \$75 annually;
- Items or services that are offered on equal terms to the general public, regardless of insurance status;
- Payments between an employer and employee;
- Waivers of cost-sharing amounts without advertisement based on financial need;
- Incentives to promote the delivery of preventive care services for pre-natal or post-natal well-baby care or services in the Guide to Clinical Preventive Services by the United States Preventive Services Task Force (USPSTF);
- Drug manufacturers that do not file claims with Medicaid; and
- A provider funded independent entity that furnishes services to the financially needy so long as the benefits are not dependent on using any particular provider's services.

### 1.4.1. References: Prohibition on Gifts to Participants

#### a) Idaho Medicaid Publications

Federal Anti-Kickback Statute, Information Release MA07-24 (12/13/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IR%20MA07-24%20Federal%20Anti-Kickback%20Statute-signed.pdf>.

#### b) Federal Regulations

"Civil Monetary Penalties." Social Security Act, Sec. 1128A(a)(5) (1996). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title11/1128A.htm](https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm).

CMPs, Assessments, and Exclusions for Beneficiary Inducement Violations, 42 CFR 1003 Subpart J (2016). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol5/pdf/CFR-2018-title42-vol5-part1003-subpartJ.pdf>.

Definitions, 42 CFR 1003.110 (2016). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol5/pdf/CFR-2018-title42-vol5-sec1003-110.pdf>.

Health Insurance Portability and Accountability Act of 1996. Public Law 104-191 (1996). Government Printing Office, <https://www.govinfo.gov/content/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf>.

Permissive Exclusions, 42 CFR 1001 Subpart C (2017). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol5/pdf/CFR-2018-title42-vol5-part1001-subpartC.pdf>.

***c) Office of the Inspector General Publications***

Offering Gifts and Other Inducements to Beneficiaries (08/2002). Office of Inspector General, Department of Health and Human Services, <https://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf>.

Office of Inspector General Policy Statement Regarding Gifts of Nominal Value to Medicare and Medicaid Beneficiaries (12/07/2016). Office of Inspector General, Department of Health and Human Services, <https://oig.hhs.gov/fraud/docs/alertsandbulletins/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf>.

## **1.5. Services for Immediate Family or Household Member**

The Department reimburses providers based on the lesser of reasonable costs or customary charges for services and items. The definition for customary charges includes the provision for Medicare rates, which considers items and services furnished to an immediate family or household member to be without charge due to the relationship between the participant and the provider. Unless otherwise stated providers cannot be reimbursed for services rendered to a participant within their immediate family or household.

For physicians and non-physician practitioners this also includes services that would be incidental to their care. This section does not apply to a non-professional corporation regardless of the relationship with any employee, stockholder, officer or director. It does apply to a professional corporation, which is any corporation owned by healthcare professionals for the purpose of practicing medicine, midwifery, dentistry, podiatry, optometry or chiropractic care.

Providers are encouraged to consult their professional organization's stance on these services as many organizations such as the American Medical Association consider the treatment of self or a close personal relationship to violate their ethical standards.

### **1.5.1. Immediate Family Definition**

An immediate family member would be:

- A spouse;
- A natural, step, in-law or adopted child;
- A natural, step, in-law or adopted parent;
- A person acting in loco parentis;
- A natural, step, in-law or adopted sibling;
- A natural, step, in-law or adopted grandchild; or
- A natural, step, in-law or adopted grandparent.

The spouse of a brother-in-law or sister-in-law would not be considered an immediate family member. Familial bonds are considered to remain in effect in the event of the death of one of the parties.

### **1.5.2. Household Member Definition**

A household member is anyone living in the provider's residence with a relationship based on blood, adoption, marriage or employment. Roommates and renters are not considered a member of the provider's household. However, services provided for a roommate or renter can still be excluded from reimbursement if they are an immediate family member.

### **1.5.3. References: Services for Immediate Family or Household Member**

#### **a) CMS Guidance**

"Chapter 16 – General Exclusions from Coverage." *Medicare Benefit Policy Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf>.

### **b) Idaho Medicaid Publications**

"Providers of Medical, Surgical, and DMEPOS, Medicaid Does not Pay for Services Rendered or Performed by Spouses and Legally Responsible Parents of Minors." *MedicAide Newsletter*, January 2019,

<https://www.idmedicaid.com/MedicAide%20Newsletters/January%202019%20MedicAide.pdf>.

### **c) Professional Organizations**

American College of Physicians Ethics Manual: Seventh Edition, Lois Snyder Sulmasy, Thomas A. Bledsoe, American College of Physicians Ethics, Professionalism and Human Rights Committee, <https://annals.org/aim/fullarticle/2720883/american-college-physicians-ethics-manual-seventh-edition>.

"Treating Self or Family: Opinion E-1.2.1." *Code of Medical Ethics: Patient-physician Relationships*, American Medical Association,

<https://www.ama-assn.org/delivering-care/ethics/treating-self-or-family>.

### **d) State Regulations**

"Customary Charges." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 010.19.

Department of Administration, State of Idaho,  
<https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Lower of Cost or Charges." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 230.06.

Department of Administration, State of Idaho,  
<https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

## **1.6. Payment Error Rate Measurement (PERM) Audits**

The Centers for Medicare and Medicaid Services (CMS) implemented the Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid and the State Children's Health Insurance Program (SCHIP) by reviewing claim payments and participant eligibility determinations every three (3) years. CMS uses a Review Contractor (RC) to perform medical records collection, statistical calculations and medical data processing review of fee-for-service (FFS) claims. The RC will select a sample of claims and call affected providers to explain the process and establish a point of contact for the audit. The RC will then send the provider by fax or mail a written request detailing what documents are needed.

Documentation must be submitted with the PERM coversheet by providers per the RC's instructions within seventy-five (75) calendar days. If the documentation submitted is insufficient to support the claim, additional documentation will be requested. Providers only have fourteen (14) days to comply with any additional requests. It is important that providers cooperate by submitting all requested documentation within the designated timeframe. Failure to provide the requested documentation in the designated time frame is in violation of Idaho Code Section 56-209h and the Idaho Medicaid Provider Agreement, which may result in disenrollment, investigation, recoupment and/or civil penalties.

The RC will have the claims and documentation reviewed by medical staff and certified coders to ensure payment was appropriate based on the Department's policy, state and federal regulations and rules. Claims out of compliance will be recouped by the Department, and providers may be required to submit a corrective action plan to prevent the issue in the future. Additionally, the Medicaid Fraud Control Unit or the Medicaid Program Integrity Unit may investigate providers for suspected fraud or abuse. Providers are still entitled to their normal appeal rights with the Department.

The Department will monitor PERM audits and follow-up with providers and the RC as necessary. This includes reviewing the result of the audit and providing the RC additional information if it believes their findings are incorrect. Providers may email their State PERM contact at [Jacquie.Kennedy-King@dhw.idaho.gov](mailto:Jacquie.Kennedy-King@dhw.idaho.gov) or CMS at [PERMProviders@cms.hhs.gov](mailto:PERMProviders@cms.hhs.gov) for any provider specific questions.

### **1.6.1. References: Payment Error Rate Measurement (PERM)**

#### ***a) CMS Guidance***

Payment Error Rate Measurement (PERM). Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/index?redirect=/PERM>.

HHS Agency Financial Reports. Department of Health and Human Services, <https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html>.

#### ***b) Federal Regulations***

Improper Payments Elimination and Recovery Act of 2010. P.L. 111-204 (2010). Government Printing Office, <https://www.govinfo.gov/content/pkg/PLAW-111publ204/pdf/PLAW-111publ204.pdf>.

Improper Payments Information Act of 2002. P.L. 107-300 (2002). Government Printing Office, <https://www.govinfo.gov/content/pkg/PLAW-107publ300/pdf/PLAW-107publ300.pdf>.

***c) State Regulations***

Administrative Remedies, Idaho Code 56-209 (2016). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-209h/>.

## 1.7. Prevention of Waste, Fraud and Abuse

Providers are responsible to establish, disseminate and enforce written policies to their employees, contractors and subcontractors that detect and prevent waste, fraud and abuse. Employee handbooks shall include reference to the laws in the written policies, protections for whistleblowers, and specific discussion of policies and procedures to comply with the False Claims Act of 1863 and Deficit Reduction Act of 2005. These handbooks must be available to all employees, contractors and agents.

Additionally, providers receiving payments of \$5,000,000 or more must provide the Department annually with a written affidavit to attest their compliance with these laws. Each year the Division of Medicaid sends reminder letters to entities determined to meet this requirement.

Compliance with these laws is a condition of payment. Failure to comply will result in termination of your provider contract, and potential recoupment and penalties. Providers are encouraged to make use of the Office of Inspector General's [Compliance Resource Portal](#) for best practices and complimentary trainings.

### 1.7.1. References: Prevention of Waste, Fraud and Abuse

#### a) Federal Regulations

Deficit Reduction Act of 2005. S. 1932 (2006). Government Printing Office, <https://www.govinfo.gov/content/pkg/BILLS-109s1932enr/pdf/BILLS-109s1932enr.pdf>.

The False Claims Act. 12 Stat. 696 (1863). The Library of Congress, <https://www.loc.gov/law/help/statutes-at-large/37th-congress/session-3/c37s3ch67.pdf>.

False Claims Amendments Act of 1986. 100 Stat. 3153 (1986). Government Printing Office, <https://www.govinfo.gov/content/pkg/STATUTE-100/pdf/STATUTE-100-Pg3153.pdf#page=1>.

Fraud Enforcement and Recovery Act of 2009. 123 Stat. 1617 (2009). Government Printing Office, <https://www.govinfo.gov/content/pkg/STATUTE-123/pdf/STATUTE-123-Pg1617.pdf#page=1>.

The Patient Protection and Affordable Care Act. H.R. 3590 (2010). Government Printing Office, <https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

#### b) Idaho Medicaid Publications

Changes in Federal Legislation Affecting Medicaid Providers, Information Release MA07-01 (01/05/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA07-01%20signed%20copy.pdf>.

Federal Anti-Kickback Statute, Information Release MA07-24 (12/13/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IR%20MA07-24%20Federal%20Anti-Kickback%20Statute-signed.pdf>.

"Provider Responsibilities for the Prevention of Waste, Fraud and Abuse." *MedicAide Newsletter*, January 2019,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/January%202019%20MedicAide.pdf>.



## **1.8. Self-Reporting Overpayments**

Providers that are aware of an overpayment by the Department must immediately repay the improper amounts. If an overpayment is identified within the time frame allowed for a claim adjustment, providers should adjust their claims per the [General Billing Instructions](#), Idaho Medicaid Provider Handbook. If the overpayment is identified beyond the allowed adjustment period, providers must submit the [Overpayment Form](#) to Gainwell Technologies. Providers will be contacted by the Medicaid Program Integrity Unit within five (5) working days to discuss repayment.

Incentives are extended to providers who responsibly self-report including:

- Extended repayment terms;
- Waiver of civil monetary penalties;
  - Civil monetary penalties cannot be waived for criminal history background compliance cases, but an audit would not be done on all employees; and
- Quick resolution of overpayments.

Situations that could cause an overpayment include, but are not limited to:

- Incorrect coding or billing;
- Services provided by an unlicensed or excluded individual; and
- Claims submitted for services that didn't occur.

### **1.8.1. References: Self-Reporting Overpayments**

#### ***a) Idaho Medicaid Publications***

"Provider Self-Report of Overpayments." *MedicAide Newsletter*, June 2018,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/June%202018%20MedicAide.pdf>.

## 2. Participant Financial Responsibility

Providers enrolled with Idaho Medicaid that provide items or services to a participant must bill any third-party liable payor and Idaho Medicaid. Any payment made by Idaho Medicaid must be accepted as payment in full. This also includes claims with third-party liability where Medicaid's reimbursement methodology considers the third-party payment to have covered the claim in full and no additional amount is paid by Medicaid. Providers cannot refuse to provide covered services because of potential third-party liability.

Unless stated otherwise by the Department (e.g. Idaho Medicaid co-pays and share of cost) no additional payment may be collected from the participant either before or after Medicaid payment, regardless of a separate contract between the participant and the provider for assumption of liability. This includes, but is not limited to:

- No-show or missed appointment fees;
- Other insurer's co-pays;
- Failure on the part of the provider to submit a complete and correct claim to the Department or other payor;
- Failure by the provider to submit a complete and correct request for prior authorization from the Department or other payor;
- Claims voided by the provider;
- Failure of the provider to follow any payor's policy or procedure; or
- Any recoupment or penalties the provider receives as a result of their action or inaction.

Providers may bill a participant when a third-party payment (e.g. automotive insurance adjustment) was made to the participant instead of the provider, in which case the participant may be billed for an amount equal to that payment.

Providers can bill participants for non-covered or excluded items and services. Prior to rendering services or providing items that are non-covered or excluded, providers must inform participants that what they are receiving is not covered under Medicaid. Providers may only bill non-covered and excluded services and items to the participant if the provider has notified the participant of their responsibility to pay in writing prior to rendering services. Idaho Medicaid does not have an official format, but the notice must specify the non-covered/excluded service or item, the cost of each service or item, and be signed by the participant. If the participant chooses to obtain services not covered or excluded by Medicaid, it is the participant's responsibility to pay for the services. See the [Non-Covered and Excluded Services](#) section for more information.

Providers are exempt from the requirement to notify the participant in writing for services provided during any period where the participant was later found retroactively eligible for Medicaid coverage. However, providers must adhere to all other requirements of being a Medicaid provider. If the provider previously collected a payment that would not be allowed by Idaho Medicaid from a participant later found eligible, the payment must be refunded.

See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for more information about third-party liability, co-payments, share of cost and reimbursement methodologies.

## **2.1. References: Participant Financial Responsibility**

### ***a) Federal Regulations***

Provider Restrictions: State Plan Requirements, 42 CFR 447.20(b) (2013). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2022-title42-vol4/pdf/CFR-2022-title42-vol4-sec447-20.pdf>.

## 2.2. Co-payments

Some participants may be subject to a co-pay. When verifying a participant's eligibility a co-payment indicator of "Exempt" or \$3.65 will be provided. Participants can only be charged a co-payment as specified by the provider handbook and when the reimbursement amount for the service is more than \$36.50 in the Medicaid Fee Schedule.

Services for wellness including preventive exams, and all medically necessary immunizations or family planning services are excluded from co-pay. These services, however, are subject to a co-payment:

- [Ambulance services](#) for a non-emergency;
- [Chiropractic](#);
- [Emergency room services](#) for a non-emergency;
- [Podiatric](#);
- [Eye and vision services](#) provided by an optometrist;
- [Physical and Occupational Therapy](#);
- [Speech Language Pathology](#);
- [Physician and Non-physician practitioner](#) services;
- [Federally Qualified Health Centers \(FQHC\)](#); and
- [Rural Health Clinics \(RHC\)](#).

The provider of services is responsible for collection of the copayment. When the co-pay is applicable, the provider's reimbursement will be reduced by the amount of the co-pay regardless of whether or not the co-pay was charged or collected by the provider. If a participant subject to a co-pay is unable to make a payment, the provider may:

- Bill the participant for the co-pay;
- For participants with incomes above 100% of the federal poverty level (FPL), refuse to provide services at that time; or
- Waive the co-pay if the provider has a written policy describing the criteria for waiving and enforcing collection of co-pays.

### 2.2.1. References: Co-payments

#### a) Federal Regulations

"Criminal Penalties for Acts Involving Federal Health Care Programs." Social Security Act, Sec. 1128B(b)(3)(D) (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1916A.htm](https://www.ssa.gov/OP_Home/ssact/title19/1916A.htm).

Medicaid Premiums and Cost Sharing, 42 CFR 447.50—447.90 (2013). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part447-subpartA.pdf>.

"State Option for Alternative Premiums and Cost Sharing." Social Security Act, Sec. 1916A (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1916A.htm](https://www.ssa.gov/OP_Home/ssact/title19/1916A.htm).

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(14) (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1902.htm](https://www.ssa.gov/OP_Home/ssact/title19/1902.htm).

"Use Of Enrollment Fees, Premiums, Deductions, Cost Sharing, And Similar Charges." Social Security Act, Sec. 1916 (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1916.htm](https://www.ssa.gov/OP_Home/ssact/title19/1916.htm).

### **b) Idaho Medicaid Publications**

Co-payment for Non-Emergency Use of Ambulance Transportation Services, Information Release MA07-04 (1/08/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA07-04.pdf>.

Co-payment for Non-Emergency Use of an Emergency Room, Information Release MA07-03 (1/05/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA07-03.pdf>.

Co-payments, Information Release MA11-26 (10/24/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA11-26.pdf>.

Co-payments (Co-pays), Information Release MA11-29 (11/22/2011). Division of Medicaid, Department of Health and Welfare, State of Idaho, <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IR%20MA11-29%20Co-payments%20phase%202.pdf>.

### **c) State Regulations**

Co-payments, Idaho Code 56-257 (2011). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-257/>.

"Collection of Copayments." *IDAPA 16.03.18*, "Medicaid Cost Sharing," Sec. 330. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160318.pdf>.

"Exception to Charging a Copayment." *IDAPA 16.03.18*, "Medicaid Cost Sharing," Sec. 325. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160318.pdf>.

Legislative Intent, Idaho Code 56-251 (2007). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-251/>.

"Medicaid Outpatient Services Subject to Copayments." *IDAPA 16.03.18*, "Medicaid Cost Sharing," Sec. 320. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160318.pdf>.

## 2.3. Share of Cost (SOC)

Share of Cost (SOC) is a financial arrangement for a participant to pay a specific portion of the monthly costs associated with a service. Share of Cost is associated to participants with a Developmental Disability Waiver, Aged and Disabled Waiver, or Skilled Nursing Facilities or ICF/IID Facilities (i.e., Long Term Care).

There are three eligibility categories (referred to as Rate Codes):

- Rate Code 14: Developmental Disability Waiver;
- Rate Code 15: Aged and Disabled Waiver; and
- Rate Code 17: Skilled Nursing Facilities (Long Term Care) or ICF/IID Facilities.

It is the provider's responsibility to verify the participant's SOC each month and collect this from the participant. The provider's allowable reimbursement will be reduced by the amount of the applicable SOC on a first claim in basis until the full amount of the SOC has been offset. Refer to [Verifying Participant Eligibility](#) and the *Eligibility Verification* section of the [Trading Partner Account \(TPA\) User Guide](#).

Claims submitted that have applicable SOC must not span over multiple months. They must be billed within a single month on a claim.

### 2.3.1. Discrepancy Contact Information

If the participant or provider believes that the SOC amount is based on outdated or incomplete information, the participant or participant's personal representative should contact Self Reliance at 1 (877) 456-1233 to review the information used in the SOC calculation.

If there is a variance between the SOC identified in the participant's notification letter and what was reported on the participants SOC eligibility verification, an e-mail may be sent to [SOCdiscrepancies@dhw.idaho.gov](mailto:SOCdiscrepancies@dhw.idaho.gov), or a fax may be sent to 1 (208) 334-5571 using the [Fax Cover Sheet](#) found on the Idaho Gainwell Technologies Medicaid website, under [Gainwell Technologies Forms](#).

### 2.3.2. Paid Claim Discrepancies

If there is a variance between the amount of SOC offset on a claim and the amount reported during the SOC participant eligibility verification, the provider can complete the [Nursing Home and Waiver Share of Cost \(SOC\) Review Request](#) form e-mailed to [idsnursinghomes@gainwelltechnologies.com](mailto:idsnursinghomes@gainwelltechnologies.com). This form is available online under [Gainwell Technologies Forms](#). The instructions to fill out the form are in the same location. All fields in the forms are **required**.

### 2.3.3. References: Participant Financial Responsibility

#### a) Federal Regulations

Acceptance of State Payment as Payment in Full, 42 CFR 447.15 (2013). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec447-15.pdf>.

#### b) State Regulations

"Responsibility for Keeping Appointments." *IDAPA 16.03.09*, "Medicaid Basic Plan Benefits," Sec. 160. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

### **3. Surveillance and Utilization Review**

Medicaid has a statewide surveillance and utilization review program that safeguards against unnecessary utilization of care and services and excessive payments. It provides for the control of the utilization of all services provided under the plan and assesses the quality of those services.

### **3.1. Provider Program Abuse**

The Medicaid Program Integrity Unit (MPIU) conducts reviews and investigations to determine whether or not a provider is incorrectly billing Medicaid. The MPIU also conducts random studies of provider payment histories to detect billing errors and over-utilization. They perform on-site visits and obtain records to verify that services billed correspond to services rendered to participants. Once services are reviewed, issues may be resolved by provider education or policy revision, recovery of funds from the provider, and/or assessment of civil monetary penalties. In more serious cases, the Department can take any or all of the following actions:

- Suspend payment pending further investigation;
- Terminate provider numbers;
- Exclude entities/individuals;
- Refer individuals/providers for criminal prosecution.

If you believe that a particular Medicaid provider is abusing the program, you may contact:

Medicaid Program Integrity Unit  
PO Box 83720  
Boise, Idaho 83720-0036  
[prvfraud@dhw.idaho.gov](mailto:prvfraud@dhw.idaho.gov)  
Fax 1(208) 334-2026



### **3.2. Retrospective Review**

A retrospective review is a determination of coverage after a claim has been submitted. It may even occur after payment has been made. Should a review find that payment for a claim was inappropriate, it may be recouped. The review checks for appropriate documentation, medical necessity, and adherence to all applicable rules, regulations, and statutes. Receipt of documentation and claim payment is not certification that the Department has conducted a review or verified the appropriateness of a claim.

Providers may appeal a finding on a retrospective review by Medicaid or its designee by requesting a reconsideration. If the provider disagrees with the result of the reconsideration, they may file a formal appeal.

#### **3.2.1. Reconsideration Request**

Prepare a written Request for Reconsideration including additional documentation to support the validity of your claim. Documentation may include medical records, guidance from the Centers for Medicare & Medicaid Services, Idaho Provider Handbooks, Idaho statute, or Idaho Administrative Procedure Acts (IDAPA). Resubmit to the reviewing agent within 28 days from the mailing date of the Notice of Decision.

Upon completion of the reconsideration review, Medicaid will issue a second Notice of Decision. If the provider or participant disagrees with the reconsideration decision made by Medicaid or its designee, they may file a Request for Appeal. The provider or participant has 28 days from the mailing date of the second Notice of Decision to submit a formal appeal.

#### **3.2.2. Appeal Request**

A formal appeal must be submitted in writing with supporting documentation within 28 days of the reconsideration's Notice of Decision to:

Hearings Coordinator  
Idaho Department of Health and Welfare Administrative Procedures Section  
P.O. Box 83720  
Boise, ID 83720-0036  
FAX 1 (208) 334-6558

Documentation may be faxed but copies of the original documents must be provided to the Department in the mail. Documentation must include:

- A copy of the first Notice of Decision from the reviewing agent;
- A copy of the Request for Reconsideration from the provider;
- A copy of the second Notice of Decision from the reviewing agent showing that the request for reconsideration was performed;
- An explanation of why the reconsideration remains contested by the provider; and
- Copies of all supporting documentation.

You will be notified in writing by a Hearing Officer to set up a date, time, and location of for the hearing.

## **4. Services for Providers**

Gainwell Technologies is the fiscal agent for the Idaho Medicaid Program. The primary objective for Gainwell Technologies is to process Medicaid claims efficiently and accurately for Idaho Medicaid providers. The Gainwell Technologies Provider Enrollment Department enrolls providers into the Idaho Medicaid Program and responds to providers' requests for information not currently available through Idaho's Medicaid Automated Customer Service (MACS). The Gainwell Technologies Provider Services Department helps to keep providers up-to-date on billing changes required by program policy changes implemented by the Division of Medicaid and to answer any questions regarding claims and eligibility.

#### 4.1. Idaho Medicaid Automated Customer Service (MACS)

Medicaid Automated Customer Service (MACS) is the interactive voice response system (IVR) that allows a computer to recognize voice and telephone keypad inputs. MACS will allow users to access a database via a telephone touchtone keypad or by speech recognition, after which they can service their own inquiries by following the instructions. MACS will respond with pre-recorded audio to further direct users on how to proceed. MACS can be used to control almost any function where the system can be broken down into a series of simple menu choices.

The following table shows the information available through MACS. The phone number for MACS is 1 (866) 686-4272.

Information Available in MACS				
Claims Information	Last Payment Amount	Mailing Addresses	Participant Information	Security Code
Claim status	Amount and date of payment	Paper claims	Copay/Deductible	Create a new code
Procedure code coverage	Number of claims paid	ResHab/PCS PA	Eligibility	Change an existing code
PA required for procedure code	Warrant/EFT number	Medical or Surgical PA	HC enrollment and referrals	
Units remaining		Dental PA	Lock-In	
Revenue code coverage		DME PA	Other Insurance/TPLs	
PA required for revenue code		Inpatient or Outpatient PA	Prior Authorizations	
Diagnosis code coverage		Transportation PA	Service Limits	
		All other PAs		
		Web Portal address		

## **4.2. Eligibility Checks**

Gainwell Technologies has provided the ability for providers to check code coverage. Due to system limitations, the system shows all benefits a code resides in. It does not show benefits specific to the participant. Gainwell does try to name the benefits that apply to a particular age group. Providers should be aware of this system limitation when determining if a participant is eligible for a service. Furthermore, providers must abide by the Idaho Medicaid Provider Handbook. If a limitation is stated in the handbook, the provider is responsible for ensuring they do not exceed that limitation regardless of the system check.

### **4.2.1. References: Eligibility Checks**

#### ***a) Medicaid Publications***

"Handbook and the Eligibility System." *MedicAide Newsletter*, January 2024,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/January%202024%20MedicAide.pdf>.

### **4.3. Information Releases**

Information releases (IR) are issued to update providers on policy, billing and claims processing changes. An IR can be published at any time to the provider portal and then will be republished in the next [MedicAide Newsletter](#). Providers are required to adhere to information communicated by an IR as part of the Compliance section of their provider agreement. The Department maintains IRs from 2001 to the present on the [Information Releases](#) webpage. IRs from before 2001 can be requested by fax or letter to:

Information Release Coordinator  
Division of Medicaid  
P.O. Box 83720  
Boise, ID 83720-0036  
Fax: 208-364-1811

#### **4.3.1. References: Information Releases**

##### ***a) State Regulations***

**"Agreements with Providers: In General."** IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 205.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

## 4.4. MedicAide Newsletter

The MedicAide newsletter is a monthly publication that communicates information to Medicaid Providers and other interested parties. The newsletter contains policy, program and billing changes as well as [Information Releases](#) published since the last edition. Providers are required to adhere to information in newsletter articles as part of the Compliance section of their provider agreement.

The newsletter is published electronically by the 5<sup>th</sup> business day of the month at Gainwell Technologies [Idaho Medicaid](#) website. Paper copies may be requested by calling 1 (866) 686-4272. Subscriptions are unavailable at this time. Back issues from May 2010 to the present are available at Gainwell Technologies website. Issues before May 2010 are available on the Department's [MedicAide Newsletter](#) webpage.

### 4.4.1. References: MedicAide Newsletter

#### a) State Regulations

**"Agreements with Providers: In General."** IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 205.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

## **4.5. Provider Handbooks**

The [Idaho Medicaid Provider Handbook](#) is the primary repository for policy and billing instructions. The handbook is updated periodically with program changes and to incorporate information communicated in [Information Releases](#) or the [Medicaid Newsletter](#). Providers are required to adhere to information in the handbook as part of the Compliance section of their provider agreement. Should the handbook ever appear to contradict relevant provisions of state or federal rules and regulations, the rules and regulations prevail.

Any paper or digital copy of these documents is considered out of date except the version appearing on Gainwell Technologies [Idaho Medicaid](#) website.

### **4.5.1. References: Provider Handbooks**

#### ***a) State Regulations***

**"Agreements with Providers: In General."** IDAPA 16.03.09, "*Medicaid Basic Plan Benefits*," Sec. 205.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

#### **4.6. Provider Service Representatives (PSRs)**

Provider service representatives are available Monday through Friday from 7 A.M. to 7 P.M. Mountain Time by calling MACS at 1 (208) 373-1424 or 1 (866) 686-4272, and saying representative or rep. Gainwell Technologies provider service representatives are trained to promptly and accurately respond to requests for information on:

- Adjustments;
- Billing instructions;
- Claim status;
- Participant benefit information;
- Participant eligibility information;
- Form requests;
- Payment information;
- Provider participation status information;
- Recoupments; and
- Third party recovery information.

When calling with questions about claim status, please have the following information ready:

- Billing provider's Idaho Medicaid provider number;
- Participant's Medicaid identification number; and
- Date(s) of service.

When calling for questions about participant eligibility, have the following information ready:

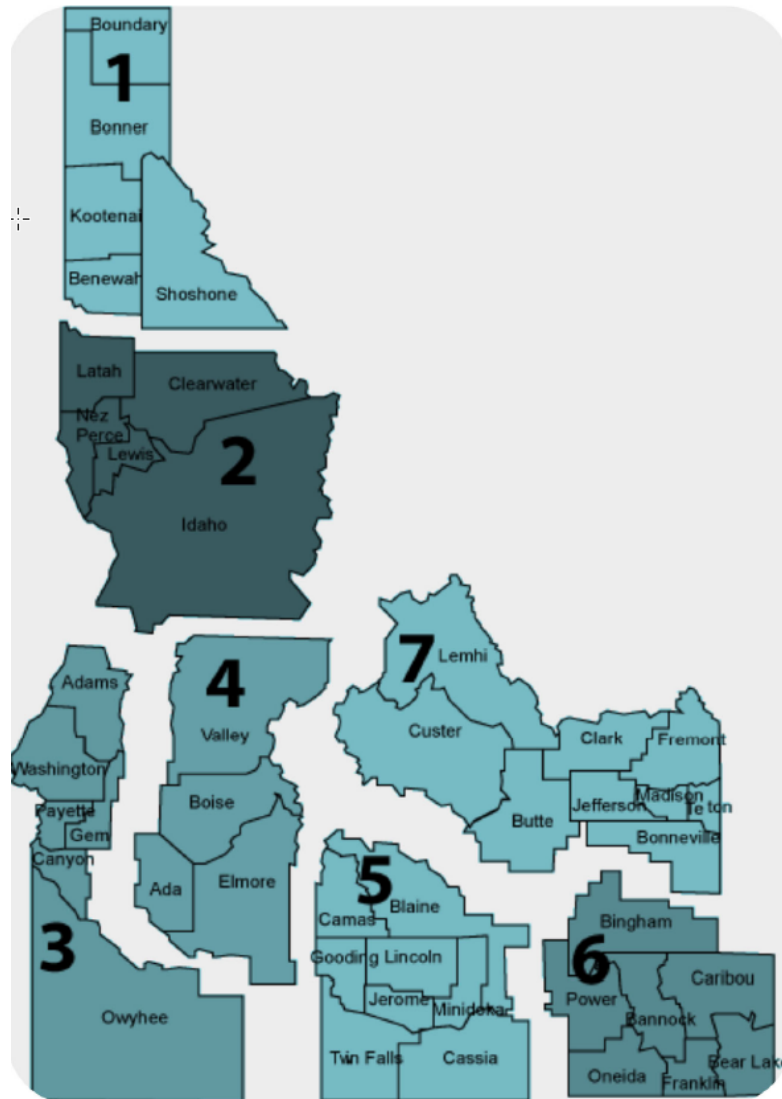
- Billing provider's Idaho provider number;
- Participant's first and last name; and
- Participant's Medicaid identification number, date of birth, or Social Security number.



### 4.7. Provider Relations Consultants (PRC)

Gainwell Technologies Provider Relations Consultants help keep providers up-to-date on billing changes required by program policy changes implemented by the Division of Medicaid. Provider Relations Consultants accomplish this by:

- Conducting provider workshops;
- Conducting live meetings for training;
- Visiting a provider’s site to conduct training; and
- Assisting providers with electronic claims submission.



**Region 1 and the state of Washington**

1 (208) 202-5735  
[Region.1@gainwelltechnologies.com](mailto:Region.1@gainwelltechnologies.com)

**Region 2 and the state of Montana**

1 (208) 202-5736  
[Region.2@gainwelltechnologies.com](mailto:Region.2@gainwelltechnologies.com)

**Region 3 and the state of Oregon**

1 (208) 202-5816  
[Region.3@gainwelltechnologies.com](mailto:Region.3@gainwelltechnologies.com)

**Region 4**

1 (208) 202-5843  
[Region.4@gainwelltechnologies.com](mailto:Region.4@gainwelltechnologies.com)

**Region 5 and the state of Nevada**

1 (208) 202-5963  
[Region.5@gainwelltechnologies.com](mailto:Region.5@gainwelltechnologies.com)

**Region 6 and the state of Utah**

1 (208) 593-7759  
[Region.6@gainwelltechnologies.com](mailto:Region.6@gainwelltechnologies.com)

**Region 7 and the state of Wyoming**

1 (208) 609-5062  
[Region.7@gainwelltechnologies.com](mailto:Region.7@gainwelltechnologies.com)

**Region 9 all other states** (not bordering Idaho)

1 (208) 609-5115  
[Region.9@gainwelltechnologies.com](mailto:Region.9@gainwelltechnologies.com)

## 5. Provider Enrollment

Idaho Medicaid enrolls two types of providers, billing and non-billing (e.g., [crossover only providers](#), and [non-billing ordering, referring and prescribing providers](#)). All providers wishing to participate in the Idaho Medicaid Program must first register for a Trading Partner Account (TPA) at <https://www.idmedicaid.com> and then follow the link for the Provider Enrollment Application upon logging in. A complete application includes a Medicaid Provider Enrollment Agreement and a W-9, which must be signed by the provider and submitted with the enrollment application along with other attachments to Gainwell Technologies through the website.

Individual providers enrolling must disclose information, including, but not limited to:

- Date of birth (DOB);
- Social Security Number (SSN);
- Licensure;
- National Provider Identifier (if applicable); and
- Convictions of any criminal offense related to the person's involvement in any program under Medicare, Medicaid, or CHIP since those programs began.

All owners, corporate officers, directors, or shareholders of legal entities to include the following: general or limited corporations; partnerships; professional corporations or associations; limited liability companies with a direct, indirect or control interest; managed care organizations AND managing employees or fiscal agents who exercise day-to-day operational or managerial control or operations must also disclose information upon enrollment in Medicaid. A disclosing entity is defined as "a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent." Disclosing entities must disclose:

- Names and addresses of any persons with an ownership or control interest in the entity;
- Names, addresses, DOBs, and SSNs of any managing employee or fiscal agent of the disclosing entity;
- Whether a person with an ownership interest is related to another person with an ownership or control interest;
- Names of other disclosing entities in which the owner, managing employee or fiscal agent has an ownership or control interest regardless of the percentage of ownership;
- Convictions of persons who have ownership or control interests in the provider entity;
- Convictions of persons who are managing employees or fiscal agents of the provider entity; and
- Whether any person with an ownership or control interest, a managing employee or a fiscal agent has voluntarily revoked, terminated or been subject to revocation or termination action of a Medicare, Medicaid or CHIP enrollment as defined by 42 CFR 455.107.

Both individuals and entities must disclose family relationships between persons with ownership or control interests in the disclosing entity.

The provider must meet all applicable state and Medicaid licensure/certification and insurance requirements to practice their profession. In addition, the provider qualification requirements for the service(s) to be provided must be met. Information supplied will be used to validate credentials. Other certification/licensure and proof of insurance may be required as provided for in [IDAPA 16.03.09, "Medicaid Basic Plan Benefits"](#) and [IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits"](#).

Continued provider participation is contingent on the ongoing maintenance of such licensure/certification and proof of insurance. The loss of, or failure to renew, the required license/certification and proof of insurance is cause to terminate a provider's participation in the Idaho Medicaid Program.

Additional information about Idaho administrative rules is available on Access Idaho at the Legislative Branch link under the Government heading. See [Appendix A Provider Agreement Example](#) for provisions that apply to all providers.

## 5.1. Non-billing Ordering, Referring and Prescribing Providers

Healthcare professionals that do not wish to be Medicaid providers can instead choose to enroll as non-billing entities for the sole purpose of ordering services and items. This allows participants to fill prescriptions or an Idaho Medicaid provider to accept a referral. Providers wishing to enroll as non-billing ordering, referring and prescribing providers must complete an enrollment application, sign the Idaho Medicaid Provider Agreement, and retain all documentation to support services ordered including the establishment of medical necessity. The Department has established a streamlined process to enroll non-billing individuals whose only relationship with the Idaho Medicaid program is to refer for specialized care or order items or services. This enrollment is for individuals only, not facilities or group provider entities. Call Idaho Medicaid Provider Enrollment toll free at 1 (866) 686-4272 for a non-billing provider enrollment form. This enrollment method *is not* for individuals who want to submit claims to Idaho Medicaid for reimbursement for their services. If an enrolled non-billing provider later chooses to start billing Idaho Medicaid, they can contact Provider Enrollment for instructions on converting their account. The exception to this are pharmacists, who are non-billing ordering, referring and prescribing providers that may have their services billed for under their pharmacy or other business NPI. Pharmacists should be listed as the referring on the claim.

### 5.1.1. References: Non-billing Ordering, Referring and Prescribing Providers

#### a) CMS Guidance

"1.5.1.B. Ordering or Referring Physicians or Other Professionals (ORP)." *Medicaid Provider Enrollment Compendium (MPEC)*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf>.

"1.5.2. When Screening is Required." *Medicaid Provider Enrollment Compendium (MPEC)*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf>.

#### b) Federal Regulations

Enrollment and Screening of Providers, 42 CFR 455.410 (2011). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf>.

#### c) Idaho Medicaid Publications

"Edits Will Change from Warn to Deny on October 1, 2017." *MedicAide Newsletter*, September 2017, <https://www.idmedicaid.com/MedicAide%20Newsletters/September%202017%20MedicAide.pdf>.

"Ordering, Prescribing, and Referring Providers." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 210.06. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

## 5.2. Crossover Only Providers

Healthcare professionals that do not wish to be a Medicaid provider can instead choose to enroll as crossover only providers to receive coinsurance and deductible payments for participants dually eligible for Medicare and Medicaid. Enrollment as a crossover only provider also allows the professional to be an [ordering, referring and prescribing provider so long as they meet all other the requirements](#). This enrollment option *is not* for individuals who want to submit claims to Idaho Medicaid for reimbursement for non-Medicare services or participants with Medicaid only.

Providers wishing to enroll as a crossover only provider must complete an enrollment application with their Medicare certification, sign the [Idaho Medicaid Provider Agreement](#), and retain all documentation to support services ordered including the establishment of medical necessity. This enrollment is for professional services only. If an enrolled provider later chooses to start billing Idaho Medicaid for these services, they can contact Provider Enrollment for instructions on converting their account.

See [General Billing Instructions](#), Idaho Medicaid Provider Handbook for more information about reimbursement for participants dually eligible for Medicare and Medicaid.

### 5.2.1. Mental Health Clinics

Idaho Medicaid's outpatient mental health and substance use disorder services are usually covered under the [Idaho Behavioral Health Plan \(IBHP\)](#) with benefits administered under contract by [Optum Idaho](#). However, participants with only [Medicare Coinsurance and Deductible](#) eligibility, benefits are not received under the IBHP. Mental Health Clinics providing services to these participants are reimbursed through Fee-For-Service Medicaid. The clinic must enroll as a crossover only provider with a group NPI or service location with all Medicare certified staff as rendering providers (e.g. Licensed Clinical Social Workers).

## 5.3. Medicaid Provider Identification Numbers

### 5.3.1. Individual Provider Numbers

The National Provider Identifier (NPI) is a requirement of HIPAA. The NPI must be used on all electronic claims and will identify healthcare providers to health plans with a unique 10-digit numeric provider identifier. An NPI can only be associated to one Tax ID, but a Tax ID can be associated to many NPI numbers or Idaho Medicaid Provider numbers. Providers who registered in the MMIS with an NPI will use that NPI on all their transactions, whether paper or electronic. Reimbursement for providers with an NPI is sent to the pay-to address associated with the NPI. Providers that do not have an NPI can apply for one online at <https://nppes.cms.hhs.gov/#/> or by calling 1 (800) 465-3203 for a paper application.

Provider-types that do not meet the HIPAA definition of a healthcare provider are considered atypical provider types. Atypical providers are generally not eligible to receive a NPI number. Instead a unique 8-digit Idaho Medicaid Provider Number is assigned during enrollment. Claim reimbursement is sent to the pay-to address associated with the Medicaid provider number. The types of providers Idaho Medicaid recognizes as atypical are listed below:

- Adult day care;
- Agency transportation provider;
- Behavior consultation/crisis management;
- Certified family homes;
- Chore services;
- Home delivered meals;
- Home modifications;
- Individual transportation provider;
- Non-emergency commercial transportation;
- PCS/aged and disabled (A&D) agency;
- 24-hour personal care service (PCS) home for children – (foster care);
- Personal emergency response systems;
- Residential Assisted Living Facility (RALF);
- Residential habilitation agency;
- Respite care;
- Self-determination fiscal employer agent;
- Supported employment service; and
- Transportation broker.

### 5.3.2. Multiple Service Locations

When billing claims, providers with multiple service locations must enter a three-digit site number (i.e. 001, 002) to identify the specific location, in addition to their NPI/Medicaid ID. The three-digit location code is identified on the provider enrollment approval letter. Providers can also obtain this number by logging into their Trading Partner Account to view the information.

This information will be entered in the following fields:

- Paper UB04, enter in field 2;
- Paper CMS-1500, enter in field 32a; or
- Electronic claims refer to [837 Professional/Institutional](#) companion guide.

### 5.3.3. Group Practice

The Centers for Medicare and Medicaid Services (CMS) requires the identification of the individual who actually performs a service when billing under a group number. The performing

provider's individual NPI/Medicaid provider number must be on the claim as well as the provider's group NPI/Medicaid number.

## **5.4. Provider Licensing**

Medicaid Providers are required to be licensed, certified, or registered with the appropriate state authority. The claims processing system verifies the effective dates of the provider's license against the date of service. Provider licensure must be up to date in their provider file or claims will be denied at the header level. Providers are required to split claims for covered and non-covered dates of service, or update their license with Gainwell Technologies and resubmit the claim.



## **5.5. Ownership and Controlling Interests**

Providers with any type of partnership, corporation or nonprofit entity are obliged in the Idaho Department of Health and Welfare Medicaid Provider Agreement that the entity and the partners, directors, officers, members, or individuals with an ownership interest of 5% or greater, are jointly and severally liable for any breach of this Provider Agreement, and that action by the Department against the Provider may result in action against all such individuals in the entity.

The agreement also stipulates that providers will furnish the Department or the U.S. Department of Health and Human Services, within thirty-five (35) days of the request, full and complete information related to certain business transactions, specifically about:

- The ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
- Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

Providers are also required in their Provider Agreement to comply with the disclosure of ownership requirements in 42 CFR Part 455, Subpart B, and 42 CFR 411.361, when applicable, and to notify the Department thirty (30) days prior to any change of ownership. The Provider Agreement is not transferable to the new owner.

## 5.6. Provider Risk Levels

42 CFR 455.450 requires states to assign a categorical risk level for each provider type. The screening level determines the processes the state must use for enrollment of new providers and revalidation of existing providers. Whenever appropriate, Idaho uses the risk levels assigned by Medicare. States are allowed to use the same risk level assigned by Medicare, but may not assign a risk level lower than Medicare. The screening requirements listed below are in addition to all other provider enrollment requirements already established.

Screening Required by the Affordable Care Act by Provider Risk Level			
Type of Screening Required	Limited	Moderate	High
Verification of any provider/supplier-specific requirements established by Medicare	X	X	X
Conduct license verifications (may include licensure checks across States)	X	X	X
Database Checks (to verify Social Security Number (SSN), the National Provider Identifier (NPI), the National Practitioner Data Bank (NPDB) licensure, an OIG exclusion; taxpayer identification number; tax delinquency; death of individual practitioner, owner, authorized official, delegated official, or supervising physician)	X	X	X
Pre and post enrollment Site Visits (Unscheduled/Unannounced)		X	X
Criminal Background Check			X
Fingerprinting			X

### 5.6.1. Limited Risk Providers

Idaho Limited Risk Provider Types
Adult Day Care
Ambulatory Surgical Center (ASC)
Assistive Tech Supplier
Audiologist
Behavior Consultation/Crisis Management
Certified Family Home (CFH)
Children's Service Coordination (CSC)
Chiropractor
Chore Services
Classic Optical
Clinic/Center - Hearing & Speech
Clinic/Center - Rehab, SA – Division of Behavioral Health
Critical Access Hospital (CAH)
Developmental Disability (DD) Case Management
Developmental Disability (DD) Child Independent Crisis Intervention/Professional
Developmental Disability (DD) Independent Therapeutic Consultation
Developmental Disability Agency (DDA)
Developmental Disability Agency (DDA) – Support Only Child Services

<b>Idaho Limited Risk Provider Types</b>
Diabetes Educator
Diagnostic Services
Dialysis Unit
Dietician
End-stage Renal Disease (ESRD) Facilities
Federally Qualified Health Clinic (FQHC)
Groups (Idaho has groups of physicians, non-physician practitioners, and therapists)
Home Modifications
Home-Delivered Meals
Hospital
Indian Health Service (IHS)
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – private
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – state
Mental Health Case Management
Mental Health Clinic
Nurse Non-Physician Practitioner
Occupational Therapist
Optician
Optometrist
Personal Care Services (PCS) Aged and Disabled (A&D) Agency
Personal Care Services (PCS) Family Alternate Care Home
Personal Care Services (PCS) Homes - DD children
Personal Emergency Response System (PERS)
PHA – Weight Management Dietician
PHA – Weight Management
Pharmacy (clinic, retail, institution, specialty, mail, unit dose)
Pharmacist
Pharmacy Infusion Therapy
Physician
Physician Assistant
Podiatrist
Pregnant Women Clinic (PWC) – CLIA
Private Duty Nursing (PDN) Agency
Public Health
Radiology/Other Techs
Rehab Mental Health
Residential Assisted Living Facility (RALF)
Residential Habilitation Agency
Respite Care
Rural Health Clinic (RHC)
School Based Services (SBS)
Social Worker
Speech Language Pathologist (SLP)
Supported Employment Services
Support Brokerage-Fiscal Employer Agent (FEA)

**Idaho Limited Risk Provider Types**

Swing Bed Units

Transportation

**5.6.2. Moderate Risk Providers****Idaho Moderate Risk Provider Types**

Lab CLIA

Ambulance

Physical Therapist

Hearing Aid Vendor

Clinic/Center – Physical Therapy (PT)

Clinic/Center – Mobile Radiology

Home Health (Existing Idaho Providers)

Pharmacy – Durable Medical Equipment (DME)

Durable Medical Equipment (DME) (Existing Idaho Providers)

Prosthetics &amp; Orthotics–existing

Portable X-ray

**5.6.3. High Risk Providers**

In addition to the provider types below, any provider will individually be considered high risk when the provider:

- Has a payment suspension based on a credible allegation of fraud occurred within the last ten years;
- Was excluded within the last ten (10) years by HHS-OIG or any state Medicaid agency;
- Has a qualifying Medicaid overpayment; or
- Is enrolling within six months of the date of the lifting of a temporary moratorium that at the time would have barred the provider’s enrollment.

**Idaho High Risk Provider Types**

Durable Medical Equipment (DME) (New to Idaho Medicaid)

Home Health (New to Idaho Medicaid)

Hospice

Skilled Nursing Facility

**5.6.4. References: Provider Risk Levels****a) Federal Regulations**

Screening Levels for Medicaid Providers, 42 CFR. 455.450 (2011). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf>.

**b) Idaho Medicaid Publications**

“Medicaid Provider Enrollment Requirements.” *MedicAide Newsletter*, October 2016, <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202016%20MedicAide.pdf>.

## **5.7. Provider Enrollment Moratoria**

At its discretion the Department may request from CMS a temporary prohibition on provider enrollment for a provider type when necessary to prevent or combat fraud, waste and abuse. The moratorium lasts for a six-month increment initially and may be repeatedly extended for the same. Any providers requesting enrollment under such a provider type during a moratorium must be denied by the Department. At this time Idaho Medicaid does not have a moratorium in place.

### **5.7.1. References: Provider Enrollment Moratoria**

#### ***a) Federal Regulations***

Temporary Moratoria, 42 CFR 455.470 (2011). Government Printing Office,  
<https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf>.

#### ***b) Idaho Medicaid Publications***

"Medicaid Provider Enrollment Requirements." *MedicAide Newsletter*, October 2016,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/October%202016%20MedicAide.pdf>.

## **5.8. Maintenance of Contact Information**

Providers shall notify the Department of any changes to the information contained in the Enrollment Application, including but not limited to their mailing address and service locations, within 30 days of the date of the change. The Department is required by Federal regulations to terminate a provider's enrollment for failure to submit timely and correct information, which may also affect the provider's enrollment in other states' Medicaid programs. The Department may allow a provider to keep their enrollment if it documents in writing that termination would not be in the best interests of the Medicaid program. Failure to keep information current may also result in recoupment and penalties.

All correspondence sent to the mailing address on file with the State's fiscal agent shall be deemed to be received by the Provider. Department correspondence will not be forwarded by a change of address with the U.S. Postal Service. See the [Provider File Updates](#) subsection for instructions on updating contact information.

### **5.8.1. References: Maintenance of Contact Information**

#### ***a) Federal Regulations***

Provider Screening and Enrollment, 42 CFR. 455 Subpart E (2011). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf>.

#### ***b) Idaho Medicaid Publications***

"Reminder to All Providers." *MedicAide Newsletter*, November 2016, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202016%20MedicAide.pdf>.

## 5.9. Provider File Updates

After enrolling, any updates that need to be made to the provider file can be done through the online portal at the Idaho Gainwell Technologies Medicaid website. Once logged into your Trading Partner Account (TPA), select the **Provider Enrollment Application** link to electronically maintain your provider record.

Provider record changes include, but are not limited to:

- Change in address;
- New phone number;
- Name change (individual, group practice, etc.);
- Change in ownership; \*see section 6.10 below
- Change in tax identification information; \*see section 6.10 below
- Change in provider status (voluntary inactive, retired, etc.)
- Add/update/end date of rendering providers; and
- Add/update/end date of service locations.

**Note:** The postal service will not forward mail or checks. All mail and checks will be returned to Gainwell Technologies.

To enroll additional providers records, visit the [Provider Enrollment User Guides](#).

## **5.10. Change in Ownership or Tax Identification Information**

Please be advised that a change in ownership or tax identification information requires a NEW provider enrollment application. The Idaho Medicaid provider agreement IS NOT transferable. Notification of a change must be made timely to the Department.

The following are examples of changes of ownership. This list is not exhaustive. In all the examples below a new provider enrollment IS required and the existing record must be termed. Providers who are unsure of whether a transaction constitutes a change of ownership should contact the Division of Medicaid.

Examples include:

1. Changes to type of organization (ex. Partnerships to limited liability company, or sole proprietorship to organization), which result in an asset or liability change.
2. Mergers, when a new corporate entity is formed, and the merging companies are non-surviving.
3. Changes in composition of a partnership (ex. removal, addition, or substitution of one or more individuals as partners).
4. Transfers, creations or changes in the control of government owned institutions between different levels of government, such as city to county, state to county, etc..
5. Transfer of title or property to another party.
6. Leasing of all or part of a provider facility.
7. Bankruptcy proceedings filing.
8. Changes to a facility that require a change in licensure or certification.

New owners should get a new NPI. This allows for a smooth billing transition and tracking of receivables, along with avoiding NPI crosswalk issues.

### **5.10.1. References: Change in Ownership or Tax Identification Information**

#### ***a) Federal Regulations***

Change of Ownership or Leasing: Effect on Provider Agreement, 42 CFR. 489.18 (1994). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2021-title42-vol5/pdf/CFR-2021-title42-vol5-sec489-18.pdf>.



## **5.11. Provider Recertification**

In accordance with state and federal regulations, Medicaid monitors the status of provider participation requirements that apply to each individual provider type. Continued licensure, certification, insurance, and other provider participation requirements are verified on an ongoing basis.

## **5.12. Provider Termination**

Medicaid is required to deny applications for provider status or terminate the Medicaid Provider Agreement of any provider suspended from the Medicare Program or another state's Medicaid program. The Department of Health and Welfare (DHW) may also terminate a provider's Medicaid status when the provider fails to comply with any term or provision of the Medicaid Provider Agreement. This includes failing to notify Medicaid or Gainwell Technologies in writing of any changes in address or ownership.

Continued provider participation is contingent on the ongoing maintenance of current licensure, certification, or insurance. Failure to renew required licenses, certification, or insurance is cause to terminate a provider's participation in the Idaho Medicaid Program.

## 5.12.1. References: Provider Enrollment

### a) CMS Guidance

*Medicaid Provider Enrollment Compendium (MPEC)*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf>.

### b) Federal Regulations

Disclosure of Information by Providers and Fiscal Agents, 42 CFR 455 Subpart B (1979). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartB.pdf>.

Provider Screening and Enrollment, 42 CFR 455 Subpart E (2011). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part455-subpartE.pdf>.

Reporting Requirements, 42 CFR 411.361 (2016). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol2/pdf/CFR-2018-title42-vol2-sec411-361.pdf>.

### c) Idaho Medicaid Publications

"Medicaid Provider Enrollment Requirements." *MedicAide Newsletter*, October 2016, <https://www.idmedicaid.com/MedicAide%20Newsletters/October%202016%20MedicAide.pdf>.

"Reminder to All Providers." *MedicAide Newsletter*, November 2016, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202016%20MedicAide.pdf>.

## **6. Participant Eligibility and Benefit Plan Coverage**

Medicaid is a medical assistance program that is jointly funded by the federal and state governments to assist in providing medical care to individuals and families. Applicants must meet each of the financial and non-financial requirements of a program to participate in its benefit plan, which may include a review of income, resources and other assets. Self-Reliance's field offices determine Medicaid eligibility and enroll eligible applicants in the appropriate benefit package.

General information for participants on services covered under the Idaho Medicaid Program are listed in the booklet, [Idaho Health Plan Coverage](#), which is available in English and Spanish from the Division of Medicaid, Department Regional Offices, or online. All services fall under either the [Medicaid Basic Plan](#) or [Medicaid Enhanced Plan](#). However, some participants' eligibility to receive those services may provide additional restrictions, limitations or benefits not otherwise available as described below.

See the [Provider Guidelines](#) for specific service coverage and billing details for individual programs and specialties. The guidelines are available online in the Provider Handbook.

### 6.1. Medicaid Identification Card

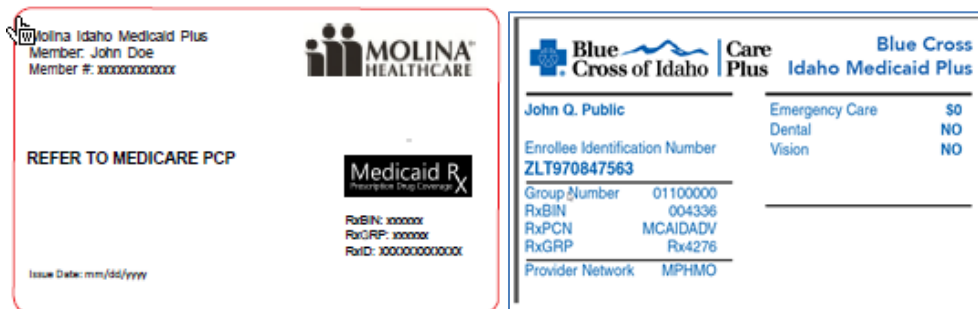
An identification card is issued when the participant is determined eligible for Medicaid benefits. All Medicaid participants, except otherwise ineligible non-citizens or presumptive eligibility (PE) participants, receive an identification card. Possession of a Medicaid ID card does not guarantee Medicaid eligibility. Providers should request the Medicaid ID card with additional picture identification and retain copies of this documentation for their records.

The participant’s Medicaid identification (MID) number is on the card. Cards issued after June 1, 2010 are a 10-digit number with no letters or symbols. Cards issued prior to June 1, 2010 are seven digits. Providers should convert the older versions by adding three zeroes to the front of the MID number.



Participants enrolled in the Idaho Medicaid Plus (IMPlus) plan or Medicare Medicaid Coordinated Plan (MMCP) are issued an alternative Medicaid card by their chosen or assigned health plan.

#### IMPlus Health Cards



#### MMCP Health Cards



## 6.2. Verifying Participant Eligibility

Participant eligibility is determined on a month-to-month basis. Providers are required to verify and document participant eligibility and Healthy Connections enrollment status on the date of service prior to rendering services to qualify for reimbursement. Medicaid only reimburses for services rendered while the participant is eligible for Medicaid benefits. Deceased participants are not eligible for services or items. Providers will not receive reimbursement for services or items provided after the participant's date of death.

### Example

A participant is eligible and has Medicaid coverage during the months of April and June. The participant was found ineligible and didn't have coverage during May.

Eligibility information can be accessed three different ways:

- Trading Partner Account (TPA) on [Gainwell Technologies Idaho Medicaid](#) website;
- MACS 1 (866) 686-4272; or
- HIPAA compliant vendor software (tested with Gainwell Technologies).

To obtain eligibility information from one of these systems, submit two participant identifiers from the following list:

- MID number;
- Social Security number (SSN);
- Last name, first name; or
- Date of birth.

Available participant eligibility information includes eligibility dates and Healthy Connections (HC) enrollment data, Medicaid special program limitations, certain service limitations, procedure code inquiries, third party recovery (TPR), Medicare coverage information, co-payments, and lock-in data. When viewing participant eligibility on a trading partner account Healthy Connections information is listed on the "Network" tab. If no information is available, then the participant is not enrolled with Healthy Connections, and a referral for services is not required.

### 6.2.1. Medicaid Automated Customer Service (MACS)

Providers can use MACS to check participant eligibility. Eligibility information is available on:

- Healthy Connections Program;
- Eligibility with special programs;
- Service limits;
- Prior authorization (PA);
- Co-payments; and
- Other health coverage.

MACS informs providers of the type of Medicaid benefits a participant is eligible for on the dates of service. More information about MACS can be found in the [Idaho Medicaid Automated Customer Service \(Idaho MACS\)](#) section of this handbook.

Participants who are eligible for the full range of Medicaid services have their benefit plans communicated as eligible for Medicaid benefits. Participants who are not eligible for the full range of Medicaid services have their restrictions reported according to their benefit plan.

**Example**

A participant eligible for the Medicaid Basic Plan would have their eligibility communicated as eligible for basic Medicaid benefits, and only benefits restricted to the basic plan are communicated.

The benefit plans for Presumptive Eligibility (PE), Lock-in, and Co-pay remain unchanged and the restrictions for participants on these plans are communicated accordingly.

**6.2.2. Trading Partner Account (TPA)**

Information regarding online billing and eligibility verification can be found in the [Trading Partner Account \(TPA\) User Guide](#). When verifying eligibility, the following information will be provided for participants enrolled in Healthy Connections:

- Network of HC clinic:
  - Healthy Connections;
  - Healthy Connections Care Management;
  - Healthy Connections Medical Home; and
  - Exempt from Healthy Connections.
- Demographics of the HC clinic:
  - Name of HC clinic;
  - Address of HC clinic;
  - Phone number of HC clinic; and
  - Hours of operation of HC clinic.

**6.2.3. Vendor Supplied Software**

Providers may contract with a software vendor and use software supplied by the vendor. Software specifications can be found on the Idaho [Gainwell Technologies Medicaid](#) website by selecting [Companion Guides](#) under the *Reference Material* menu. The specifications assist the vendor in duplicating the program requirements and allows providers to obtain the same information available as the Idaho Gainwell Technologies Medicaid website. All vendor software must successfully test transactions with Gainwell Technologies before use. Providers can check eligibility using vendor software, if the software is modified to meet the requirements of the HIPAA ASC X12 270/271, version 5010 format, and if the vendor successfully tests the transactions with Gainwell Technologies.

**a) Electronic Visit Verification (EVV) Software**

Providers who are required to submit EVV data through the Sandata EVV Aggregator may contract with any EVV software vendor of their choice as long as the software is certified as compatible by Sandata. EVV software specifications ([OpenEVV-AltEVV](#)) can be found on the Idaho [Gainwell Technologies Medicaid](#) website by selecting [Companion Guides](#) under the *Reference Material* menu. The specifications assist the vendor in duplicating the EVV program requirements and allows providers to obtain the same information available as Sandata. All providers must successfully test and certify their EVV software with Sandata to verify compatibility with the EVV Aggregator in order to be eligible for payment.

**6.2.4. Medicaid Participants with Medicare**

When verifying eligibility for Idaho Medicaid participants with Medicare one of the coverage codes in the following subsections will be returned. See the [General Billing Instructions](#), Idaho

Medicaid Provider Handbook for more information on third-party liability and Medicaid participants with Medicare.

### **a) Part B Premium Coverage**

If the participant only has Part B Premium Coverage, they have eligibility under Specified Low-Income Beneficiary (SLMB)/Part B Premium. This coverage is to pay for the participants Medicare Part B Premium only. These participants do not have Medicaid benefits and should be considered a Medicare only member.

### **b) Part B Premium Coverage/Enhanced Coverage**

These are participants with dual eligibility under Medicaid and Medicare. The Department pays their Medicare premium up to the lowest allowed amount for coinsurance and deductible. These participants also have Medicaid benefits for services that are not covered by Medicare.

### **c) Medicare Coinsurance & Deductible**

These are participants with eligibility under QMB/Medicare Coinsurance. This coverage is to pay for the participant's Medicare Part B Premium, and any coinsurance and deductible amounts for Medicare covered services. These participants do not have access to benefits outside Medicare coverage.

### **d) MMCP Coverage/IMPlus**

These participants are enrolled with a managed care organization (MCO). The Network ID will have the name of the administrator. Unless otherwise stated claims should be billed to the MCO administrator instead of Gainwell Technologies.

## **6.2.5. References: Verifying Participant Eligibility**

### **a) Idaho Medicaid Publications**

"Clarification on Dual Eligible Participants." *MedicAide Newsletter*, April 2019, <https://www.idmedicaid.com/MedicAide%20Newsletters/April%202019%20MedicAide.pdf>.

### **b) State Regulations**

"Conditions for Payment." *IDAPA 16.03.09*, "Medicaid Basic Plan Benefits," Sec. 210.01. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.



### **6.3. Participant Program Abuse/Lock-In Program**

Medicaid reviews participant utilization to determine if services are being used at a frequency or amount that may be delivered at a level harmful to the participant and to identify services that are not medically necessary. Abuse can include frequent use of emergency room facilities for non-emergent conditions, frequent use of multiple controlled substances, use of multiple prescribing physicians and/or pharmacies, excessive provider visits, overlapping prescription drugs with the same drug class, and drug seeking behavior as identified by a medical professional.

To prevent abuse, Medicaid has implemented the participant lock-in program. Participants identified as abusing or over-utilizing the program may be limited to emergency services only, or the use of one physician/provider and one pharmacy. Services outside of documented emergencies by other providers will not be reimbursed. This prevents these participants from going from doctor to doctor, or from pharmacy to pharmacy, to obtain excessive services.

Participants entered in the Lock-in program will be notified by the Department in writing and have thirty-five (35) days to designate a physician/provider and pharmacy or twenty-eight (28) days to file an appeal. If a participant does not make a selection or file an appeal, they will be restricted to services for documented emergencies only and may be suspended from receiving Medicaid if abuse continues.

If a provider suspects a Medicaid participant is demonstrating utilization patterns, which may be considered abusive, not medically necessary, potentially endangering the participant's health and safety, or drug seeking behavior in obtaining prescription drugs, they should notify Medicaid of their concerns. Medicaid will review the participant's medical history to determine whether the participant is a candidate for the lock-in program.

#### **6.3.1. Primary Care Physician (PCP)**

The PCP for lock-in participants is responsible for coordination of routine medical care and making referrals to specialists as necessary. The PCP explains to the lock-in participant all procedures to follow when the office is closed, or there is an urgent or emergency situation. This coordination of care and the participant's knowledge of office procedures should help reduce the unnecessary use of the emergency room.

If the participant needs to see a physician other than the PCP, the PCP gives the participant a referral to another physician or clinic to ensure payment. See the [Referrals](#) section for more information.

If a PCP no longer wishes to provide services to the lock-in participant, the PCP must send a written notice to the participant stating the reasons for dismissal with a copy of the letter sent to the Healthy Connections Representative for that region.

#### **6.3.2. Designated Pharmacy**

A designated pharmacy has the responsibility of monitoring the participant's drug use pattern. The pharmacy should only fill prescriptions from the PCP, or from referred physicians the pharmacy confirms with the PCP.

### **6.3.3.      References: Participant Abuse/Lock-in Program**

#### ***a) State Regulations***

"Participant Lock-in." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 910 – 918.  
Department of Administration, State of Idaho,  
<https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

## **6.4. Medicaid Basic Plan**

The Medicaid Basic Plan has been designed to achieve and maintain wellness by emphasizing prevention and proactively managing health. It is the default plan for Medicaid participants.

Under some circumstances, participants in the Medicaid Basic Plan with a medical necessity for enhanced services may be eligible for reassignment to the Medicaid Enhanced Plan. This determination will be a joint decision made by the Self Reliance Unit in the Division of Welfare and the appropriate unit in the Division of Medicaid.

## **6.5. Medicaid Enhanced Plan**

The Medicaid Enhanced Plan includes all of the benefits found in the Medicaid Basic Plan, and additional benefits to cover needs of people with disabilities or special health needs. Participants enrolled in this plan will be eligible for the full range of Medicaid covered services.

## 6.6. Presumptive Eligibility (PE)

Presumptive Eligibility (PE) assists Idaho residents not currently receiving medical assistance from the state or county, who do not have sufficient resources for private medical coverage. Presumptive eligibility provides immediate, presumed coverage for qualified candidates. The maximum coverage period is 45 days while the participant applies for coverage. A Medicaid enrolled hospital with a current Memorandum of Understanding (MOU) with the Department for PE may provide assistance to individuals in completing and submitting applications for health coverage. Staff must receive Department approved training in PE before they can complete an application and make a PE determination. A record of this training must be maintained and available to the Department upon request. For more information on the training process, please contact your local DHW eligibility office or visit the [Presumptive Medicaid Eligibility Providers](#) webpage.

PE is only available for the groups below when they meet all other eligibility criteria:

- Children up to age nineteen (19);
- Parents or caretaker relatives of eligible children;
- Pregnant women (See the [Presumptive Eligibility for Pregnant Women \(PW\)](#) section for restrictions);
- Adults eighteen (18) to twenty-six (26) who received Idaho Medicaid through the foster care program on their 18<sup>th</sup> birthday; and
- Individuals twenty-one (21) through sixty-five (65) years of age requiring treatment for breast and cervical cancer diagnosed under the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) (See the [Breast and Cervical Cancer \(BCC\) Program](#) section for more information).

PE determinations are reimbursable using HCPC T1023 (Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter). Claims must include the participant's full name, MID number and date of birth.

### 6.6.1. References: Presumptive Eligibility (PE)

#### **a) Federal Regulations**

Options for Coverage of Special Groups under Presumptive Eligibility, 42 CFR 435 Subpart L (2001). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-part435-subpartL.pdf>.

"Presumptive Eligibility for Certain Breast or Cervical Cancer Patients." Social Security Act, Sec. 1920B (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1920B.htm](https://www.ssa.gov/OP_Home/ssact/title19/1920B.htm).

"Presumptive Eligibility for Children." Social Security Act, Sec. 1920A (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1920A.htm](https://www.ssa.gov/OP_Home/ssact/title19/1920A.htm).

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(47) (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1902.htm](https://www.ssa.gov/OP_Home/ssact/title19/1902.htm).

#### **b) State Regulations**

"Presumptive Eligibility for Children and Parents." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 545—546. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

"Women Diagnosed with Breast or Cervical Cancer." IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)," Sec. 802. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160305.pdf>.

## 6.7. Breast and Cervical Cancer (BCC) Program

The Breast and Cervical Cancer (BCC) program allows the state to provide Medicaid benefits to uninsured participants, who are not otherwise eligible for Medicaid, when they are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. In order to be eligible, an applicant must be initially screened and diagnosed through a local Women's Health Check Office (usually the district health department) participating in the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

Medicaid coverage lasts for the duration of their cancer treatment, and ends when a participant's plan of care reflects a status of surveillance, follow-up or maintenance. Additionally, coverage will end if a participant's treatment relies on an unproven procedure in lieu of primary or adjuvant treatment methods.

The applicant can be presumed eligible as described in [Presumptive Eligibility \(PE\)](#) before a formal Medicaid determination. Although Medicaid resource limits do not apply, the applicant must:

- Have an income between 138% and 250% of the federal poverty level;
- Be diagnosed with breast or cervical cancer through the Women's Health Check Program;
- Be at least twenty-one (21) years old and under the age of sixty-five (65);
- Have no creditable health insurance (if insured, the plan does not cover the same type of cancer);
- Be an Idaho resident;
- Be a U.S. citizen or meet requirements for legal noncitizen;
- Not reside in an ineligible institution; and
- Not be fleeing prosecution of a felony, custody, or confinement of a felony conviction or violating a condition of probation or parole.

### 6.7.1. References: Breast and Cervical Cancer (BCC) Program

#### *a) Federal Regulations*

Breast and Cervical Cancer Mortality Prevention Act of 1990. H.R. 4790 (1990). Government Printing Office, <https://www.govinfo.gov/app/details/STATUTE-104/STATUTE-104-Pg409>.

Breast and Cervical Cancer Prevention Act of 2000. H.R. 4386 (2000). Government Printing Office, <https://www.govinfo.gov/content/pkg/BILLS-106hr4790rh/pdf/BILLS-106hr4790rh.pdf>.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Centers for Disease Control and Prevention. <https://www.cdc.gov/cancer/nbccedp/>.

Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001. S. 1741 (2001). Government Printing Office, <https://www.govinfo.gov/app/details/CREC-2001-12-19/CREC-2001-12-19-pt2-PgH10904>.

#### *b) State Regulations*

"Woman Diagnosed with Breast or Cervical Cancer." *IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, & Disabled (AABD),"* Sec. 802. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160305.pdf>.

## **6.8. Early & Periodic Screening, Diagnostic & Treatment (EPSDT)**

The EPSDT benefit, or Children's Medicaid, was designed to help ensure that all Medicaid-eligible children up to the age of twenty-one (21) receive preventive health care and early intervention services needed to maximize each child's potential for healthy growth and development. The benefit allows children to receive additional services that are not covered for adults and increase access to services that have limitations on amount, duration, frequency and location (e.g., hourly and location limits on Personal Care Services). Services that would not typically be allowed due to duplication, overlap or multiple services at the same time or date of service may be considered if the services are medically necessary. Idaho Medicaid does not have an expenditure cap or wait list for services under EPSDT, however, providers may have a waitlist for appointments or scheduling procedures.

Providers of EPSDT services have all of the same requirements as other providers of their type and specialty.

Services can only be covered under EPSDT when the service is:

- Determined to be medical in nature;
- Safe, effective and generally recognized as an accepted method of medical practice or treatment;
- Not determined to be experimental, investigational or cosmetic in nature;
- Under a category of service listed in 1905(a) of the Social Security Act;
- Medically necessary to correct or ameliorate (needed to sustain or support) an illness or a health condition;
- For an illness or health condition diagnosed by a physician, therapist, or other licensed practitioner operating within the scope of their licensure; and
- Supported as medically necessary by the utilization of other services to treat the illness or health condition.

All claims for services approved under EPSDT must have the EP modifier on the claim line.

### **6.8.1. EPSDT and Waiver Services**

Participants up to the age of twenty-one (21) on a waiver have the same access to EPSDT services as a non-waiver participant. Services designated as habilitative or rehabilitative are covered under the State Plan for these participants with increased access under EPSDT. Services are considered for coverage under both EPSDT and their waiver. Support type services are not covered under EPSDT as they fail to meet the requirement for a 1905(a) service. Any service provided under EPSDT will not impact a participant's budget or share of cost.

### **6.8.2. EPSDT Request Procedure**

See the subsection below for the request procedure for services under State Plan, outside of State Plan, outpatient behavioral health and dental services. The parent, guardian or participant will receive a Notice of Decision from the Department or their designee informing them whether the request was approved or denied. The Notice of Decision may also list alternative services that are available. If the request is denied, the parent, guardian or participant, if over eighteen (18), may appeal the decision. Instructions for appeals are on the Notice of Decision.



### **6.8.3. Request Procedure: Services Under State Plan**

Services that require a prior authorization are considered under EPSDT during the prior authorization process. However, if a service does not usually require a prior authorization, a request can be submitted with a note on the coversheet requesting a review under EPSDT and the reason for the request (e.g., for not meeting criteria, over limitations, etc.). Prior authorization requests without a legitimate cause will be returned unreviewed. Services covered under the State Plan should be requested through the service's normal request channel with all regularly required documentation (e.g., durable medical equipment through the Medical Care Unit). Requests are usually completed in fifteen business days or less.

### **6.8.4. Request Procedure: Services Not in State Plan**

If services not covered under the State Plan are needed, a [Request for Additional Services \(RAS\) form](#) must be submitted to the Department for prior authorization. All services under EPSDT must fall into a category of service listed in 1905(a) of the Social Security Act, be considered safe, effective, and meet acceptable standards of medical practice.

The Request for Additional Services form must be completed and signed by a competent participant over eighteen (18) or their parent or guardian. All requests must be submitted with supporting documentation and an order from a physician or non-physician practitioner. This may require coordination with other providers to obtain. Services not under State Plan may take longer to review if:

- A new provider must be secured to perform the treatment;
- Additional documentation is needed to determine medical necessity;
- Providers fail to submit requested materials in a timely manner;
- Research is necessary to determine impacts to care; or
- The case is particularly complex and requires coordination between multiple agencies and providers to guarantee appropriate care.

For other questions, or general information, please email your request to [EPSDTrequest@dhw.idaho.gov](mailto:EPSDTrequest@dhw.idaho.gov).

### **6.8.5. Request Procedure: Outpatient Behavioral Health**

Community-based mental health services are provided under the Idaho Behavioral Health Plan by Optum Idaho's provider network. EPSDT requests for community-based mental health services must be completed on the [Optum Idaho EPSDT Form](#). For more information contact Optum Idaho by calling 1-855-202-0973 or visit the [Optum Idaho](#) website. Prior authorization requests for behavioral health services not provided in the community under the Idaho Behavioral Health Plan should be requested through the Division of Medicaid.

### **6.8.6. Request Procedure: Dental Services**

Preventive and restorative dental services are provided under the Idaho Smiles plan by Managed Care of North America's (MCNA) provider network. EPSDT requests for dental services must be designated on the MCNA prior authorization form. For more information or the prior authorization form contact Idaho Smiles by calling 1-855-233-6262 or visit [Idaho Smiles](#) website.

## **6.8.7. References: Early & Periodic Screening, Diagnostic & Treatment (EPSDT)**

### ***a) CMS Guidance***

"Chapter 5 – Early and Periodic Screening." *The State Medicaid Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

Early and Periodic Screening, Diagnostic, and Treatment. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>.

*EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, [https://www.medicaid.gov/medicaid/benefits/downloads/epsdt\\_coverage\\_guide.pdf](https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf).

### ***b) Federal Regulations***

"Definitions." Social Security Act, Sec. 1905(r) (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1905.htm](https://www.ssa.gov/OP_Home/ssact/title19/1905.htm).

EPSDT and Other Required Benefits, 42 CFR 440.35 (2013). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-345.pdf>.

State Plans for Medical Assistance, 42 U.S.C. Sec. 1396a (1984). Government Printing Office, <https://www.govinfo.gov/content/pkg/USCODE-2017-title42/pdf/USCODE-2017-title42-chap7-subchapXIX-sec1396a.pdf>.

### ***c) State Regulations***

"Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 880 – 883. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

## 6.9. Incarcerated Persons

Medicaid benefits are not available for inmates of government jails or prison facilities, unless the inmate, the medical institution and the services rendered meet all the provisions for reimbursement as provided within the "[Reimbursement Policy for Individuals under the Authority of Idaho's Public Institutions](#)".

Inmates of a public institution operated under the authority of the State of Idaho, or its political subdivision, may be eligible for select Medicaid benefits in a hospital, freestanding psychiatric hospital or institution for mental disease enrolled with Idaho Medicaid and open to the public. Inmates must otherwise be eligible for Medicaid and be inpatient status for a minimum of twenty-four (24) hours. Healthcare services provided to residents of Idaho who are eligible for Idaho Medicaid and who are residing in Public Institutions outside of the territorial boundaries of the State of Idaho are excluded from reimbursement under this policy and are the responsibility of the Public Institution with authority over that individual.

When all provisions are met, the applicant's incarceration status no longer disqualifies them from Medicaid eligibility for Basic or Enhanced plans. The applicant is then evaluated for Medicaid eligibility as if they were not incarcerated. Providers should come to an agreement with the Public Institution responsible for the individual to determine which entity will apply for Medicaid on the applicant's behalf when they meet these requirements.

Eligibility for incarcerated participants is available retroactively. Medicaid coverage begins the day the inmate is admitted into the medical institution and ends the day of discharge from the medical institution. However, incarcerated participants do not have the same benefits as other participants. Only these services are covered for inmates, and only when all other Idaho Medicaid requirements for the service are fulfilled:

- Inpatient room and board;
- Ancillary services directly related to the inpatient stay; and
- Emergency transportation services for transfers occurring after inpatient status has been determined and only when directly between hospitals, freestanding psychiatric hospitals and institution for mental diseases for continued inpatient treatment.

### 6.9.1. Incarcerated Persons: Third-Party Liability

In addition to all regular third-party liability requirements in the [General Billing Instructions](#), Idaho Medicaid Provider Handbook, healthcare services related to the negligent acts of a third-party, including correctional institutions or law enforcement agencies, are their responsibility. [Non-covered and excluded services](#) are the responsibility of the Public Institution with custody of the inmate. This includes any service not mentioned in the section above and expenses related to law enforcement personnel or security.

### 6.9.2. References: Incarcerated Persons

#### a) CMS Guidance

"Beneficiaries in Custody Under a Penal Authority." *MLN Fact Sheet ICN 908084, March 2018*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-Services-Furnished-to-Beneficiaries-in-Custody-Under-Penal-Authority-Fact-Sheet-ICN908084.pdf>.

"Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority and Examples of Application of Government Entity

Exclusion." *MLN Matters MM6880*, July 2016, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6880.pdf>.

"To Facilitate successful re-entry for individuals transitioning from incarceration to their communities." *Survey and Certification Letter# 16-21-ALL*. Center for Medicaid and State Operations, Department of Health and Human Services, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-21.pdf>.

"Updated Guidance to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals." *State Health Official Letter# 016-007*. Center for Medicaid and State Operations, Department of Health and Human Services, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16007.pdf>.

### ***b) Federal Regulations***

Definitions relating to institutional status, 42 CFR 435.1010 (1986). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec435-1010.pdf>.

"Definitions." Social Security Act, Sec. 1905(a)(29)(A) (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1905.htm](https://www.ssa.gov/OP_Home/ssact/title19/1905.htm).

### ***c) Idaho Medicaid Publications***

"**Medicaid Program Integrity Unit:** Billing for Incarcerated Clients." *MedicAide Newsletter*, November 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/November%202018%20MedicAide.pdf>.

Reimbursement Policy Change for Individuals who are Incarcerated (Residents) of Correctional Facilities (Public Institutions) within Idaho, Information Release MA19-15 (12/18/2019). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3368&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1>.

### ***d) State Regulations***

"Medical Exception for Inmates." *IDAPA 16.03.01*, "Eligibility for Health Care Assistance for Families and Children," Sec. 281. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

State Charitable Institutions, Idaho Code Title 66. Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title66/>.

## **6.10. Katie Beckett Medicaid Eligibility**

Katie Beckett Medicaid, also known as Home Care for Certain Disabled Children, enables children under the age of nineteen (19) with special health care needs or disabilities to be cared for at home instead of an institution. Eligibility for Medicaid is based on the disabled child's income and assets without taking into account the income of their parents or guardians. The cost of care at home is compared to the cost of institutionalization when determining eligibility. Once approved for Medicaid, participants have all the benefits on the Enhanced Plan. In the event that a participant becomes institutionalized, the family should contact Self Reliance to update their eligibility.

Katie Beckett participants are subject to copayments and premiums as these are based on the household's income, which is above 133% of the federal poverty limit (FPL). Participants with a household income under 133% are eligible for other Medicaid eligibility.

### **6.10.1. References: Katie Beckett Medicaid Eligibility**

#### ***a) Federal Regulations***

Individuals Under Age 19 Who Would Be Eligible For Medicaid If They Were In A Medical Institution, 42 CFR 435.225 (1990). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2022-title42-vol4/pdf/CFR-2022-title42-vol4-sec435-225.pdf>.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(e)(3) (2020). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1902.htm](https://www.ssa.gov/OP_Home/ssact/title19/1902.htm).

#### ***b) Idaho State Plan***

"Optional Groups Other Than the Medically Needy." Idaho Medicaid State Plan, Attachment 2.2. Division of Medicaid, Department of Health and Welfare, State of Idaho.

#### ***c) State Regulations***

"Certain Disabled Children." IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, & Disabled (AABD)," Sec. 785. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160305.pdf>.

### 6.11. Medicare Savings Program

The Department has agreements with the Social Security Administration and Centers for Medicare and Medicaid Services (CMS), which allows the state to enroll people in the Premium Hospital Insurance Program (also referred to as Premium HI or Medicare Part A) and Supplementary Medical Insurance (also referred to as SMI or Medicare Part B). The agreements allow Medicaid participants who are entitled to Medicare to have their Part A and/or Part B Medicare premiums paid by Medicaid. Participants do not have to be 65 years old or older to be eligible for Medicare. See the subsections below for the different kinds of Part A and Part B Medicare Savings Programs.

See the “Qualified Medicare Beneficiaries (QMB) Medicare/Medicaid Billing Information” subsection of the [General Billing Instructions](#), Idaho Medicaid Provider Handbook, for more information.

#### 6.11.1. Part A Medicare Savings Programs

There are two types of Part A Medicare Savings Programs:

- Regular Type Part A; and
- Qualified Disabled Working Individual (QDWI) Part A

The Regular Type Part A Medicare Savings Program is for individuals who are not entitled to premium-free Medicare Part A benefits. These individuals must apply for Medicare with the Social Security Administration and be determined eligible for self-pay type Medicare. These individuals have a Medicare claim number with a Beneficiary Identification Code (BIC) of M. This code is found at the end of the Medicare claim number.

The Qualified Disabled Working Individual (QDWI) Part A Medicare Savings Program is for individuals that have lost Medicare Part A (HI) entitlement solely because of work and are entitled to enroll in Part A Medicare under §1818A of the Social Security Act. The Qualified Disabled Working Individual Program does not include state payment of Part B Medicare premiums.

#### 6.11.2. Part B Medicare Savings Programs

The various types of Part B Medicare Savings Programs are listed in the table below.

Part B Medicare Savings Program						
Part B Medicare Savings Program	Individual is entitled to Medicare	Individual is entitled to Medicaid	Medicaid Prior Authorization Rules Apply for Medicare Covered Services	Medicaid Claim Editing Applies		
Qualified Medicare Beneficiary (QMB-Only)	Medicaid Pays the Medicare Premium	Individual is entitled to Medicaid	Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.	Medicaid Prior Authorization Rules Apply for Medicare Covered Services	Medicaid Claim Editing Applies	
	Y	N		N	N	

Part B Medicare Savings Program							
Part B Medicare Savings Program	Individual is entitled to Medicare	Individual is entitled to Medicaid	Medicaid Pays the Medicare Premium	Individual is entitled to Medicaid	Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.	Medicaid Prior Authorization Rules Apply for Medicare Covered Services	Medicaid Claim Editing Applies
Qualified Medicare Beneficiary with Medicaid QMB + (QMB Plus)	Y	Y	N	Y	N	Y	
Specified Low Income Medicare Beneficiary (SLMB)	Y	N	N	Y	N	N	
Specified Low Income Medicare Beneficiary with Medicaid eligibility SLMB + (SLMB Plus)	Y	Y	N	Y	N	Y	
Medicaid (with deemed Cash Assistance Recipient)	Y	Y	N	Y	N	Y	
Medicaid – Non-Cash (also known as Medical Assistance Only) (MAO)	Y	Y	N	Y	N	Y	
Qualified Individual 1 (QI1)	Y	N	N	Y	N	N	

### 6.11.3. Dually Eligible Medicare Beneficiaries

Individuals that are enrolled in Medicare, and eligible for Medicaid benefits, are considered dually eligible participants. Dually eligible participants receive Medicare Part A and/or Part B premium coverage, and coinsurance and deductible reimbursement consideration for Medicare covered services. Pharmacy items or other services not covered by the dually eligible participant’s Medicare benefits may be covered under the participant’s Medicaid benefits.

### 6.11.4. Medicare Part D

Under the Medicare Modernization Act, dually eligible individuals no longer receive their drug coverage from Medicaid and instead select or are automatically enrolled into private Medicare prescription drug plans. Medicaid may still cover certain essential drugs excluded by law from the Medicare Part D, Prescription Drug Program. Medicare must be billed prior to submitting drug claims to Medicaid. If the Medicare Explanation of Benefits (EOB) indicates that the requested medication is one of the medications not covered by law, then Medicaid may reimburse.

## **6.11.5. References: Medicare Savings Program**

### ***a) Federal Regulations***

Medicare Catastrophic Coverage Act of 1988. H.R. 2470 (1988). Government Printing Office, <https://www.congress.gov/bill/100th-congress/house-bill/2470>.

"State Agreements for Coverage of Eligible Individuals Who are Receiving Money Payments Under Public Assistance Programs or are Eligible for Medical Assistance." Social Security Act, Sec. 1843 (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title18/1843.htm](https://www.ssa.gov/OP_Home/ssact/title18/1843.htm).



## **6.12. Managed Care Programs for Dual Eligible Participants**

The Idaho Medicaid Plus (IMPlus) plan and Medicare Medicaid Coordinated Plan (MMCP) are managed care service delivery program options for dual eligible participants. The purpose of these plans is to integrate care for individuals who are currently served by both Medicare and Medicaid and meet certain eligibility requirements. These programs are designed to coordinate delivery of primary, preventive, acute, behavioral, and long-term care services and supports.

Participants will continue to use their Medicaid ID (MID) numbers as established under the [General Participant Eligibility Information](#) section. Participating Medicare Advantage Plans offering MMCP programs will also issue a plan identification number specific to their company.

### **6.12.1. Idaho Medicaid Plus (IMPlus)**

Participants who are 21 years old or older, enrolled in both Medicare Part A and Part B, eligible for full Medicaid, who reside in an IMPlus coverage area, who do not voluntarily enroll in MMCP, and who are not in an excluded or exempt population are required to enroll in IMPlus. Participants who do not make an active selection of a health plan to administer their IMPlus coverage will be automatically enrolled in IMPlus and auto-assigned to a participating health plan.

### **6.12.2. Medicare-Medicaid Coordinated Plan (MMCP)**

Participants who are 21 years old or older, enrolled in Medicare Part A and Part B, eligible for full Medicaid, and reside in an MMCP coverage area are eligible to voluntarily enroll in MMCP through an MMCP health plan.

### **6.12.3. Billing Procedures for Managed Care Participants**

These services must be billed to an MMCP health plan using participant's health plan-specific identification number:

- Hospital services;
- Medical services;
- Prescription drug services;
- Behavioral health services;
- Aged & Disabled (A&D) Waiver Services;
- Personal Care Services (PCS);
- Nursing Home (NH);
- Community-Based Rehabilitation Services; and
- Transition Management and Transition Services.

These services must be billed to an IMPlus health plan using participant's health plan-specific identification number:

- Behavioral health services;
- Aged & Disabled (A&D) Waiver Services;
- Personal Care Services (PCS);
- Nursing Home (NH);
- Community-Based Rehabilitation Services; and
- Transition Management and Transition Services.

Providers may bill Medicaid for services listed below using the Medicaid ID (MID) number assigned to the participant for either managed care program.

**Adult Developmental Disability (DD) Waiver:**

- Non-Medical Transportation provided by an Agency;
- Non-Medical Transportation provided by an Individual;
- Non-Medical Transportation provided through a Bus Pass;
- Specialized Medical Equipment;
- Individual Supported Living;
- Group Supported Living;
- Daily Supported Living Services Intense Support;
- Daily Supported Living Services Intense Support School Based, School Days;
- Daily Supported Living Services High Support;
- Daily Supported Living Services High Support School Based, School Days;
- Behavioral Consultation by a QIDP/Clinician;
- Behavioral Consultation by a Psychiatrist;
- Behavioral Consultation Emergency Intervention Technician;
- Supported Employment;
- Adult Day Health;
- Chore Services (Skilled);
- Residential Habilitation – CFH;
- Personal Emergency Response System Installation and first month's rent;
- Personal Emergency Response System Rent/monthly;
- Environmental Accessibility Adaptations;
- Home Delivered Meals;
- Skilled Nursing Services, Independent RN;
- Skilled Nursing Services, Agency LPN;
- Skilled Nursing Services, Agency RN;
- Nursing Oversight Services of LPN;
- Nursing Oversight Services of Agency RN;
- Nursing Oversight Services of Independent RN;
- Respite Care; and
- Respite Care Daily.

**Adult DD State Plan HCBS:**

- Developmental Therapy Evaluation;
- Home/Community Individual and/or Group Developmental Therapy for Adults;
- Center Based Individual and/or Group Developmental Therapy for Adults;
- Community Crisis Supports;
- Interpretive Services, oral (to assist Enrollees to receive DD services); and
- Interpretive Services, sign language (to assist Enrollees to receive DD services).

**Consumer Directed Services:**

- Fiscal Employer Agent; and
- Community Supports (to include Support Broker services).

### **6.13. Otherwise Ineligible Non-citizens (OINC)**

Individuals who do not meet the citizenship or qualified non-citizen requirements may be eligible for medical services necessary to treat an emergency medical condition. An emergency medical condition exists when the condition could reasonably be expected to seriously harm the person's health, cause serious impairment to bodily functions, or cause serious dysfunction to any body part or organ, without immediate medical attention. Childbirth qualifies as an emergency, but ante and postpartum services do not. Medicaid eligibility for OINC begins no earlier than the date the participant experiences the medical emergency and ends the date the emergency condition stops. A length of stay review by the Quality Improvement Organization, Telligen, is not required for participants with eligibility under OINC. The Medical Care Unit will make determinations on the appropriate length of stay during the eligibility review process.

#### **6.13.1. Applying for Eligibility**

The general application used to apply for Medicaid is also used for OINC applicants. Applications should be submitted after the emergency condition has ended. Hospitals may attach medical records with applications if they are helping the applicant apply for assistance. Completed applications are submitted to:

Self-Reliance Program  
PO Box 83720  
Boise, ID 83720-0026

Phone: 1 (877) 456-1233  
Fax: 1 (866) 434-8278

The Division of Medicaid's Medical Care Unit determines whether the condition is an emergency and if the treatment services will be covered by Idaho Medicaid.

#### **6.13.2. Prior Authorizations: Otherwise Ineligible Non-Citizens**

Services requiring a prior authorization should be submitted to the designated reviewer for that service after the participant is approved for eligibility. Providers should note on the prior authorization request that a retrospective review is being requested for a participant with retroactive eligibility. A prior authorization for length of stay is not necessary.

#### **6.13.3. References: Otherwise Ineligible Non-Citizens**

##### ***a) Idaho Medicaid Publications***

"Non-Citizen Emergency Medical." *MedicAide Newsletter*, June 2009, <https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/June%20Newsletter%20Final.pdf>.

##### ***b) State Regulations***

"Emergency Medical Condition." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 250. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

"Ineligible Non-Citizen." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 402.03. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

"Individuals Who Do Not Meet The Citizenship or Qualified Non-Citizen Requirements." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 240. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

"Ineligible Non-Citizen with Emergency Medical Condition." *IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD),"* Sec. 801. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160305.pdf>.

"Non-Citizen." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 11.05. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

## **6.14. The Pregnant Women (PW) Program**

The Pregnant Women (PW) program was developed to provide medical assistance to encourage individuals to seek prenatal care early in a pregnancy and preserve the health of both mother and infant. The program assists Idaho residents with a verified pregnancy not currently receiving medical assistance from the state or county, and without sufficient resources for private medical coverage. Participants found eligible under the PW program have the same coverage as participants on the Medicaid Basic Plan. Coverage through the program continues after delivery during the postpartum period for sixty (60) days, and extends until the last day of the month in which the sixtieth day occurs. Participants on the PW program will be evaluated for other Medicaid eligibility at the end of their coverage.

### **6.14.1. Presumptive Eligibility for Pregnant Women (PW)**

Presumptive eligibility for pregnant women is designed to provide participants prenatal care between being diagnosed pregnant and receiving an eligibility determination. PE for pregnant women only covers outpatient prenatal care and not deliveries, miscarriages, or abortions. Medical coverage for the PW Program during the PE period is restricted to ambulatory outpatient, pregnancy-related services only. Pregnancy-related services may be rendered by any qualified Medicaid provider.

Routine prenatal services are covered, as well as some additional services such as nutrition counseling, risk-reduction follow-up, and social service counseling. Providers are not required to bill another insurance resource, if it exists, before billing Medicaid for prenatal services during the PE period.

The PE Program does not cover PW inpatient services. Medicaid does not pay for any type of abortion for participants on the PE Program. Also, PE participants are not covered for any delivery services. Services not covered under Medicaid are the participant's responsibility. If the PE participant has applied for the PW Program or any other Medicaid program, and is determined eligible, hospital inpatient services may be covered.

### **6.14.2. References: Pregnant Women (PW)**

#### ***a) Idaho Medicaid Publications***

"Extended (Postpartum) Medicaid for Pregnant Women." *IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, & Disabled (AABD),"* Sec. 786. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160305.pdf>.

"Presumptive Eligibility for Pregnant Women." *IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children,"* Sec. 502. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

#### ***b) Federal Regulations***

Medicare Catastrophic Coverage Act of 1988. H.R. 2470 (1988). Government Printing Office, <https://www.congress.gov/bill/100th-congress/house-bill/2470>.

"Presumptive Eligibility for Pregnant Women." Social Security Act, Sec. 1920 (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1920.htm](https://www.ssa.gov/OP_Home/ssact/title19/1920.htm).

Required Services for the Categorically Needy, 42 CFR 440.210 (1995). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-210.pdf>.

## 6.15. Refugee Medical Assistance Program

The Refugee Medical Assistance Program provides eligibility to certain refugees who are not otherwise eligible for Medicaid or CHIP. Coverage is limited to eight months, beginning when the refugee arrives in the United States. Children born to the refugee during that time period are also eligible for the Refugee Medical Assistance Program, but only as long as their parent's coverage remains in effect. At the conclusion of the program's coverage, participants will be evaluated for coverage under other eligibility programs.

In order to qualify for Medicaid eligibility through the Refugee Medical Assistance Program, the applicant must:

- Meet the federal definition of refugee for the purposes of the program;
- Not be otherwise eligible for Medicaid or CHIP; and
- Have an income under 150% of the federal poverty level (FPL).

Refugees whose income exceeds 150% of the FPL may still be eligible under a special "spend down" consideration if the remainder of their income after medical expenses are deducted drops their income below 150% of the FPL.

Coverage under the Refugee Medical Assistance Program is contingent on Idaho's receipt of federal funding. In the event that funds are not received, this program will be suspended without advance notice.

### 6.15.1. References: Refugee Medical Assistance Program

#### *a) Federal Regulations*

Cuban/Haitian Entrant Program, 45 CFR 401 (1982). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title45-vol3/pdf/CFR-2019-title45-vol3-part401.pdf>.

Refugee Act of 1980. 8 U.S.C. 1521 (1979). Government Printing Office, <https://www.govinfo.gov/content/pkg/USCODE-2018-title8/pdf/USCODE-2018-title8-chap12-subchapIV-sec1521.pdf>.

Refugee Medical Assistance, 45 CFR 400 Subpart G (1989). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2019-title45-vol3/pdf/CFR-2019-title45-vol3-part400-subpartG.pdf>.

#### *b) State Regulations*

IDAPA 16.03.06, "Refugee Medical Assistance." Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160306.pdf>.

## 6.16. Youth Empowerment Services (YES)

Youth Empowerment Services (YES) provides a doorway to Medicaid eligibility for children under the age of eighteen (18) with a serious emotional disturbance (SED) and functional impairment. Once approved for Medicaid, participants have all the benefits on the Enhanced Plan, plus respite care through the [Idaho Behavioral Health Plan](#) and person-centered service planning. The participant must complete an assessment and update the person-centered service plan at least every 12 months to maintain eligibility under the program.

In order to qualify for Medicaid eligibility through YES, the applicant must:

- Have a verified SED and functional impairment;
- Have an income under 300% of the federal poverty level (FPL);
- Be under the age of eighteen (18);
- Be an Idaho resident;
- Be a U.S. citizen or meet requirements for legal noncitizen;
- Cooperate with obtaining a medical support order for a non-custodial parent unless good cause can be established;
- Not reside in an ineligible institution; and
- Not be fleeing prosecution of a felony, custody, or confinement of a felony conviction or violating a condition of probation or parole.

A serious emotional disturbance is defined as a diagnosable mental health, emotional or behavioral disorder, or a neuropsychiatric condition which results in a serious disability. The diagnosis must be made in alignment with the Diagnostic and Statistical Manual of Mental Disorders (DSM). A disability caused by the diagnosis is considered serious if it causes a substantial impairment of thought, perception, affect or behavior in family, school or community settings, and requires sustained treatment interventions. A substance use disorder does not, by itself, constitute a serious emotional disturbance, although it may coexist with serious emotional disturbance.

The SED and functional impairment must be verified by Medicaid's Independent Assessment contractor (Liberty Healthcare) using a Comprehensive Diagnostic Assessment (CDA) and the Child and Adolescent Needs and Strengths (CANS) tool. Liberty Healthcare will complete the CDA and CANS in the applicant's home and contact them within one business day with the results and next steps. These assessments are provided at no cost to the family or applicant seeking eligibility. A CDA completed by another provider can be used if it was completed in the last six (6) months.

Providers can direct potential applicants to contact Liberty Healthcare at 1 (877) 305-3469 for the free assessment. Other services may be available for children with an SED who do not meet the additional requirements for Medicaid eligibility; e.g., family income exceeding 300% FPL. See the [Youth Empowerment Services](#) website for more information.

### 6.16.1. References: Youth Empowerment Services

#### a) Idaho Medicaid Publications

"New Independent Assessment Contractor for Children's Mental Health Services." *MedicAide Newsletter*, March 2018,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf>.

"YES Project Update for Healthy Connections and the September MedicAide Issue." *MedicAide Newsletter*, September 2018,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/September%202018%20MedicAide.pdf>.



### **b) State Regulations**

Children's Mental Health Services: Definitions, Idaho Code 16-2403 (2019). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title16/t16ch24/sect16-2403/>.

Eligibility for Medical Assistance, Idaho Code 56-254 (2017). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-254/>.

"Premiums for Participation Under the Youth Empowerment Services (YES) Program." *IDAPA 16.03.18, "Medicaid Cost-Sharing,"* Sec. 207. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160318.pdf>.

"Youth Empowerment Services (YES) Home and Community-Based Services (HCBS) State Plan Option." *IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits,"* Sec. 635 – 638. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160310.pdf>.

"Youth Empowerment Services (YES) Program Children." *IDAPA 16.03.01, "Health Care Assistance for Families & Children,"* Sec. 540. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160301.pdf>.

### **c) Settlement Agreement**

Idaho Implementation Plan (2016). Jeff D., et al. v. Clement Leroy Otter, et al., <https://youthempowermentservices.idaho.gov/Portals/105/Documents/YESImplementationPlan.pdf>.

Jeff D., et al. v. Clement Leroy Otter, et al. (2015). Case No. 4:80-CV-04091-BLW, <https://youthempowermentservices.idaho.gov/Portals/105/Documents/JeffDOfficial%20Agreement.pdf>.

## 7. Healthy Connections (HC)

Healthy Connections (HC) is the Idaho Medicaid primary care program in which a primary care provider or team provides comprehensive and continuous medical care to a participant with the goal of improving health outcomes. Our mission is to ensure Medicaid participants receive the care they need, when they need it, and in the appropriate setting. The Healthy Connections program is structured to incentivize HC providers to transform to the Patient Centered Medical Home (PCMH) model of care whereby a participant's treatment is coordinated through their primary care provider and their team, which can include organizations, hospitals or other entities.

The goals of HC are to:

- Ensure access to healthcare;
- Improve the quality of healthcare and overall well-being of Medicaid participants;
- Emphasize care coordination and continuity of care;
- Encourage participants to be involved in their healthcare decisions; and
- Achieve cost efficiencies for the Idaho Medicaid Program.

Medicaid participant enrollment into HC is required in the majority of counties statewide. Individuals qualifying for Idaho Medicaid will receive correspondence requesting they identify their current Primary Care Provider (PCP) or choose an HC clinic.

## 7.1. Healthy Connections Provider Enrollment

Idaho Medicaid primary care providers participate in Healthy Connections by signing a Coordinated Care Provider Agreement in addition to the Idaho Medicaid Provider Agreement. Coordinated Care Provider Agreements are available from the Regional Healthy Connections Representatives. Addresses and telephone numbers for the regional HC offices are listed in the [Directory](#), Idaho Medicaid Provider Handbook, and at <https://healthyconnections.idaho.gov>.

What is a primary care provider? An MD, DO, PA, Nurse Practitioner, etc., who participates in the Healthy Connections program with a contracted organization to coordinate and monitor primary care services.

What are primary care services? Services including preventive services, diagnosis and treatment of acute injury and sickness, and management of long-term conditions.

In the Healthy Connections (HC) Program, Primary Care Providers qualify for tiers and are incentivized to implement a Patient Centered Medical Home (PCMH) model of care and improve participant outcomes. HC service locations offering enhanced participant care and PCMH characteristics may qualify for higher tier placement. Upon approval of tier placement, the HC service location is issued an HC Coordinated Care Agreement Addendum which outlines requirements to maintain tier status and monthly primary care case management fee.

Providers are required to keep their record current and notify Gainwell Technologies of any changes in their record to ensure accurate participant enrollment in Healthy Connections, including:

- Enroll all rendering PCPs and each HC service location in the MMIS system for the purposes of assigning participants at the location where they receive primary care services.
- Keep all of the provider enrollment information current in the MMIS system by completing any maintenance items within 28 days of the change as required in the Idaho Medicaid Provider Agreement.
- Updated provider record information will be acted on once submitted and approved through the provider enrollment application in HealthPAS.

The HC Service Location information (i.e. name and demographics) entered in the Gainwell Technology system will appear on the following:

- HC Network Directory (HC website)
- HC Rosters (Gainwell system)
  - Online dynamic roster (PCP Roster)
  - HC monthly Case Management report (Gainwell system - file exchange)
- Verifying participant eligibility (Gainwell system)
  - Includes clinic name and office hours
- HC Referral lookup (Gainwell system)
- HC enrollment participant letters
  - Clinic name and demographics

### **TERMINING HEALTHY CONNECTIONS (HC) CONTRACT FOR VALUE CARE ORGANIZATION (VCO) COMPLIANCE**

Existing HC Clinics/Organizations that have their HC contract termed, or New HC Clinics/Organizations that do not affiliate with a VCO will be restricted from re-contracting with the HC program until the Clinic/Organization's contract with a VCO is in effect for the next performance year.

### 7.1.1. Healthy Connections Primary Care Provider Network Directory

A directory of Healthy Connections (HC) clinics is made available on the [HC](#) webpage. Changes to the network directory will be posted to the webpage daily. Failure to keep the clinic's records up-to-date in the Gainwell Technologies system could result in inaccurate information populating in the HC Network Directory.

Some common changes or provider record updates submitted to Gainwell Technologies could include:

- Change of ownership;
- Change of address or phone number;
- Adding or closing a service location;
- Office hours;
- Panel Limitations (see *new section* HC Clinic Panel Limits)
- Adding or removing rendering providers; and
- Provider contact information.

### 7.1.2. Healthy Connections Clinic Panel Limit Entry

The HC Primary Care Providers are required to keep the information in the following table entered in the Provider Enrollment Application on Health Pas.

HealthPas Portal Question/Entry	Explanation
This practice will accept patients both new to your practice and established patients new to Medicaid. Is your practice open to new Medicaid patients?	If answered <b>YES</b> , your practice will accept any patient who is <b>new</b> to your practice, as well as established patients new to Idaho Medicaid. HC Network directory will show "Accepting New Medicaid."
Is your practice open to new Medicaid patients? <i>If answered no, the following 2 questions appear:</i> Is your clinic limited to existing patients only? Does this clinic accept family members of existing patients?	If answered <b>NO</b> , your practice will NOT accept any <b>new</b> Idaho Medicaid patients. Any patient requesting enrollment to your clinic will be directed to contact you for approval. You will then need to contact Healthy Connections giving your approval. HC Network directory will show "NOT Accepting New Medicaid."
Does this clinic provide OB services? Is this clinic limited to Pregnant Individuals?	<b>IMPORTANT CHANGE:</b> If YES to "does this clinic provide OB services" your practice provides OB care <u>as well as Primary Care</u> . Answer NO to the "is this clinic limited to Pregnant individuals" Yes is no longer allowed per policy.
Will this clinic allow HC staff to enroll and/or assign patients who have not identified a PCP?	If <b>YES</b> , HC will assign Idaho Medicaid patients who have not notified HC of their choice and may not be a current patient with your clinic. (mandatory assignments)
After Hours Coverage (must choose one)	How do you provide After Hours Coverage? <ul style="list-style-type: none"> <li>• Answering machine directs patients to call the covering medical professional.</li> <li>• Answering service contacts the covering medical professional.</li> <li>• Phones forwarded to on-call medical professional</li> </ul>

HealthPas Portal Question/Entry	Explanation
	<ul style="list-style-type: none"> <li>• After hours nurse.</li> <li>• Alternate coverage arrangement (must verify with HC rep if meets Coordinated Care Agreement).</li> </ul>
Clinic Contact Information	The following clinic contacts (if applicable) (Name, email and Phone Number): Office Manager; Biller; and Credentialer.
PCMH Information	PCMH Contact; PCMH Physician Champion; PCMH Care Coordinator; and EMR Name.
PCMH Accreditation	If you are quality certified, indicate the recognition you have achieved, effective date, and name of the Electronic Health Record you use: NCQA; AAAHC; Joint Commission; URAC; or Other.
Office Hours	Hours you are open to see patients for primary care. May enter multiple time segments for one day (example – closed for lunch).
HC rendering primary care providers	HC Organizations are required to keep the status of PCP information current in HealthPAS to populate on HC Network Directory. Checking the “PCP” box on each service location the rendering provider is affiliated with will result with that rendering provider showing as a PCP at that location on the HC Network Directory.

INFORMATION TO REPORT TO HC REPRESENTATIVE	
Information Needed	Explanation
Age limitations/restrictions	Any limitations you may have for age. Example: under a certain age/over a certain age.
Type of Practice	The type of practice you are. Example: Family Practice, RHC, FQHC, Indian Health, Pediatrics, etc.
Clinic Contacts	Additional contacts needed for Healthy Connections: Referral coordinator, Other office contacts.
IHDE Status	Connectivity with the IHDE system, either View, or bi-directional.

### 7.1.3. Healthy Connections Clinic Panel Limit Guidelines

The following are the guidelines to determine some of the panel limitations:

- **Accepting New Medicaid:** Clinic must have the capacity for members to establish care within two (2) months of enrollment. If clinic does not have the capacity for

members to establish within this timeframe, clinic must set their panel to Not Accepting New Medicaid.

- If a participant has not established care, and has an urgent medical need, clinic is required to provide “timely access to care” either by seeing the participant or providing a one-time referral and working with participant to schedule an appointment.
- **Accepting Mandatory Assignment:** The assignments will occur when the participant doesn’t choose a PCP, and they are within the panel limits (i.e. age limits, etc.). The clinic requirements for assignments are as follows:
  - When a participant is assigned to clinic, the clinic is required to allow assigned participant(s) to establish care, even if the panel subsequently has closed to accepting mandatory assignments; and
  - If a participant has not established care, and has an urgent medical need, clinic is required to provide “timely access to care” either by seeing the participant or providing a one-time referral and work with patient to schedule an appointment.

#### 7.1.4. Healthy Connections Tier Requirements

The following are the requirements for each of the three Healthy Connections tiers. If applying or advancing to Tier II or Tier III, please see those applications on our website for more specifics about the following requirements.

##### **TIER I – HEALTHY CONNECTIONS**

In order to qualify for Tier I of the Healthy Connections program, the provider must:

- Provide primary care services;
- Monitor and coordinate the participant’s care;
- Provide timely referrals for medically necessary services;
- Provide twenty-four (24) hour, 7-days a week availability of information, referral and treatment for emergency medical conditions; and
- Participate as a partner in a Healthy Connections Value Care Organization (VCO):
  - This can be accomplished by contracting directly with the Department as a Healthy Connections VCO or partnering with a Healthy Connections VCO.
  - Healthy Connections Tribal, IHS, state-owned or Public Health District clinics are exempt from this requirement.

##### **TIER II - HEALTHY CONNECTIONS CARE MANAGEMENT**

In addition to Tier I requirements listed above, the HC clinic must provide the following:

- Clinic must meet a minimum of 30 hours of patient access to care.
- Enhanced patient access to care – must meet one of the following:
  - 46 hours of access to care for patients;
  - Nearby Service Location with extended hours and shared EMR within same organization;
  - Patient portal to enhance access to care;
  - Virtual Care - remote healthcare services; or
  - Other as approved by the Department.
- Demonstrate enrollee outreach and education activities to establish and maintain the patient/provider relationship. At a minimum to include:
  - Outreach to non-engaged enrollees; and
  - Provide patient/family education and self-management support.
- Demonstrate a continuous quality improvement program directed at increased performance in quality measures.

- Demonstrate dedicated care coordinator staff or equivalent support for coordination of patient care.
- Demonstrate a referral tracking and follow-up system is in place for purposes of care coordination.
- Demonstrate interoperability met by one of the following:
  - The timely exchange of patient-level data with local, regional or state-wide healthcare systems to support improved coordination of patient care; or
  - An established bi-directional connection to the Idaho Health Data Exchange (IHDE) with demonstrated share relationship.

**TIER III - HEALTHY CONNECTIONS MEDICAL HOME**

In addition to the requirements in Tiers I & II, the HC clinic must maintain PCMH recognition, including NCQA Patient Centered Medical Home recognition, Utilization Review Accreditation Commission (URAC), Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC) or other Patient Centered Medical Home national recognition.

**HC Clinic Tier Movement Process**

- HC clinics must complete a Tier Application for the higher tier they wish to apply for. The tier application can be found at <https://healthyconnections.idaho.gov>.
- Completed tier applications, along with required documentation, should be faxed to the Healthy Connections Consolidated Unit at 1 (888) 532-0014, or scanned and e-mailed to [HCCR7@dhw.idaho.gov](mailto:HCCR7@dhw.idaho.gov).
- Tier applications must be received with all required documentation **and approved by the 15<sup>th</sup> of the month** for the change and case management payment to be effective the first of the following month.
- HC clinics will receive official notice of action taken on tier applications.
- Applications will be processed in the order received.

**7.1.5. Healthy Connections Coordinated Care Agreement and Tier Compliance by Tier**

In addition to the Idaho Medicaid Provider Agreement, every Healthy Connections clinic/organization, at the Tax ID level, is required to sign an HC Coordinated Care Agreement. Providers may be subject to sanctions for being deemed out of compliance as per the HC Coordinated Care Agreement.

HC Staff will conduct periodic reviews of HC organization’s ability to maintain compliance with the HC Coordinated Care Agreement and specific tier requirements. Clinics will be responsible for providing proof of meeting Tier requirements at a minimum annually (unless otherwise specified). As part of this review, HC Staff may ask for documentation that provides proof of meeting specific requirements. Compliance specific information including, but not limited to, the following table:

HC Tier Compliance Process				
Tier	Requirement	Compliance Verification	Frequency	Compliance Level
I, II & III	Provide 24 hour, 7-days a week availability of information, referral and treatment for emergency medical conditions	After hours phone call to service location resulting in reaching an after-hours medical professional	Annually	Service Location
I, II & III	Affiliate with a Healthy Connections VCO	Verified by the Department	Annually	Organization Tax ID

HC Tier Compliance Process				
Tier	Requirement	Compliance Verification	Frequency	Compliance Level
II & III*	Outreach to non-engaged patients done annually	Proof of communication to non-engaged patients, randomly selected by the Department	Annually, at a minimum	Organization
II & III*	Patient/family education and self-management support for chronic conditions done annually	Examples of educational material given to patients	Annually	Organization
II & III*	Quality improvement activities meant to improve 1 or more quality measures.	Written description of current quality measure improvement activities or PDSA including outcome	Bi-annually	Service Location or Organization
II & III*	Referral tracking and follow-up system for care coordination	Screen shot of current log or electronic system used that demonstrates: Tracking referral reports, flag and follow up on over-due reports Flag abnormal results and notification of family of all results and Follow up of patient accessing urgent care, ED and hospitalizations	Annually	Service Location or Organization
II & III	Clinic must provide a minimum of 30 hours of patient access to primary care each week	Service location posted hours must reflect accurately in on-line provider record	Annually, at a minimum.	Service Location
II & III	Enhanced access to care met by ONE of the following: 46 hours of access to primary care. Nearby service location with expanded patient access and shared EMR Patient portal with required features. Virtual Care Other as approved by Department.	Department will verify enhanced access met as indicated on tier application and may require documentation of any updates	Annually, at a minimum	Service Location
II & III	Designated Care Coordinator on staff OR Equivalent staff providing coordination of patient care	Department will verify care coordination met as indicated on tier application and may require documentation of any updates	Annually	Service Location or Organization
II & III	Demonstrate interoperability A. The timely exchange of patient-level data with	Department will verify interoperability met as indicated on tier application and may	Annually	Organization



HC Tier Compliance Process				
Tier	Requirement	Compliance Verification	Frequency	Compliance Level
	local, regional or state-wide healthcare systems to support improved coordination of patient care. OR B. An established bi-directional connection to the Idaho Health Data Exchange (IHDE) with demonstrated share relationship	require documentation of any updates		
III	National PCMH recognition	Copy of certification	Annually	Service Location

\*Tier III clinics will potentially meet these requirements depending on their PCMH national recognition obtained.

### 7.1.6. Healthy Connections Corrective Action Process (CAP)

When Idaho Medicaid becomes aware that a clinic is out of compliance for one of the Tier requirements, the corrective action process will begin. If compliance is not met within the timeframe outlined below, the outcome could include one of the following: Regression of tier, Case management suspension, or Termination as a Healthy Connections provider.

Corrective action steps:

**Step One:** Clinic will be contacted verbally to discuss the non-compliance and possible solution. Clinic will be given fifteen (15) business days to correct the non-compliance issue.

**Step Two:** At day sixteen (16), if compliance is not met, a formal corrective action letter will be emailed to the clinic contact that has been established at first contact. Clinic will have an additional fifteen (15) business days to correct the non-compliance issue.

**Step Three:** At day thirty-one (31), if compliance is not met, a second formal corrective action letter will be emailed and mailed certified, return receipt. Clinic will have an additional fifteen (15) days to correct the non-compliance issue.

**Step Four:** After the forty-five (45) days have expired:

- If non-compliance is for 24/7 requirement, clinic will be termed as a Healthy Connections provider, and a letter will be mailed, certified, return receipt.
- If non-compliance is for other Tier requirements, clinic will be regressed to appropriate tier (example Tier 3 to Tier 2). A formal letter will be mailed, certified, return receipt.

If regression occurs, clinic can apply for higher Tier once compliance has been met.

### 7.1.7. Healthy Connections Case Management Payment

In addition to payment for services rendered, Healthy Connections (HC) clinics are paid a monthly case management fee. The monthly case management fee is paid for every participant enrolled with the HC clinic on the first day of each month. The case management payment is based on the tier level of the HC clinic as of the first of the month.

The case management payment is generally processed on the Tuesday of the first full week of the month. The monthly Healthy Connections roster reports are then available following the processing of the case management payment.

HC clinics qualify for one of the following three tiers of reimbursement for all enrolled participants:

Medicaid Plan	Healthy Connections Tier I	Healthy Connections Care Management Tier II	Healthy Connections Medical Home Tier III
All Enrolled participants	\$3.00	\$7.00	\$9.50

### 7.1.8. Healthy Connections Participant Rosters

The following two Primary Care rosters are available to PCPs.

- An online, dynamic Primary Care Roster is available on the [Gainwell Technologies Medicaid](#) website through your Trading Partner Account and is called the PCP Roster. This is a list of currently enrolled HC participants and the PCP is able to verify eligibility or issue a referral from this roster. This roster can be exported to either Excel format or in PDF form. The contact information on the exportable report can be used to contact participants and encourage them to be engaged in their healthcare.
  - To further support HC providers in coordinating their patient care, the following are some of the fields included on the exportable Excel or PDF list of participants:
    - Participant name;
    - Phone Number;
    - Address;
    - Head of Household; and
    - Enrollment Indicator (Mandatory or Voluntary enrollment).
- The Monthly Healthy Connections Roster report is a list of participants enrolled to a Healthy Connections service location effective the first day of the month, and includes case management payment information. The report is divided in to four sections: new enrollees, ongoing enrollees, lost eligibility, and dis-enrollees. This serves as the HC Case Management Payment report. This monthly roster is uploaded to the Organization's secure portal under the File Exchange 'Reports' section and is available in both PDF and Excel formats.

An announcement will be posted to the Gainwell Technologies Health PAS website when the rosters become available.

## 7.2. Participant Enrollment

Medicaid providers should always verify participant eligibility and Healthy Connections (HC) enrollment prior to rendering services, as described in the [Verifying Participant Eligibility](#) section. For participants enrolled in Healthy Connections, the PCP information will be provided through the automated and/or online system. If an HC PCP is not indicated, an HC referral is not required.

Enrollment in HC is mandatory for most Medicaid participants and required in the majority of counties statewide. Participants not enrolled in HC are mailed an enrollment form and given up to 90 days to inform us of their choice of PCP. When a Medicaid participant does not choose a PCP and they live in a mandatory county, the participant is assigned to an HC PCP.

HC clinics are required to absorb any participant enrolled to their clinic even if a specific provider is no longer with that HC clinic. If the clinic does not have the capacity to absorb those participants, they must change their panel to "Not Accepting New Medicaid".

### 7.2.1. Voluntary Participant Enrollment in Healthy Connections

Participants not enrolled in Healthy Connections (HC), can complete an enrollment form at an HC clinic and have it faxed to 1 (888) 532-0014 or e-mailed to [HCCR7@dhw.idaho.gov](mailto:HCCR7@dhw.idaho.gov). Assisting participants to enroll to an HC clinic will help avoid the possibility of assignment to a different HC clinic.

### 7.2.2. Participant Enrollment Guidelines

- Enrollment in HC is mandatory for most Medicaid participants.
- Enrollment requests must be submitted by the participant or an authorized representative.
- Enrollment to the HC clinic will be effective the date the enrollment request is approved.
- Each enrolled participant is sent a written notice listing the name, phone number, and address of their HC clinic. This notice is generated and mailed the day after the participant's enrollment is entered.
- Family participants are not required to choose the same HC clinic.
- Medicaid participants may enroll to an HC clinic in one of the following ways.
  - Preferred method - Enroll online at the [Healthy Connections website](https://healthyconnections.idaho.gov) <https://healthyconnections.idaho.gov>, choosing the blue link "Find a Healthy Connections PCP".
  - Complete and return an HC Enrollment form received in the mail;
  - Complete enrollment form at clinic and have it faxed to the Healthy Connections Consolidated Unit at 1 (888) 532-0014; or
  - Call the HC Consolidated Unit at 1 (888) 528-5861 to enroll over the phone
- Clinic is required to absorb any participants enrolled to their clinic even if a specific provider is no longer with the HC clinic.
- The HC Network Directory can be found at <https://healthyconnections.idaho.gov>.

### 7.2.3. Enrollment to clinic with panel limitations

Healthy Connections (HC) clinics have the option to request a closed panel and not accept new Medicaid participants or request panel limitations for enrollment. Limited or closed panel clinics may arrange with HC to process enrollments without prior approval when any of the following conditions are met:

- Participants are currently established as shown by claims within last 12 months.
- Participants have an upcoming scheduled appointment or recent appointment.
- Participants with family members currently established.

If the above conditions are not met, or the clinic is closed to new Medicaid, participants will be directed to the clinic for enrollment approval. The clinic must contact Healthy Connections with the approval for the participant to be enrolled in one of the following ways:

- Enrollment form from the clinic, signed by the participant or their authorized representative.
- Phone call from clinic validating enrollment request received from participant.

It is the responsibility of the organization to communicate panel limitations to all locations participating in Healthy Connections.

#### **7.2.4. Mandatory Participant Enrollment in Healthy Connections**

If a primary care provider (PCP)/clinic chooses to accept mandatory assignment participants, the assignments will occur within the panel limits the PCP/clinic has provided to Healthy Connections (HC) (i.e., accepting new Medicaid, age limits, etc.).

The requirements for assignments are as follows:

- When a participant is assigned to PCP/clinic, the clinic is required to allow assigned participant(s) to establish care, even if the panel subsequently has closed to accepting mandatory assignments; and
- If a participant has not established care, and has an urgent medical need, PCP/clinic is required to provide “timely access to care” either by seeing the participant or providing a one-time referral.
- If the clinic cannot absorb patients due to a provider leaving the location, or assigned participants cannot access care timely, the clinic must set their panel limits to “Not Accepting New Medicaid”, and change their panel limits to not accepting mandatory assignments.

It is recommended that PCP/clinics check the Healthy Connections roster each month to see list of newly assigned participants and conduct outreach to encourage establishing care.

Participants not submitting a choice of provider will be assigned to an HC clinic up to 90-days after eligibility, to be effective the first of the following month, based on the following criteria:

- Assign participants to a clinic where they are currently receiving care.
- Assign family members to a clinic where other family members are enrolled, if appropriate.
- Assign participants to a prior Healthy Connections clinic, when applicable.
- Assign participants to a clinic based on geographic location.
- Assign participants based on rotation schedule agreed upon by clinic.

#### **7.2.5. Changing Enrollment in Healthy Connections**

Healthy Connections participants will be enrolled based on a fixed enrollment process. A set period of time is designated during the year when participants are allowed to change their PCP without cause. This is commonly known as the “annual enrollment period”. Fixed enrollment encourages a long-term provider-patient relationship resulting in the participant receiving a consistent source of care, provides for better patient outcomes and supports the value-based model of care.

Changes in enrollment are to be submitted by the participant or an authorized representative. HC clinics may submit HC enrollment forms on behalf of a participant, as long as the enrollment form is completed and signed by the participant or an authorized representative.

Participants or their authorized representatives are allowed to initiate a change without a special circumstance when it is:

- The annual enrollment period during July and August;
- Within the first ninety (90) days of enrollment with a *new* HC service location/clinic;
- Due to automatic re-enrollment and the participant misses any part of the annual open enrollment period; or
- A different service location/clinic within the HC Organization (same Tax ID).

Participants are allowed to initiate a change under the following special circumstances during the Fixed Enrollment Period:

- Participant requests different PCP than one assigned by the Department;
- Participant moved outside of the PCP's service area;
- Participant requests change because the PCP does not, due to moral or religious reasons, cover the service the participant seeks;
- Participant requests different PCP to allow members of a household to be enrolled with the same PCP (one medical home);
- Participant requests change due to changing to/from a specialty provider (i.e., Pediatrics, etc.);
- Participant chooses to follow PCP to a different HC organization, to maintain the existing relationship with the PCP;
- Participant requests change due to poor quality of care, as verified by the Department;
- Participant requests change due to lack of access to covered services, as verified by the Department;
- Participant requests change due to lack of access to providers experienced in dealing with the participant's health care needs, as verified by the Department;
- Participant requests change in PCP due to foster care placement;
- Participant requests different PCP due to incompatible primary insurance coverage;
- Participant requests change due to a provider determining related services are not available within the provider network and would result in putting the participant at unnecessary risk to receive services separately;
- Participant requests change due to administrative error of the Department; or
- Other reasons determined to be acceptable by the Department.

Requests to change providers will be verified and approved if they meet Fixed Enrollment criteria. A request to change is not guaranteed and may not be acted on immediately. As a result, it is important for providers to obtain referrals from the provider of record in the system prior to rendering services.

The special circumstance request form can be found at <https://healthyconnections.idaho.gov>.

***Failure to adhere to these policies may result in investigation by the Medicaid Program Integrity Unit.***

## **7.2.6. References: Changing Enrollment in Healthy Connections**

### ***a) Idaho Medicaid Publications***

Fixed Enrollment Changes for the Idaho Medicaid Healthy Connections Program, Information Release MA19-12 (8/1/2019). Division of Medicaid, Department of Health and Welfare, State of Idaho,

<https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA1912.pdf>.

## **7.2.7. Exceptions & Exemptions to HC Enrollment**

Participants meeting the exception or exemption criteria in this section are not required to enroll in the Healthy Connections Program. A referral is not needed for services rendered to participants not enrolled in Healthy Connections.

Participants are not required to enroll in Healthy Connections who meet the following exception criteria:

- The participant has an eligibility period that is less than three (3) months;
- The participant has an eligibility period that is only retroactive;
- The participant only has Qualified Medicare Beneficiary eligibility;
- The participant is enrolled in one of the managed care programs for Dual Eligible participants;
- The participant resides in long-term care or ICF/IID facility; or
- The participant resides in a non-mandatory county where there are not adequate numbers of providers to deliver primary care case management services.

Participants may opt out of Healthy Connections by requesting and qualifying for one of the following exemption reasons:

- Participant is unable to access a Healthy Connections provider within a distance of thirty (30) miles or within thirty (30) minutes to obtain primary care services;
- Participant has an existing relationship with a primary care provider or clinic (currently under the care) who is not participating in Healthy Connections. However, once the participant chooses to enroll with or receive services from an HC clinic, the participant no longer qualifies for an exemption (verified annually);
- Participant has Medicare as their primary healthcare plan;
- Participant is a member of a federally recognized tribe; or
- Participant is under 19 years of age and is:
  - Eligible for SSI under Title XVI;
  - Eligible under section 1902(e)(3) of the Act, qualified disabled children; or
  - Receiving foster care or adoption assistance.

Exempted participants not enrolled in Healthy Connections will appear as “Exempt from Healthy Connections” when checking eligibility. At any time, a participant with an exemption, but not an exception, may opt to enroll with a Healthy Connections provider.

## 7.2.8. References: Exceptions & Exemptions to HC Enrollment

### a) State Regulations

"Exemption from Participation." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 561.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

## 7.2.9. Participant Disenrollment by the Provider

A PCP may choose to withdraw as the participant's primary care provider and must give written notice to both the participant and the Department at least (30) days prior to the date of disenrollment. Failure by the PCP to notify Healthy Connections will result in continued obligation to provide care and/or referrals until notice is received. *The Department may waive this notice on a case-by-case basis.* The written notice from the PCP must give the enrollee the reason for the request for disenrollment.

A PCP may request disenrollment of a participant because:

- Participant has been previously discharged from the practice – PCP to provide copy of dismissal notice sent to participant
- A documented, ongoing pattern of failure on the part of the participant to keep scheduled appointments
- A documented situation where there is an inability by the PCP, after making a reasonable effort to maintain a mutually satisfactory PCP/participant relationship
- Behavior of the participant that is disruptive or abusive (and not related to his/her special needs) to the extent that the PCP's ability to furnish services to the participant or other participants is impaired.

A PCP may not request disenrollment because of:

- An adverse change in the participant's health status
- The participant's over/under utilization of medical services
- The participant's diminished mental capacity
- The participant's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs a PCP's ability to furnish services to the participant or other participants)

Upon the reassignment of the participant to a new PCP, the former PCP must transfer a copy of the participant's medical records to the new PCP when requested by the participant.

## 7.3. Referrals

A referral is a documented communication from a participant's PCP of record to another Medicaid provider for a specific covered service. The participant's HC clinic is responsible for providing primary care, managing the participant's care and making referrals for **medically necessary services**. The PCP plays a key role in linking participants with community resources to facilitate referrals and respond to the participant's medical and social needs.

### 7.3.1. Important Referral Policy Reminders

- Referrals must always be received **prior** to delivery of care.
- Backdated or retroactive referrals are not acceptable. Any service provided with a backdated or retroactive referral is considered to be non-covered and may be subject to recoupment and civil monetary penalties.
- Referral requirements apply regardless of Medicare or other insurance coverage.
- The referral must be documented in the records of both the referring and receiving providers to be valid.
- Referrals entered online in the HealthPAS portal meet the referral documentation requirements.
- Once received a referral remains active even if the participant changes their enrollment with an HC clinic.
- Providers receiving referrals may also forward the referral to another Medicaid provider as long as the date and scope of the referral meets the condition stated in the original referral.
- The referral requirement for primary care services accessed between HC clinics affiliated either by the same NPI, Tax ID or Provider Network owned by the same organization (not VCO affiliation) is at the discretion of the HC clinic/organization of record.
- Referral authority may be externally delegated to an "outside organization" for the purposes of care coverage. However, externally delegated referral authority must be documented in the covering HC service location for the specific visit.
- In the event that a service not requiring a referral begins and must be changed to a service that requires a referral, one is not required. However, the medical documentation must support the service change.
- Referrals cannot be accepted in lieu of a prior authorization. PA's are for certain services that require review and approval prior to being provided.
- When verifying eligibility, if no HC clinic is indicated or "Exempt from Healthy Connections" is returned, no referral is required.
- If a participant has not established care, and has an urgent medical need, clinic is required to provide "timely access to care" either by seeing the participant or providing a one-time referral and working with participant to schedule an appointment.
- Healthy Connections enrolls to the clinic, not a specific provider. Any HC provider that participates and provides primary care can authorize a referral for any enrolled participant.
- Historical note: In March 2020, referral requirements were suspended due to the COVID-19 pandemic. Effective July 1, 2021, referral requirements were reinstated.

### 7.3.2. Referral Elements

Effective 2/1/2016, the following are the required core referral elements:

- Date issued;
- Name of HC PCP or clinic issuing referral;
- Participant information;



- Referred-to provider;
- Start and end date of the referral (not to exceed one year);
- Diagnosis and/or Condition (entered in Notes section in HealthPAS); and
- Referral reason:
  - Consultation/diagnosis only;
  - Diagnose, treat, and/or forward to specialty provider;
  - One time visit until seen by PCP; and
  - Any additional referral limits or restrictions.

### 7.3.3. Method of Referral

A referral must be communicated by one of the following methods:

- **Electronic referral** (e.g., Gainwell Technologies HealthPAS portal or HC clinic electronic Medical Record {EMR});
- **Paper referral** (e.g., HC Referral form, prescription pad, etc.);
- **Verbal Referral** (e.g., calling an order into a specialist); or
- **Admit Order** (e.g., hospital direct admit by participant's HC clinic PCP).

### 7.3.4. Advantages of Electronic Referrals

There are many advantages to submitting an online electronic referral, including:

- **Improved Accessibility and Communication of Data** - The PCP, referred-to-provider and Department staff can access the referral online anytime;
- **Enhanced Capacity** – Resource for PCP to provide better coordinated care by having access to participant referrals entered online;
- **Integrity** - Authorized visits and/or date span of specified services are clear and concise;
- **Secure** - HIPAA compliant referral process; and
- **Timesaver** - No handling or storage of a paper referral.

Refer to the *Referrals* section of the [Trading Partner Account \(TPA\) User Guide](#) found in the **User Guides** under the *Reference Material* menu on the Gainwell Technologies Idaho Medicaid website for instructions to enter or retrieve online referrals.

### 7.3.5. Follow-up Communication Requirements for Referrals

Providers who receive Healthy Connections referrals must communicate their assessment, recommendations, or progress back to the HC PCP of record within a timely manner. Services provided for an extended period shall be reported to the PCP with an annual report, or more frequently if significant changes occur in the patient's overall health. Failure to communicate findings to the PCP may result in services being considered non-covered and subject to recoupment.

### 7.3.6. Services Not Requiring an HC PCP Referral

The following services do not require a referral by the Healthy Connections Primary Care Provider. If the service is not on this list, it may require a referral. Services are hyperlinked where applicable to direct providers to the appropriate section of the Idaho Medicaid Provider Handbook. Services must meet the requirements below and the definition of the service category to qualify.

The following services do not require a referral by the PCP:

- [Adult Developmental Disability Services](#), effective 03/13/2020;

- [Anesthesiology Services](#), effective 04/01/2007;
- [Audiology Services](#) performed in the office of a certified audiologist;
- [Children’s Developmental Disabilities Services](#), effective 09/01/2013;
- [Children’s Habilitation Intervention Services](#), effective 07/01/2019
- [Chiropractic Services](#) effective 04/01/2022
  - 18 and over, referral required after 6 visits
  - Less than 18, referral required for all visits
- [Colonoscopies](#), effective 10/01/2021;
- [Dental Services](#);
- [Durable Medical Equipment](#), effective 02/01/2016;
  - This service should be coordinated with the participant’s primary care provider.
- [Emergency Services](#), effective 01/01/2013;
  - As defined in [IDAPA 16.03.09.10.24](#) as a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
    - Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child in serious jeopardy;
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part.
- [Family Planning Services](#);
  - Specific items covered are diagnosis, treatment, contraceptive supplies, related counseling and restricted sterilization for pregnancy prevention.
- [Home Health Services](#), effective 10/01/2021;
- [Hospice Services](#), effective 02/01/2016;
  - This service should be coordinated with the participant’s primary care provider.
- [Hospital Admissions](#) resulting directly from the facility’s emergency room, effective 12/01/2012;
  - Discharge planning must be coordinated with the HC PCP.
- [Immunizations](#) without an office visit, effective 04/01/2007;
  - All providers administering immunizations are asked to either provide the participant's PCP with immunization records, or to record administered immunizations in the Idaho Immunization Registry and Information System (IRIS) to assure continuity of care and avoid duplication of services.
- [Intermediate Care Facility for Individuals with Intellectual Disabilities \(ICF/IID\) Services](#);
  - This includes all services delivered to participants residing in an ICF/IID, regardless of place of service.
- [Indian Health Clinic Services](#) provided to an American Indian/Alaskan Native;
- [Infant Toddler Program Services](#), effective 09/01/2013;
- [Influenza Shots](#);
  - Providers administering influenza shots are asked either to provide the participant’s PCP with documentation of the shot, or to record the immunization in the Idaho Immunization Registry and Information system to assure continuity of care and avoid duplication of services.
- [Laboratory Services](#) including pathology, effective 04/01/2007;
- [Licensed Midwife Services](#);
- [Mammography Services](#);
- [Occupational Therapy Services](#), effective 02/01/2016;
  - This service should be coordinated with the participant’s primary care provider.
- [Outpatient Mental Health Services](#) ;
- [Personal Care Services \(PCS\)](#);

- **[PCS Case Management](#)**;
- **Pharmacy Services** or [prescription drugs](#);
- **[Physical Therapy](#)**, effective 02/01/2016;
  - This service should be coordinated with the participant's primary care provider.
- **[Podiatry Services](#)** performed in the office;
- **[Pregnancy-Related Services](#)**, effective 01/01/2013;
  - This service should be coordinated with the participant's primary care provider.
- **[Radiology Services](#)**, effective 04/01/2007;
- **[Respiratory Services](#)**, effective 02/01/2016;
- **[School Based Health Center \(SBHC\)](#)** for acute services when coordinated with the participant's primary care provider within three business days, effective 01/01/2020;
- **[School-Based Services](#)**;
  - Includes all health-related services provided by a school district under an Individual Education Plan (IEP).
- **Services managed directly by the Department**, as defined in the Provider Handbook, Provider Guidelines;
- **[Skilled Nursing Facility Services](#)**;
  - This includes all services delivered to participants residing in a skilled nursing facility.
- **[Speech Language Pathology](#)**, effective 2/1/16;
  - This service should be coordinated with the participant's primary care provider.
- **[Sexually Transmitted Disease Testing and Treatment](#)**;
- **[Substance Use Disorder \(SUD\) Services](#)**;
  - Pursuant to the Code of Federal Regulations at Title 42, Chapter I, Subchapter A, Part 2, "Confidentiality of Substance Use Disorder Patient Records" a Healthy Connections referral is not required to access or receive SUD services for any participant with a SUD diagnosis regardless of diagnosis position, primary, secondary or tertiary.
- **[Transportation Services](#)**;
- **[Urgent Care Services](#)**, effective 01/01/2020;
- **[Vision Services](#)** performed in the offices of ophthalmologists and optometrists and eyeglasses; and
- **[Waiver Services for the Aged and Disabled](#)**.

### 7.3.7. Reimbursement for Services Requiring a Referral

It is the responsibility of the billing provider to ensure a referral is documented and meets the requirements outlined in the Provider Handbook prior to rendering services. Claims will process regardless of referral status. The referral field in the claims processing system is a misnomer and is intended for prior authorization numbers. Entering a referral number on the claim will cause the claim to deny. Services provided and billed to Medicaid without a referral, when one is required, are subject to sanctions, recoupment or both. Billing Medicaid for services without a correct and complete referral is not allowed. Any payments received as a result of a missing or incomplete referral are subject to recoupment and/or assessment of civil monetary penalties by the Department.

See the [Participant Financial Responsibility](#) section for more information about when billing participants is permissible.

### 7.3.8. School Based Health Centers

A School Based Health Center (SBHC) is defined as a health center located at an elementary, middle, or high school. College health services do not qualify as an SBHC. SBHCs do not

require a referral for **acute care services** provided to a student so long as all requirements of this section are met:

- The participant's PCP must be contacted within three business days with written or electronic documentation for coordination of care.
- Documentation must include:
  - A visit summary;
  - Prescriptions or orders issued; and
  - Any other information the PCP may need to be aware of.
- If secondary or specialty care is medically necessary, the SBHC provider will refer the student back to their HC PCP.
- The student's parent/guardian must be contacted with the visit outcome and any follow-up care recommendations.

An SBHC is eligible to be a mobile unit. A provider must enroll each of the locations under their pay-to NPI to represent which school the services would be occurring at. If a mobile SBHC provider delivered services at a non-school location, they would need to bill a place of service location that is equivalent to a generic mobile unit in addition to the place of service identifier.

The SBHC will be subject to periodic evaluation of policy compliance for care coordination by Department staff to include patient medical record reviews.

### **7.3.9. References: School Based Health Centers**

#### **a) Idaho Medicaid Publications**

"School-Based Health Centers." *MedicAide Newsletter*, May 2023, <https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf>.

### **7.3.10. Urgent Care Services**

Effective January 1, 2020, Healthy Connections referrals will not be required for urgent care services accessed at urgent care centers, Health Districts or Healthy Connections Clinics that meet the criteria below. Urgent care services for this purpose are medical services used in the treatment of acute illness or injury which require prompt attention, but generally are not serious enough to require an emergency room visit.

Participants are encouraged to always call their Primary Care Provider first as they may offer same day or walk-in appointments. If their Primary Care Provider's office is closed or they are unable to be seen immediately for an urgent medical need, they may be seen at a qualified Urgent Care, Health District or Healthy Connections Clinic. The Department encourages providers to work together within their medical neighborhoods to effectively coordinate patient care. Urgent care service providers have the option to treat participants or contact their PCP to determine if they have availability to treat an urgent medical need.

Providers that meet the criteria for urgent care services not needing a referral are:

1. **Urgent Care Centers** – for purposes of this referral policy, defined as:
  - a. Evaluates and treats a broad spectrum of illness and injury
  - b. Offers walk-in appointments as the primary scheduling model
  - c. Is open at least one additional hour per weekday outside the standard Monday-Friday 8:00-5:00, or an additional five hours on the weekend

2. **Health Districts**
  - a. Offers walk-in or same day appointments
3. **Healthy Connections Clinics** that meet the following enhanced access criteria:
  - a. Offers walk-in or same day appointments
  - b. Is open at least one additional hour per weekday outside the standard Monday-Friday 8:00-5:00, or an additional five hours on the weekend

In addition to meeting the above criteria, Urgent Care Centers, Health Districts or Healthy Connections Clinics are required to:

1. **Communicate** the visit summary directly to the patient's Healthy Connections Clinic of record within three (3) business days of the visit. At a minimum, this shall include:
  - a. Facts and Findings
  - b. Prescriptions and DME ordered
  - c. Other pertinent healthcare information
2. **Direct** the patient to their Healthy Connections Clinic of record:
  - a. For ongoing treatment or coordination of chronic/complex conditions
  - b. When specialty or follow-up care is needed
  - c. For those seeking wellness services
3. **Educate** patients when urgent care is appropriate

Providers required to meet these criteria will be subject to periodic evaluation of policy compliance. Compliance requirements to include:

1. Proof of direct communication must be documented by both the provider rendering the urgent care service AND the Healthy Connections clinic of record.
  - a. The communication requirement would be met when the urgent care service provider and Healthy Connections Clinic of record are under the same organization and share an Electronic Medical Record (EMR)
  - b. Record of visit in the Idaho Health Data Exchange (IHDE), while encouraged, without direct communication to the Healthy Connections Clinic of record does not meet the communication requirements.
2. Urgent Care Service Providers are required to, at a minimum, direct participants to their Healthy Connections Clinic of record for follow-up visits, wellness care or scheduled appointments.

**Failure to meet these requirements may result in services considered non-covered and subject to recoupment and/or a civil monetary penalty.**

### **7.3.11. References: Urgent Care Services**

#### ***a) Idaho Medicaid Publications***

Healthy Connections Urgent Care Service Referral Policy effective January 1, 2020, Information Release MA19-17 (12/13/2019). Division of Medicaid, Department of Health and Welfare, State of Idaho,

<https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3353&dbid=0&repo=PUBLIC-DOCUMENTS>

### **7.3.12. References: Referrals**

#### **a) Idaho Medicaid Publications**

"Changes in Children's Developmental Disability Services and Healthy Connections Referral Requirement." *MedicAide Newsletter*, August 2013,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/August%202013%20MedicAide.pdf>

"Healthy Connections Electronic Referral Option and Other Important Policy Updates – Effective 12/1/12." *MedicAide Newsletter*, December 2012,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/December%202012%20MedicAide.pdf>.

"Healthy Connections Primary Care Provider Webinars presented by Optum Idaho: Importance of Coordinating Behavioral Health Services with Primary Care Providers." *MedicAide Newsletter*, August 2013,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/August%202013%20MedicAide.pdf>  
Reimbursement and Referral Changes for the Idaho Medicaid Healthy Connections and Health Home Programs, Information Release MA16-02 (02/05/2016). Division of Medicaid, Department of Health and Welfare, State of Idaho,  
<http://healthandwelfare.idaho.gov/Portals/0/Providers/IRMA1602.pdf>.

Removal of Requirement for Healthy Connections Referral for Outpatient Dental Services, Information Release MA07-18 (10/01/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho,  
<https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=26569&dbid=0&repo=PUBLIC-DOCUMENTS>.

Removal of Requirement for Healthy Connections Referral for Select Services, Information Release MA07-19 (10/01/2007). Division of Medicaid, Department of Health and Welfare, State of Idaho,  
<https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=26568&dbid=0&repo=PUBLIC-DOCUMENTS>

## **7.4. Program Liaison**

The HC Program provides staff to help resolve program related problems providers may encounter. Contact information for regional Healthy Connections Representatives can be found at <https://healthyconnections.idaho.gov/>. Providers can also contact their local Provider Relations Consultant (PRC) with Gainwell Technologies to obtain information, training, or to answer billing questions. Refer to the [Directory](#), Idaho Medicaid Provider Handbook for specific contact information.

## 8. Healthy Connections Value Care

The Healthy Connections Value Care (HCVC) program, started on July 1, 2021, builds on the success of the transition to the Patient Centered Medical Home (PCMH) model of care and draws on experience from other states. Under this program, Value Care Organizations (VCOs), contracted with the Department, are held accountable for improving participant health outcomes and controlling costs. Idaho Medicaid Healthy Connections (HC) organizations may choose to form their own VCO and contract directly with the Department. Alternatively, they may choose to affiliate with hospitals, primary care organizations, and other medical service organizations to form a VCO, which then contracts with the Department. The goals of HCVC:

- Improve the health of Idahoans;
- Provide high-quality, cost effective care
- Reward organizations by sharing shared savings

New value care organization (VCO) contracts or changes in existing VCO contracts are due annually by September 1st. Each VCO must have a minimum of 2,000 attributed participants. VCO contracts must include Healthy Connections (HC) service locations and acute care hospital affiliations.

An agreement between each VCO and affiliated HC organization shall be in place prior to each performance year. This is a separate and unique agreement from the Healthy Connections Coordinated Care Agreement. It is the responsibility of the VCO to report changes in affiliated HC service locations to the Department.

- The VCO will inform the Department of their risk options.
- The Department will inform the VCO of their quality targets and the statewide standardized total cost of care per member per month (PMPM) cost.

The VCO contract with the Department will renew automatically annually. For additional information, please review the HCVC contract found on the HC website at <https://healthyconnections.idaho.gov>.

The term for the initial year of the Value Care contract will be from 07/01/2021 to 12/31/2022. The first performance period will be from 01/01/2022 to 12/31/2022 and all successive performance periods will be based on calendar year. The performance period is when VCO's will be held accountable for meeting cost and quality targets.

### 8.1.1. References: Healthy Connections Value Care

#### ***a) Idaho Medicaid Publications***

Healthy Connections Value Care, Information Release MA21-13 (04/30/2021). Division of Medicaid, Department of Health and Welfare, State of Idaho, <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=18027&dbid=0&repo=PUBLIC-DOCUMENTS>.



## 8.2. Guidelines for HC Organization Affiliation with VCOs

Under the new July 1, 2021 Healthy Connections (HC) Coordinated Care Agreement, most HC organizations are required to affiliate with a value care organization (VCO) of their choice.

Newly enrolled HC organizations will be required to affiliate with a VCO no later than August 31 annually. This requirement applies to all new HC Organizations that have contracted with Healthy Connections through May 31 of each year. These VCO affiliations will be effective for the next performance year beginning January 1<sup>st</sup> annually.

When existing HC organizations affiliated to a VCO add a new HC service location, the new HC service location will automatically be affiliated to the same VCO.

HC organizations exempt from the VCO affiliation requirement include:

- Indian health services clinics;
- Tribal clinics;
- State owned clinics; and
- Public Health Districts clinics.

The HC case management payment will continue to be paid directly to the HC organization.

## 8.3. General Value Care Terms and Conditions

Terms	Value Care Organization
Quality Measures	First year, 6 applicable quality measures.
Minimum Participants	2,000
Term of Agreement	Annual automatic renewal.
Stop Loss Threshold	\$100,000 per participant.
Stop Loss Co-Payment	20% of amount between \$100,000 and \$500,000. Cost >\$500,000 no co-payment.
Minimum Savings/Loss Threshold	Performance year savings/loss must exceed a minimum (1%) of the gross target to trigger VCO's savings or loss.
Option #1 Symmetrical Minimum/Maximum Risk Share	Year 1: 25% of savings or loss. Year 2: 50% of savings or loss. Year 3: 50% of savings or loss. Maximum risk share each year – 80%.
Option #2 Upside Savings Only	Year 1: Upside Only – 5% share only for SFY 2022. Year 2: 25% of savings or loss. Year 3: 50% of savings or loss. Maximum Risk Share Year 2 and 3 – 80%.
Maximum Savings or Risk Limit	Not to exceed 15% of VCO target Per Member Per Month.
Participant Attribution	7+ months assigned to VCO.
Target Development	Statewide.
Performance Year	January 1 – December 31 First performance year (Year 1) is January 1, 2022 – December 31, 2022.

## 8.4. HCVC Participant Attribution Model

Healthy Connections Value Care (HCVC) participants are attributed to a value care organization (VCO) for the purposes of calculating the Total Cost of Care (TCOC) and for the Quality Program. Participant attribution to a VCO is based on the Medicaid participants that are assigned to the VCO-affiliated HC service locations. For a participant's cost and member months to be included in the base year/performance year calculation, a participant must be enrolled in HC for a minimum of seven months. A participant may be assigned to different Healthy Connections Service Locations within the same VCO to be attributed.

### Attribution Example 1: 12 months of Healthy Connections Program eligibility

7 months Assigned to VCO 1.  
5 months Assigned to VCO 2.  
Participant would be attributed to VCO 1 for the entire 12-month period and all claims incurred during the period would be attributed to VCO 1 and included in the TCOC calculation.

### Attribution Example 2: 7 months of Healthy Connections Program eligibility

7 months Assigned to VCO 1.  
5 months eligible for Medicaid but not enrolled in the Healthy Connections Program.  
Participant would be attributed to VCO 1 for the 7 months they were assigned to VCO 1 and all claims incurred during the 7 month period would be attributed to VCO 1 and included in the TCOC calculation.

### Attribution Example 3: 12 months of Healthy Connections Program eligibility

6 months Assigned to VCO 1.  
6 months Assigned to VCO 2.  
Participant would not be attributed to either VCO or included in the Base Year calculation due to the participant not meeting the 7-month minimum assignment requirement to qualify for attribution.

## 8.5. Total Cost of Care (TCOC)

Total cost of care (TCOC) is the formula used to measure and evaluate the VCO's performance in controlling the cost of care provided to attributed participants. The Total Cost of Care Formula:

$$\text{VCO Gross Target PMPM} = \text{Statewide Base Year PMPM} / \text{Statewide Base Year Risk Score} \times \text{Annual Program Change Factor} \times \text{VCO Performance Year Risk Score}$$

Base Year Statewide PMPM	Base Year Statewide MARA Risk Score	Base Year Statewide Risk adjusted PMPM	Annual Program Change Factor	Performance Year VCO MARA Risk Score	Gross Target PMPM	Performance Year VCO Paid PMPM	Gross Savings/ (Loss) PMPM
1	2	3 = 1/2	4	5	6 = 3*4*5	7	8 = 7-6

\*For complete definitions for each component, please refer to the Healthy Connections Value Care contract.

### 8.5.1. Annual Program Change Factor

A statewide factor applied to trend costs forward in setting the gross target PMPM for each VCO.

### 8.5.2. VCO Gross Target Per Member Per Month (PMPM)s

Each VCO gross target is limited by a trend factor less than past growth to control costs and adjusted for the VCO’s population health by performance year risk score. Risk scores are calculated for each attributed participant each year using the Milliman MARA CXAdjuster Risk Scoring methodology. The risk score is based on all medical and pharmacy claims and not limited to those services included in the HCVC model. Both the statewide risk score and VCO level risk score is limited to attributed participants only. Managed care claims, such as behavioral health and dental, are excluded in determining the risk score.

VCO’s that achieve cost savings by spending less than their gross target, while also improving quality, can share in those savings. VCO’s that do not meet their gross target will be responsible for a share of the excess for spending beyond their target. Final VCO gross target PMPM will not be finalized until after the run-out period for the performance year.

### 8.5.3. Included Costs

The following costs will be included when calculating TCOC:

- Diagnostic services (lab tests, imaging, etc.);
- Durable medical equipment;
- Emergency medical transport;
- Hospice Care;
- Home Health services;
- Inpatient Hospital services;
- Outpatient Hospital services;
- Inpatient behavioral health;
- Outpatient facilities including ambulatory surgery; and
- Professional services (primary care, specialty care, physical therapy, speech therapy, etc.).

### 8.5.4. Excluded Costs

The following costs will be excluded when calculating TCOC:

- Behavioral health services administered through a managed-care contract;
- Dental services administered through a managed-care contract;

- Home and Community-Based Waiver Services (e.g. services provided to participants in their home or community rather than institutions, such as personal care services or meals);
- Long-term Supports & Services;
- Non-emergent medical transportation services administered through a managed-care contract;
- Nursing Home or Intermediate Care Facilities;
- Pharmacy;
- Skilled Nursing; and
- Healthy Connections Case Management Payments.

### **8.5.5. Excluded Participant Categories**

A list of Medicaid participants who may be assigned to an HC Service Location within the VCO, but who are excluded from the HCVC program:

- Dual-eligible participants (eligible for both Medicaid and Medicare);
- Participants made eligible through Medicaid Expansion. This exclusion is applicable only to performance year 2022 (Year 1);
- VCO Risk Options:
  - For CY 2022 (Year 1), VCO's can choose to participate free of financial risk and with a limited share in rewards (upside only), in order to understand their data and learn what does and does not work for their population;
  - VCO's that choose to take on risk will share in rewards if they meet budget and quality targets; and
  - VCO's that accept risk but exceed their budget target will be responsible for a share of that excess spending.

## **8.6. Quality Performance Program**

The goal of the Quality Performance Program is to incentivize continuous improvement in quality measures. All "qualifying" quality measures are included in the value care organization (VCO)'s quality payment calculation. To be considered a "qualifying" quality measure, the VCO shall have a minimum of thirty (30) participants in the base and performance year measure's denominator. The quality measure's baseline score is based on participants attributed to the VCO. For the first performance year, quality targets will be based on SFY 2019. The quality measure performance outcome will be calculated annually based on the participants attributed to the VCO during the performance year.

### **8.6.1. Quality Measure Targets**

Quality targets will help incentivize continuous improvement toward the statewide goal over time. The statewide goal is set at the higher of the Statewide average or the National 90<sup>th</sup> percentile score for the Medicaid program. Value care organizations (VCO) will receive credit for meeting quality targets if they demonstrate an incremental increase from their individual baseline score or meet the statewide goal. Quality measures will help ensure that VCOs are improving the quality of care and not just reducing costs.

### **8.6.2. Common Set of Quality Measures**

The performance year (CY2022) six quality measures are outlined below. Specific criteria for each measure can be found on the website. The measure timeframes are automatically calibrated to the specific timeframe of the HCVC program. For example, if measure reads 'per year' the year measured coincides with the HCVC program performance year.

Healthy Connections Quality Measures	
1	<b>HEDIS CDC DIABETES HBA1C TEST</b> indicates the percentage of patients with type 1 or type 2 diabetes, aged 18 to 75 years, who had an HbA1c test done.
2	<b>HEDIS W30_15 6 or more well child visits in first 15 months; indicates</b> the percentage of children, during their first 15 months of life, who had six or more well-child visits with a primary care practitioner.
3	<b>HEDIS WCV WELL CARE PCP VISITS ADOLESCENTS</b> indicates the percentage of adolescents, aged 3-21 years, who had at least one comprehensive well-care visit with a primary care physician (PCP) or a gynecologist during the measurement year.
4	<b>HEDIS BCS BREAST CANCER SCREENING</b> indicates the percentage of women, aged 52 to 74 years at the end of the measurement period, who had a mammogram done during a 27- month measurement period.
5	<b>AMBULATORY CARE EMERGENCY DEPT VISITS</b> Calculates the number of emergency department (ED) visits per 1,000 enrolled months.
6	<b>READMISSIONS WITHIN 30 DAYS AGE 18 TO 64 and READMISSIONS WITHIN 30 DAYS AGE &gt; 64</b> calculates the percentage of acute inpatient stays during the reporting time period, for Participants aged 18 years and older, that were followed by an acute readmission for any diagnosis within 30 days of discharge.

### 8.6.3. Annual Improvement Targets

To qualify for incentive payments value care organization (VCO) shall demonstrate the greater of a ten percent (10%) incremental improvement from the difference between the state goal and VCO baseline score, OR meet the statewide goal. The incremental improvement must be a minimum of three percent (3%) points from the VCO’s baseline score. Quality measure performance targets will be provided to each VCO prior to the performance year.

Improvement Target Formula	
Initial Calculation	Improvement target
<b>[State Goal] – [VCO Baseline] = [Difference]</b>	<b>[VCO Baseline] + [Incremental Improvement] = [Improvement Target]</b>
<b>[Difference] x 10% = [Incremental Improvement]</b>	

When the difference between the statewide goal and the VCO baseline is significant, the VCO will receive credit for the measure by meeting the incremental improvement target.

**Example 1: Improvement Target**

VCO’s baseline score for quality measure is 30%. The statewide goal is 70%. The incremental improvement target would be 34%.

**Initial Calculation:**  $[70.0\%] - [30.0\%] = 40\% \times 10\% = 4\%$

The improvement target would apply as the initial calculation is greater than the 3% point minimum.

**Improvement Target:**  $30.0\% + 4.0\% = 34\%$

In some cases, when the incremental improvement calculation does not result in a significant improvement, the minimum three percent (3%) point improvement applies.

**Example 2: Improvement Target**

VCO’s baseline score for quality measure is 50.6%. The statewide goal is 70%. The incremental improvement target would be 53.6%.

**Initial Calculation:**  $[70.0\%] - [50.6\%] = 19.4\% \times 10\% = 1.94\%$

The incremental improvement target is less than the 3% point, thus the minimum improvement of 3% point is applied, resulting in an improvement target of 53.6%.

**Improvement Target:**  $50.6\% + 3\% = 53.6\%$

In some instances, the improvement target based on meeting the three percent (3%) point minimum could exceed statewide goals. In this case, the VCO must only meet the statewide goal to receive credit for this measure.

**Example 3: Improvement Target**

VCO’s baseline score for the quality measure is 66.7% while the statewide goal is 68%.

**Initial Calculation:**  $[68\%] - [66.7\%] = 1.3\% \times 10\% = 0.13\%$

The incremental improvement target is less than the 3%.

**Improvement Target:**  $66.7\% + 3\% = 69.7\%$

However, the 3% point minimum improvement point is not applicable, as the result exceeds the statewide goal of 68%. The VCO would only need a 1.3% increase to meet the improvement target, which in this situation is meeting the statewide goal.

### 8.6.4. Quality Performance Payment Distribution

As an organization meets more statewide goals or improvement targets, it receives a higher payment. If the VCO does not meet the improvement target or statewide goal on any of their designated measures, the VCO would not qualify to receive any shared savings.

Quality Performance Payment Distribution			
# Applicable Measures	# Measures Target Met	Savings Payout	Payout Calculation
6	6	100%	4

6	5	100%	4
6	4	100%	4/4
6	3	75%	3/4
6	2	50%	2/4
6	1	25%	1/4
6	0	0%	0/4

### 8.6.5. Quality Measures Under Consideration for Future Years

Idaho Medicaid will be collaborating with participating VCOs and a broad group of stakeholders on the development of future year quality measures. Each year Idaho Medicaid will publish, by the end of the third quarter, the set of quality measures that will apply to participating VCOs the following year.

## 8.7. Data Deliverables

To support value care organizations (VCO) in their pursuit of providing cost-effective quality care, data deliverables will be shared by the Department as outlined in the Healthy Connections Value Care Contract Exhibit 2, Article II data deliverable schedule. VCOs will have access to a secure SFTP account where this information will be housed. A listing of the data deliverables is as follows:

- **Participant Enrollment Report.** Participant enrollment data outlined in the data dictionary for participants assigned to Healthy Connection Service Locations participating with a VCO. The VCO shall receive this report during the Performance Year and for a period prior to the Performance Year as defined in Article II.
- **Participant Attribution Report.** A report reflecting the assigned participants, outlined in the data dictionary, who qualify as attributed participants to the VCO during the base year for purposes of determining the VCO's gross target Per Member Per Month (PMPM).
- **MARA Risk Score.** A report reflecting the MARA risk score for each participant attributed to the VCO during the performance year for purposes of determining the VCO's gross target PMPM. Additional MARA Risk Score reports will be provided to the VCO for each participant assigned to the VCO during the performance year.
- **Medical Claims Report.** VCO shall receive medical claim data for participants assigned to the VCO during the performance year and for a period prior to the performance year.
- **Pharmacy Claims Report** VCO shall receive pharmacy claims data for participants assigned to the VCO during the performance year and for a period prior to the performance year.
- **Initial and Interim Total Cost of Care (TCOC) Saving/Loss Report.** Initial and interim TCOC savings/loss report reflecting the base year figures including base year statewide actual cost PMPM, base year statewide risk score, risk standardized PMPM estimated trend factor, performance year VCO risk score for currently assigned participant and estimated VCO gross target PMPM. Interim updates of the VCO's TCOC calculation will be provided during the performance year.
- **Quality Performance Program Report.** An initial report reflecting the VCO's quality performance will be provided prior to the performance year, containing the VCO quality baseline data, statewide quality average, statewide quality targets, VCO's quality targets and quality performance for current participant enrollment. Interim updates of the VCO's quality performance will be provided during the performance year.

- **Gaps in Care Report.** A report reflecting a list of participants assigned to HC service locations participating with a VCO and indicating if the applicable quality measure(s) numerator and denominator criteria have not been met. This report to be provided during the performance year.

## **8.8. Cost Settlement Process**

The HCVC cost settlement process can be found in the HCVC Contract Exhibit 1, Article VI.

## **8.9. Advisory Groups**

### **Statewide Care Collaborative (SCC)**

An SCC will be established by the Department as a venue for the Department and the value care organizations (VCO) to monitor and evaluate the performance of the program in meeting its goals and objectives. The SCC will also provide a forum for raising concerns and recommending solutions regarding issues that may arise in the delivery of healthcare to Participants. SCC participation will include representatives of the Department and representatives of each contracted VCO in the state.

### **Community Health Outcome Improvement Coalition (CHOICE)**

The Department may establish or utilize an existing community advisory group to serve as the CHOICE for each region. The CHOICE will help identify opportunities to improve health and wellness, create health equity and address the social determinants of health in their communities, among other activities. The VCOs in each region, with input from the Department, will facilitate meetings, manage agendas and establish topics for discussion. The CHOICE will meet quarterly.

## **8.10. Contract Compliance**

The Department will monitor the contracted value care organizations (VCO) for compliance with the Healthy Connections Value Care contract and exhibits to ensure that quality and access to care are not impacted adversely. The Department will monitor Healthy Connections enrollment/disenrollment reports and cost/utilization patterns of Medicaid participants attributed to a VCO provider. The Department will also review the shared savings payment methodology and the data and analyses used to establish trends, baselines, benchmarks, risk adjustments and other inputs which establish the shared savings payments and recommend necessary adjustments to ensure the goals for the HCVC program are being met.



## 9. Covered Services and Limitations: General

### 9.1. Medical Necessity

State Medicaid programs are mandated to only pay for medically necessary services and items covered in Idaho Medicaid's State Plan for adults twenty-one years of age and older. A service or item is considered medically necessary when it is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, cause functionally significant deformity or malfunction. Only effective treatments that are the most conservative (including setting, duration and frequency), or least costly, are considered eligible. The setting a participant receives services in, and the methods or items utilized must be safe and effective. The service or item must be of a quality that meets professionally-recognized standards of health care and substantiated by records including evidence of such medical necessity and quality. Items and services are not provided for the convenience of the patient, provider or caregiver. Diagnoses on claim submissions must support medical necessity for the services provided.

Children up to the age of 21 have an expanded definition for medical necessity to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan. Although services under EPSDT do not have to be within the State Plan, they must fall into a category of service listed in 1905(a) of the Social Security Act, be considered safe and effective, and meet acceptable standards of medical practice. If services not covered under the State Plan are needed, a [Request for Additional Services \(RAS\) form](#) must be submitted to the Department for prior authorization.

A service or item that has received FDA approval or its own CPT®/HCPCS code is not automatically considered a medically necessary service or item. It must be consistent with generally accepted professional medical standards of care and be verified through independent study published in peer-reviewed literature before being considered for medical necessity. In the absence of Idaho Medicaid direction for medical necessity criteria of covered items and services, the provider should default to Medicare standards.

Screening services are generally not medically necessary. Screening is used to detect an undiagnosed disease where early detection may prevent harm, and where the patient has no signs, symptoms, laboratory evidence, radiological evidence or personal history of the disease. Idaho Medicaid covers screening services as mandated by the Affordable Care Act (ACA) and recommended by the US Preventive Services Task Force (USPSTF) with an "A" or "B" recommendation, or when listed in the American Academy of Pediatrics Bright Futures periodicity schedule.

See [Non-Covered and Excluded Services](#) for information about items and services that may not be reimbursable. See the [Early & Periodic Screening, Diagnostic & Treatment \(EPSDT\)](#) section for more information and how to request services that may exceed those under State Plan for participants under the age of 21.

#### 9.1.1. References: Medical Necessity

##### a) Federal Regulations

"Definitions." Social Security Act, Sec. 1905(r) (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1905.htm](https://www.ssa.gov/OP_Home/ssact/title19/1905.htm).

The Patient Protection and Affordable Care Act. H.R. 3590 (2010). Government Printing Office,  
<https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

State Plans for Medical Assistance, 42 U.S.C. Sec. 1396a (1984). Government Printing Office, <https://www.govinfo.gov/content/pkg/USCODE-2017-title42/pdf/USCODE-2017-title42-chap7-subchapXIX-sec1396a.pdf>.

"State Plans for Medical Assistance." Social Security Act, Sec. 1902(a)(30) (1935). Social Security Administration, [https://www.ssa.gov/OP\\_Home/ssact/title19/1902.htm](https://www.ssa.gov/OP_Home/ssact/title19/1902.htm).

Sufficiency of Amount, Duration, and Scope, 42 CFR 440.230(d) (1981). Government Printing Office, <https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-230.pdf>.

### ***b) State Regulations***

"Definitions: I Through O." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 011. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 880 – 883. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255 (2006). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255/>.

"Prevention Services." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 580 – 649. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

## 9.2. Experimental/Investigational Services

The Department uses the terms experimental and investigational interchangeably. Treatments and procedures are considered experimental if they are used to gain further evidence or knowledge, or to test the usefulness (i.e., efficacy) of a drug or treatment. All services and follow-ups directly associated with an experimental service are also excluded from reimbursement. The Department lists services it considers experimental throughout the handbook for provider convenience, however, on services without stated guidance from the Department providers bear a responsibility to determine if a service meets the definition of [Medical Necessity](#) and if it would be considered experimental. A service would be experimental if:

- It is being provided as part of a phase 1 clinical trial;
- There is inadequate data to provide the reasonable expectation that the service would be as effective as the standard treatment for a condition;
- Expert opinion suggests additional information is needed to assess the safety or efficacy of a treatment or procedure;
- It is determined experimental or investigational under Medicare or their local area contractor, Noridian Healthcare; or
- It is considered investigational by the Food and Drug Administration (FDA).

Services determined to be experimental are not eligible for coverage under Early & Periodic Screening, Diagnostic & Treatment (EPSDT). Procedures and treatments may be eligible for coverage with a prior authorization under a focused case review on a case-by-case basis for participants of any age with a life threatening medical illness and no other available treatment options. The Department may at its discretion seek an independent professional opinion if there is insufficient information to render a coverage decision. A focused case review involves a Department analysis of the proposed procedure or treatment and:

- The anticipated benefit and risks to the participant's health;
- Documentation of the participant's previous treatments and outcomes;
- Medicare's coverage in national coverage guidelines;
- The phase of clinical trial the procedure or treatment is in (if applicable);
- Written guidance from national organizations;
- Clinical data and peer-reviewed literature;
- Ethics Committee review, if appropriate; and
- A cost-benefit analysis consisting of:
  - Estimated long-term cost if the request is approved or denied; and
  - Potential long-term impacts to Idaho Medicaid if the request is approved.

Services approved under a focused case review that fall into Medicare's clinical trial policy, investigational device exemption policy or coverage with evidence development must use modifiers Q0 and Q1 on outpatient claims to differentiate between routine and investigational clinical services. ICD-10-CM Z00.6 must be included on the claim in the primary or secondary position.

Outpatient Experimental/Investigational Modifiers	
Modifier	Description
Q0	Investigational clinical service provided in a clinical research study that is in an approved clinical research study. This modifier will price the claim line at zero.
Q1	Routine clinical service provided in a clinical research study that is in an approved clinical research study. This modifier will not affect claim line pricing.

## 9.2.1. References: Experimental/Investigational Services

### a) CMS Guidance

Items and Services Not Covered Under Medicare. Centers for Medicare & Medicaid Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-and-Services-Not-Covered-Under-Medicare-Booklet-ICN906765.pdf>.

"Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims." *MLN Matters MM8401*, June 2014, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8401.pdf>.

"National Coverage Determination (NCD) for Routine Costs in Clinical Trials (310.1)." *Medicare National Coverage Determinations (NCD) Manual*. Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=1>.

"Non-Covered Services." *Noridian Healthcare Solutions*, 16 April 2018, [https://med.noridianmedicare.com/web/jeb/topics/non-covered-services#non-Covered\\_statutorily\\_excluded](https://med.noridianmedicare.com/web/jeb/topics/non-covered-services#non-Covered_statutorily_excluded).

### b) Idaho Medicaid Publications

"Billing Idaho Medicaid with CMS Modifiers Q0 and Q1." *MedicAide Newsletter*, December 2016, <https://www.idmedicaid.com/MedicAide%20Newsletters/December%202016%20MedicAide.pdf>.

### c) State Regulations

"EPSDT Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 880 – 889. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Excluded Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 390. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Investigational Procedures or Treatments: Procedural Requirements." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 443. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

Medical Assistance Program – Services to be Provided – Experimental Services or Procedures Excluded, Idaho Code 56-209(d) (2006). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-209d/>.

### 9.3. Qualifying Clinical Trials

The definition of a “qualifying clinical trial” is a trial related to “the prevention, detection, or treatment of any serious or life-threatening disease or condition.” This includes a trial funded by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), or other federal-approved entities.

Routine costs are covered during a clinical trial and include any item or service provided to “prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the provision of such items or services to the participant would otherwise be covered outside the course of participation in the qualifying clinical trial under the state plan or waiver. The investigational item or service that is the subject of the clinical trial is not covered. Services not covered under the state plan or waiver but required by the clinical trial are not covered.

Routine participant costs are covered regardless of where the clinical trial is conducted, including out-of-state, or based on whether the principal investigator or provider treating the participant in connection with the clinical trial is outside of the network of the participant’s MCO. Usual requirements regarding rates, billing processes, and prior authorization for out-of-state care, diagnostics, and interventions apply. Routine participant cost does not include any item or service provided to the participant solely to satisfy data collection and analysis for the qualifying clinical trial that is not used in the direct clinical management of the participant and is not otherwise covered under the state plan or waiver.

Idaho Medicaid requests for an **attestation form** to be completed and faxed to the Medical Care Unit at 877-314-8782 before participants start receiving services through a clinical trial. The attestation form must be signed by the principal investigator (PI) or their delegated authority (if they have a documented process for the delegation of authority) and the participant’s health care provider that is providing the care during the trial.

Participation in a clinical trial itself does not require prior authorization (PA). However, services associated with routine medical costs while in a clinical trial may have PA requirements that still apply. Submit completed PA request using an Idaho Medicaid Surgery & Procedure PA form, when required. Fax the complete form and required documentation to 877-314-8779. For participants in an MCO, providers must follow the process required by the MCO.

#### 9.3.1. References: Qualifying Clinical Trials

##### a) CMS Guidance

Mandatory Medicaid Coverage of Routine Patient Costs Furnished in Connection with Participation in Qualifying Clinical Trials,  
<https://www.medicare.gov/federal-policy-guidance/downloads/smd21005.pdf>

##### b) Idaho Medicaid Publications

“Qualifying Clinical Trials.” *MedicAide Newsletter*, May 2023,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf>.

## 9.5. Service Limitations

Service limitations restrict services based on state and federal rules and regulations. Each procedure and revenue code may be reviewed for a variety of limitations. Limitations include, but are not limited to:

- Services bundled when rendered by the same provider;
- Amount of services or items in a given time frame;
- Reimbursement caps during a time period;
- Medical necessity;
- Age of the participant; and
- Lifetime procedures.

Some services that exceed limitations may be covered with a prior authorization. Refer to your specific [Provider Guidelines](#) carefully for additional information.

Policy limitations can be reviewed on request if the allowed amount doesn't meet the average participants' needs. Supporting documentation should be submitted to demonstrate why the current limitation would not meet the average participant's medical needs. Requests may be submitted to [MCPT@dhw.idaho.gov](mailto:MCPT@dhw.idaho.gov).

## **9.6. Informational Codes**

Services represented by informational only codes are not excluded from coverage by statute and meet all technical requirements for coverage, but have been determined non-covered for separate reimbursement because they are considered reimbursed in the coverage of another procedure code.

Informational only codes do not appear on the Idaho Medicaid Fee Schedule as they are considered non-covered services for the purposes of reimbursement. A code that is informational only is not separately reimbursable regardless of the revenue code, CPT® or HCPCS code selected for billing. Services coded as informational only cannot be billed under a CPT® or HCPCS defined as unlisted or miscellaneous or billed under a revenue code that does not require a CPT® or HCPCS. These billing practice will be subject to recoupment and penalties. See Idaho Medicaid Claim Standards in the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for more information about correct coding.

### **9.6.1. References: Informational Codes**

#### **a) Idaho Medicaid Publications**

"Non-Covered Services." *MedicAide Newsletter*, April 2023,  
<https://www.idmedicaid.com/MedicAide%20Newsletters/April%202023%20MedicAide.pdf>.

## 9.7. Non-Covered and Excluded Services

Specific non-covered services and circumstances are detailed throughout the provider handbook. Non-covered services are not excluded from coverage by statute and meet all technical requirements for coverage, but have been determined non-covered because of one of the following:

- The service is not within the scope of the participant's eligibility for coverage;
- The service requires a Healthy Connections referral and one isn't available;
- The participant has exhausted their allowed amount;
- The service is covered in a bundle with another service, and may not be unbundled; or
- The service is not reasonable and medically necessary. See the [Medical Necessity](#) section for more information.

Services represented by codes not appearing on the Idaho Medicaid Fee Schedule are considered non-covered services.

Excluded services are those services that are not allowed to be covered by state or federal statute or rule. See the [List of Excluded Services](#) section for more information.

The following fees and situations do not fall under the Department's definition of a non-covered or excluded service and can never be billed to a participant:

- No-show or missed appointment fees;
- Other insurer's co-pays;
- Failure on the part of the provider to submit a complete and correct claim to the Department or other payor;
- Failure by the provider to submit a complete and correct request for prior authorization from the Department or other payor;
- Claims voided by the provider;
- Failure of the provider to follow any payor's policy or procedure; or
- Any recoupment or penalties the provider receives as a result of their action or inaction.

A service that is non-covered or excluded is not reimbursable regardless of the revenue code, CPT® or HCPCS code selected for billing. Non-covered or excluded services billed under a CPT® or HCPCS defined as unlisted or miscellaneous will be subject to recoupment and penalties. Non-covered or excluded services billed under a revenue code that does not require a CPT® or HCPCS will also be subject to recoupment and penalties. See Idaho Medicaid Claim Standards in the [General Billing Instructions](#), Idaho Medicaid Provider Handbook for more information about correct coding. See [Participant Financial Responsibility](#) section for information on when and how participants may be billed.

### 9.7.1. List of Excluded Services

Services excluded from coverage by statute or rule include:

#### **Acupuncture**

#### **Biofeedback Therapy**

Biofeedback for urinary incontinence, however, is a covered service.

#### **Complications**



The treatment of complications, consequences, or repair of any excluded medical procedure is not covered. Medicaid may authorize treatment with supporting documentation from a physician if the resultant condition is determined by Medicaid to be life threatening.

### **Cosmetic Surgery**

All surgery that is generally cosmetic in nature is excluded from payment unless it is found to be medically necessary, such as reconstructive surgery, and is prior authorized.

### **Elective Treatments**

Elective medical and surgical treatments are not covered without a prior authorization except for family planning services.

### **Eye Exercise Therapy**

### **Fertility-Related Services**

Fertility-related services are not covered. This includes: testing; artificial insemination; consultations; counseling; donation of ovum, sperm, or surrogate womb; genetic testing and/or counseling for family planning; in vitro fertilization; office exams; penile implants; or reversal of sterilization.

### **Group Exercise Therapy**

### **Group Hydrotherapy**

### **Experimental/Investigational Services**

### **Laetrile Therapy**

### **Naturopathic Services**

### **Screening Services**

Screening services are excluded except those with recommendations of "A" or "B" by the United States Preventive Services Task Force (USPSTF) or identified in the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule. In the event that recommendations from the USPSTF and AAP conflict, the Department follows the USPSTF.

### **Surgical Procedures on the Cornea for Myopia**

### **Vitamin Injections**

Vitamin injections are not covered if they are not needed for a specific diagnosis.

## **9.7.2. Exceptions to Non-Covered and Excluded Services**

Some non-covered or excluded services and procedures that require treatment, services, or supplies not included in the regular scope of Medicaid coverage may be payable when identified as medically necessary during a Child Wellness exam, sometimes referred to as Early & Periodic Screening, Diagnostic & Treatment (EPSDT). Coverage under EPSDT must be prior authorized by Medicaid and is not available for experimental or investigational services. See the [Early & Periodic Screening, Diagnostic & Treatment \(EPSDT\)](#) section for more information.

### 9.7.3. References: Non-Covered and Excluded Services

#### a) CMS Guidance

Items and Services Not Covered Under Medicare. Centers for Medicare & Medicaid Services, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Items-and-Services-Not-Covered-Under-Medicare-Booklet-ICN906765.pdf>.

"Non-Covered Services." *Noridian Healthcare Solutions*, 16 April 2018, [https://med.noridianmedicare.com/web/jeb/topics/non-covered-services#non-Covered\\_statutorily\\_excluded](https://med.noridianmedicare.com/web/jeb/topics/non-covered-services#non-Covered_statutorily_excluded).

#### b) Idaho Medicaid Publications

"Non-Covered Services." *MedicAide Newsletter*, April 2023, <https://www.idmedicaid.com/MedicAide%20Newsletters/April%202023%20MedicAide.pdf>.

"Screening Services Not Mandated are Statutorily Excluded from Reimbursement." *MedicAide Newsletter*, March 2018, <https://www.idmedicaid.com/MedicAide%20Newsletters/March%202018%20MedicAide.pdf>.

#### c) Regulations

"EPSDT Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 880 – 889. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Excluded Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 390. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

## **9.8. Dental**

Dental services are administered through Idaho Smiles as of July 1, 2011. No other claims are payable through Gainwell Technologies unless otherwise explicitly noted. All reimbursement for dental claims and services is handled through Idaho Smiles. Please call 1 (855) 235-6262 or visit the [Idaho Smiles](#) website for more information on this program.

See the [Ambulatory Surgical Centers](#), Idaho Medicaid Provider Handbook for coverage of dental procedures in an ASC.

See the [Physician and Non-Physician Practitioner](#), Idaho Medicaid Provider Handbook for coverage of dental anesthesia for pediatrics provided in the office.

## **9.9. Early Intervention Services**

Early Intervention Services are designed to work with families to meet the developmental needs of each child. Services are provided through Individuals with Disabilities Education Act (IDEA) Part C in accordance with 42 CFR 440.130(d). As the lead agency for IDEA Part C services, the Infant Toddler Program (ITP) may receive Medicaid reimbursement as detailed in the Department Intra-Agency Agreement for these medically necessary services through the following Medicaid benefits:

- Intake Screening;
- Developmental Screening;
- PT, OT, SLP Evaluations;
- Developmental Evaluation;
- Early Intervention Assessment;
- Early Intervention;
- Joint Visit;
- Teaming;
- Interpretive Services;
- Service Coordination;
- Transportation; and
- Assistive Technology.

### **9.9.1. Early Intervention Services Eligibility**

Eligibility for Early Intervention Services is determined by ITP in accordance with IDEA Part C requirements and Medicaid regulations as specified in the Department Intra-Agency Agreement available at [id.medicaid.com](http://id.medicaid.com) under the "Reference Material" tab. To be eligible for Medicaid reimbursement for covered services, the child must:

- Be age birth through the end of their 36th month; and
- Have a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay; or
- Experience delays in one or more of the following areas:
  - Cognitive development;
  - Physical development, including vision and hearing;
  - Communication development;
  - Social or emotional development; or
  - Adaptive development.

### **9.9.2. Evaluations**

Evaluations must support services billed to Medicaid, be updated as needed to accurately reflect the child's current status and be recommended by a physician. Evaluations completed for educational services only cannot be billed to Medicaid. Evaluations must include the following information:

- Summary of Findings;
- Recommendations for treatment; and
- Dated signature of professional completing the evaluation.

### **9.9.3. Assessments**

Assessments must support services billed to Medicaid and be used to identify strengths and needs and services appropriate to meet those needs. Assessments must include the following information:

- Indication the parent or legal guardian of the child were included in the assessment process; and
- Dated signature of professional completing the assessment.

### **9.9.4. Documentation**

The Infant Toddler Program must ensure a child's record contains information in accordance to IDEA Part C requirements and all Medicaid regulations as detailed in the Department Intra-Agency Agreement. The following information must be included in the record of each child enrolled in ITP:

- Eligibility Determination;
- Physician recommendation;
- Evaluations/Assessments;
- Individualized Family Service Plan (IFSP);
- Continuing Service Report(s); and
- Other child specific documentation listed in the Department Intra-Agency Agreement.

### **9.9.5. Provider Staff Qualifications**

Early intervention services for infants and toddlers enrolled in Idaho Medicaid are provided by the ITP. The ITP must hold a valid Idaho Medicaid provider agreement and comply with all provider enrollment and screening requirements as specified in [IDAPA 16.03.09](#).

All personnel providing early intervention services must be employed by or contracted with the ITP, meet established certification or licensing standards, meet IDEA, Part C requirements and meet all Medicaid regulations as specified within the Department Intra-Agency Agreement.

### **9.9.6. Medicaid Reimbursable IDEA Part C Services**

IDEA Part C services reimbursed based on the [early intervention fee schedule](#) include:

- Intake Screening;
- Developmental Screening;
- PT, OT, SLP Evaluations;
- Developmental Evaluation;
- Early Intervention Assessment;
- Early Intervention;
- Joint Visit;
- Teaming; and
- Interpretive Services.

IDEA Part C services reimbursed in ways other than the [early intervention fee schedule](#) include:

- Service Coordination;
- Transportation; and

- Assistive Technology.

When providing services, the Infant Toddler Program must ensure early intervention services are provided in accordance to IDEA Part C requirements and Medicaid regulations as detailed in the Department Intra-Agency Agreement.

### **9.9.7. Payment for Services**

Medicaid reimburses for early intervention services in accordance with Medicaid established rates and reimbursement methodology. The ITP must:

- Accept Medicaid payment as payment in full and may not bill participants for the balance;
- Ensure contracted providers do not submit a separate claim to Medicaid as the performing provider for services billed under ITP's provider number;
- Pursue third party payments before billing Medicaid for all services except screening, evaluation and assessment; and
- Provide [Virtual Care Services](#) in accordance with the Idaho Medicaid Provider Handbook.

Reimbursement is subject to pre-payment and post-payment review in accordance with [Section 56-209\(h\)\(j\)\(3\)](#), Idaho Code and recoupment in accordance with [IDAPA 16.05.07](#), "The Investigation and Enforcement of Fraud, Abuse and Misconduct."

### **9.9.8. Prior Authorization**

Prior authorization is not required for services on the [early intervention fee schedule](#). Prior authorization is required for transportation and certain durable medical equipment and supplies. Prior authorization will be based on a determination of medical necessity made by DHW or its designee.

### **9.9.9. Procedure Codes**

All claims submitted must contain a 5-digit health related service procedure code for billing. See the [early intervention fee schedule](#) for covered services and additional information. Treatment must be provided in accordance with the IFSP.

### **9.9.10. Place of Service Codes**

Early Intervention services can only be provided in the following POS:

- 12 Home; or
- 99 Other (Community).

## 9.10. Interpretive Services

Providers are required by law to provide interpretive services to assist participants who are blind, deaf or who do not speak or understand English. This requirement may be waived if an emergency situation exists with an imminent threat to the safety and welfare of the participant or public, or it may be waived if the participant specifically requests an adult family member or friend be their interpreter/translator.

### 9.10.1. Interpretive Services Documentation

Documentation must be maintained to support reimbursement of interpretive services. At a minimum documentation must contain:

- The name and Medicaid Identification Number of the participant;
- If services are not for the participant, the name of the person and their relationship to the participant's care;
- The name, title and signature of the Medicaid provider rendering services;
- Description of the Medicaid service being received, and the type of interpretive service provided;
- The name, title and signature of the person rendering interpretive services;
- The date, time and duration of the interpretive services; and
- The necessity for any wait time being requested.

The need for interpretive services must be in the individualized education plan (IEP) if provided for a school-based service.

### 9.10.2. Interpretive Services for Sterilization Procedures

The interpreter/translator is responsible for ensuring the sterilization consent form is effectively, accurately and impartially communicated to the participant or their guardian. The statement certifies the interpreter/translator's discharge of their duty, their belief that the participant understood the procedure, and that the participant was allowed to ask questions. If the interpreter/translator fails to complete the statement correctly, all claims regarding the sterilization will be denied including claims from the hospital, physician and anesthesiologist. See Sterilization Procedures in the [Physician and Non-Physician Practitioner](#), Idaho Medicaid Provider Handbook for more information.

### 9.10.3. Interpretive Services – Reimbursement

Idaho Medicaid will reimburse for interpretation, translation, Braille and sign language services provided to participants in person or through virtual care. Reimbursement is also available when interpretive services are provided to the parent or guardian of a child under 18. The service is only eligible for reimbursement if the provider has no alternative means of oral or written communication. No additional reimbursement is available for multilingual providers that share a language with the participant. Interpreters and translators must meet state and professional licensure requirements and be at least eighteen years of age. See the [Virtual Care Services](#) section for more information about reimbursement eligibility using virtual care services.

Idaho Medicaid does not reimburse for:

- Administrative services such as:
  - Scheduling or cancelling appointments;
  - Making reminder calls;
  - The interpreter's travel time; or
  - No show appointments;
- Services in conjunction with a non-covered, non-reimbursable, or excluded service;

- Services provided by an immediate family member such as a parent, spouse, sibling or child;
- Services provided through a Medicaid managed care contractor. Contact the managed care contractor to see if they reimburse separately for interpretive services;
- Teaching sign language;
- Providers not on the fee-for-service model;
- Services through institutional providers, hospitals or facilities; or
- The interpreter or translator's waiting time, except when the participant is in surgery or receiving other covered services such as radiology.

Interpretive Services are billed under T1013 (Language Interpretive – Oral Services, per 15 minutes) and T1013-CG (Sign Language Interpretive Services, per 15 minutes).

#### **9.10.4. References: Interpretive Services**

##### ***a) Federal Guidance***

Guidance on Nondiscrimination in Telehealth: Federal Protections to Ensure Accessibility to People with Disabilities and Limited English Proficient Persons. Office for Civil Rights, Department of Health and Human Services, <https://www.hhs.gov/sites/default/files/guidance-on-nondiscrimination-in-telehealth.pdf>.

##### ***b) Federal Regulations***

American with Disabilities Act of 1989. 104 STAT. 327 (1990). Government Printing Office, <https://www.gpo.gov/fdsys/granule/STATUTE-104/STATUTE-104-Pg327/content-detail.html>.

Civil Rights Act of 1964, Title VI. 78 STAT. 241 (1964). Government Printing Office, <https://www.gpo.gov/fdsys/granule/STATUTE-78/STATUTE-78-Pg241/content-detail.html>.

Equal Opportunity for Individuals with Disabilities, 42 U.S.C. CH. 126 (1990). Government Printing Office, <https://www.gpo.gov/fdsys/pkg/USCODE-2009-title42/html/USCODE-2009-title42-chap126.htm>.

Nondiscrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance, 45 CFR 84 (1977). Government Printing Office, <https://www.ecfr.gov/cgi-bin/text-idx?SID=8f4679a063515aae4c95f7b930716d7c&mc=true&node=pt45.1.84&rgn=div5>.

Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance and... Under Title I of The Patient Protection and Affordable Care Act, 45 CFR 92 (2016). Government Printing Office, <https://www.ecfr.gov/cgi-bin/text-idx?SID=8f4679a063515aae4c95f7b930716d7c&mc=true&node=pt45.1.92&rgn=div5>.

Nondiscrimination Under Programs Receiving Federal Assistance Through the Department of Health and Human Services Effectuation of Title VI of the Civil Rights Act of 1964, 45 CFR 80 (1979). Government Printing Office, <https://www.ecfr.gov/cgi-bin/text-idx?SID=8f4679a063515aae4c95f7b930716d7c&mc=true&node=pt45.1.80&rgn=div5>.

Other Applicable Federal Regulations, 42 CFR 430.2 (1988). Government Printing Office,



[https://www.ecfr.gov/cgi-bin/text-idx?SID=8f4679a063515aae4c95f7b930716d7c&mc=true&node=se42.4.430\\_12&rgn=div8](https://www.ecfr.gov/cgi-bin/text-idx?SID=8f4679a063515aae4c95f7b930716d7c&mc=true&node=se42.4.430_12&rgn=div8).

Rehabilitation Act of 1973, Section 504. H.R. 8070 (1973). Government Printing Office, <https://www.gpo.gov/fdsys/pkg/STATUTE-87/pdf/STATUTE-87-Pg355.pdf>.

### **c) Idaho Medicaid Publications**

"Interpretive Services." *MedicAide Newsletter*, December 2008, <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/December%20Newsletter%20final.pdf>.

"Interpretive Services." *MedicAide Newsletter*, January 2010, <http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/January%202010%20MedicAide%20Newsletter%20Final.pdf>.

"New Code for Billing Sign Language Services." *MedicAide Newsletter*, December 2006, [http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/2006\\_12.pdf](http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/2006_12.pdf).

"Providing Sign and Oral Language Interpretive Services." *MedicAide Newsletter*, September 2012, <https://www.idmedicaid.com/MedicAide%20Newsletters/September%202012%20MedicAide.pdf>.

"Reimbursement for Interpretation, Translation, and Sign Language Services." *MedicAide Newsletter*, January 2017, <https://www.idmedicaid.com/MedicAide%20Newsletters/January%202017%20MedicAide.pdf>.

### **9.11. Non-Emergent Medical Transportation**

Effective March 6, 2018, Idaho Medicaid has contracted with MTM (Medical Transportation Management Inc.) to handle all non-emergency medical transportation services. Please visit [www.mtm-inc.net/idaho](http://www.mtm-inc.net/idaho) or call 1 (877) 503-1261 for more information.

## 9.12. Virtual Care Services

Virtual care or telehealth means providing medically necessary health care services without actual physical contact, through the use of electronic means. Under Idaho Medicaid this means the participant and the provider are interacting in real-time or “live” from two physically different locations, by video or telephone. Services delivered through virtual care will be considered for reimbursement when rendered within the provider’s scope of practice and billed according to all applicable administrative rules, policy, federal and state regulations.

Any covered service may be delivered via virtual care when:

- The service can be safely and effectively delivered via virtual care and the medium utilized;
- The service fully meets the code definition when provided via virtual care;
- The service is billed with the FQ or GT modifier; and
- All other existing coverage criteria are met.

If virtual services are offered, it is the rendering provider’s responsibility to ensure meaningful access to virtual services for individuals with limited English proficiency. Meaningful access includes but is not limited to ensuring high quality audio with a clear and audible transmission of voices and adequate training to users of the technology. Any electronic or written information must be provided to the participant before the virtual care appointment and provided in a form and manner which the participant can understand. The provider must make reasonable accommodations through methods such as a translator or qualified interpreter when necessary.

The participant must be informed and consent to the delivery models, any applicable cost-sharing, provider qualifications, treatment methods, or limitations and virtual care technologies and provided adequate training on how to use the technology. The rendering provider at the distant site must also disclose to the participant their identity, current location, telephone number and Idaho license number. Providers can deliver virtual care services from any location in the United States. Providers must meet all applicable licensure requirements required by the State of Idaho. If the participant (or legal guardian) indicates at any point that they want to stop using the technology, the service should cease immediately, and an alternative (in-person) appointment should be scheduled. Providers are subject to all applicable state and federal laws regarding protected health information and personal privacy.

Services provided via asynchronous communication are not reimbursable under Idaho Medicaid. However, remote monitoring services are covered for established patients. Remote Therapeutic Monitoring (RTM) and Remote Physiological Monitoring (RPM) cannot be billed together and must be billed as a distinct and separate service. Services provided via asynchronous communication are not reimbursable under Idaho Medicaid. However, remote monitoring services are covered.

Medicaid policy is not subject to Medicare restrictions for virtual care unless the participant has Medicare primary. Otherwise, all Medicaid providers, including federally qualified health centers (FQHC’s), rural health centers (RHC’s), and Indian health clinics (IHC’s) may bill for virtual care services according to these guidelines.

Reporting of test results only is not covered as a virtual care service.

### 9.12.1. Virtual Care Services – Technical Requirements

Video must be provided in real-time with full motion video and audio that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses

in communication. Transmission of voices must be clear and audible.

### **9.12.2. Virtual Care Services – Documentation**

The individual treatment record must include written documentation of evaluation process, the services provided, participant consent, participant outcomes, and those services were delivered via virtual care. The documentation must be of the same quality as is originated during an in-person visit, including but not limited to, billing the CPT® or HCPCS code with the number of minutes closest to the actual time spent providing the service, service type, amount, frequency, duration and time spent with the participant. If the code is a timed code of 15-minute increments, it must be billed with a number of units as described in the Billing 15-Minute Timed Codes section of the [General Billing Instructions](#), Idaho Medicaid Provider Handbook. These documentation requirements are specific to delivery via virtual care and are in addition to any other documentation requirements specific to the area of service (i.e., IEP requirements for school-based services).

### **9.12.3. Virtual Care Services – Reimbursement**

Only one eligible provider may be reimbursed per service per participant per date of service. No reimbursement is available for the use of equipment at the originating or remote sites. Reimbursement is also not available for services that are interrupted and/or terminated early due to equipment difficulties. Claims for services delivered via virtual care will be reimbursed at the same rate as face-to-face services. A service is considered audio only if 50% or more of the service is provided via audio only. Virtual service visits will be subject to retrospective review as appropriate.

Idaho Medicaid uses places of service 02 (Telehealth provided other than in patient's home) and 10 (Telehealth provided in patient's home). Providers must use these places of service on claims for virtual care. Claims for virtual care must include one of the following modifiers:

- FQ – A telehealth service was furnished using real-time audio-only communication technology.
- GT – A telehealth service was furnished using real-time audio-visual communication technology.

Additionally, providers can also use the following modifier in conjunction with one of the above:

- FR – A supervising practitioner was present through a real-time two-way, audio/video communication technology.

FQHC, RHC or IHS providers should not report the GT or FQ modifier with encounter code T1015, but should include it with each applicable supporting code.

### **9.12.4. References: Virtual Care Services**

#### **a) CMS Guidance**

"Chapter 15 – Covered Medical and Other Health Services." *Medicare Benefit Policy Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>.

"Chapter 12 – Physicians/Nonphysician Practitioners." *Medicare Claims Processing Manual*, Centers for Medicare and Medicaid Services, Department of Health and Human Services,

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>.

“CY2022 Telehealth Update Medicare Physician Fee Schedule.” Centers for Medicare and Medicaid Services, 14 January 2022,

<https://www.cms.gov/files/document/mm12549-cy2022-telehealth-update-medicare-physician-fee-schedule.pdf>.

“Telehealth.” Centers for Medicare and Medicaid Services, 1 December 2021,

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>.

### **b) Federal Guidance**

Guidance on Nondiscrimination in Telehealth: Federal Protections to Ensure Accessibility to People with Disabilities and Limited English Proficient Persons. Office for Civil Rights, Department of Health and Human Services,

<https://www.hhs.gov/sites/default/files/guidance-on-nondiscrimination-in-telehealth.pdf>.

### **c) Federal Regulations**

Payment for Telehealth Services, 42 CFR 414.65 (2001). Government Printing Office,

<https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol3/pdf/CFR-2018-title42-vol3-sec414-65.pdf>.

Telehealth Services, 42 CFR 410.78 (2001). Government Printing Office,

<https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol2/pdf/CFR-2018-title42-vol2-sec410-78.pdf>.

### **d) Idaho Medicaid Publications**

“Telehealth Place of Services (POS).” *MedicAide Newsletter*, July 2019,

<https://www.idmedicaid.com/MedicAide%20Newsletters/July%202019%20MedicAide.pdf>.

Telehealth Policy, Information Release MA16-20 (12/23/2017). Division of Medicaid, Department of Health and Welfare, State of Idaho,

<http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA1620.pdf>.

“Telehealth Services.” *MedicAide Newsletter*, May 2023,

<https://www.idmedicaid.com/MedicAide%20Newsletters/May%202023%20MedicAide.pdf>.

Telehealth Therapies, Information Release MA16-07 (5/9/2016). Division of Medicaid, Department of Health and Welfare, State of Idaho,

<http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/IRMA1607.pdf>.

Updated Telehealth Policy, Information Release MA18-07 (7/2/2018). Division of Medicaid, Department of Health and Welfare, State of Idaho,

<https://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA1807.pdf>.

Updated Telehealth Policy, Information Release MA15-11 (12/31/2015). Division of Medicaid, Department of Health and Welfare, State of Idaho,

<http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA15-11.pdf>.

### ***e) State Regulations***

Idaho Virtual Care Access Act, Idaho Code 54-57 (2023). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title54/t54ch57/>.

The Medical Consent and Natural Death Act, Idaho Code 39-4507 (2005). Idaho State Legislature, <https://legislature.idaho.gov/statutesrules/idstat/title39/t39ch45/sect39-4507/>.

"Virtual Care." *IDAPA 16.03.09*, "Medicaid Basic Plan Benefits," Sec. 210.09. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

## 9.13. Weight Management Services

Weight management services are covered for Medicaid participants through the behavioral benefit of the Preventive Health Assistance (PHA) program. Weight management services are not administered through the Idaho Behavioral Health Plan. Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed for provider convenience. Providers of a type and specialty with a section of the [Idaho Medicaid Provider Handbook](#) under the Provider Guidelines heading must also follow that section. Additional handbook sections that always apply to providers of this service include the following:

- [General Billing Instructions](#); and
- [Glossary](#).

Handbooks can only be used properly in context. Providers must be familiar with the handbooks that affect them and their services. The numbering in handbooks is also important to make note of as subsections rely on the content of the sections above them.

### Example

Section 1.2.3(a) The Answer requires the reader to have also read Section 1, Section 1.2 and Section 1.2.3 to be able to properly apply Section 1.2.3(a).

### 9.13.1. Eligible Participants: Weight Management Services

Medicaid participants with basic or enhanced benefit plans are eligible for weight management services through the behavioral benefit of the Preventive Health Assistance (PHA) program. Participants must indicate on their periodic Health Questionnaire a desire to change behaviors related to weight management and apply for PHA benefits to be added to their Medicaid eligibility. Medicaid participants enrolled in one of the [Managed Care Programs for Dual Eligible Participants](#) or eligible for Medicaid through [Katie Beckett](#) are not eligible for PHA benefits.

Participants interested in the Preventive Health Assistance (PHA) program begin by visiting their primary care provider (PCP). The primary care provider:

- Determines if the participant meets the BMI requirements for their age group to have one of the covered diagnoses in the table below;
- Confirms the participant is enrolled in either the Basic or Enhanced plan; and
- Discusses weight management programs with patient and help to identify obtainable goals.

Covered Diagnoses for Weight Management Services	
ICD-10-CM	Description
E66.01	Morbid (severe) obesity due to excess calories. 100lbs overweight.
E66.09	Other obesity due to excess calories. BMI of 30 or higher.
E66.1	Drug-induced obesity. BMI of 30 or higher.
E66.3	Overweight. BMI between 25 and 29.9. Participants over the age of 21 with this diagnosis are not eligible.
E66.8	Other obesity. BMI of 30 or higher.
E66.9	Obesity, unspecified. BMI of 30 or higher.
R63.6	Underweight

If the PCP determines the participant meets the criteria for the behavioral PHA benefit, the PCP prints and completes section 1 of the [Idaho Medicaid Preventive Health Assistance \(PHA\)](#)

[Weight Management Agreement Form](#) and provides it to the participant or their guardian. The PCP should also provide the [WM Provider List](#) if the participant hasn't already found an enrolled weight management services provider.

The participant must select a weight management program from an enrolled provider. The participant then completes and returns the form to the Medical Care Unit (MCU) within two months of the PCP documenting their height and weight on the form. The MCU will determine eligibility and send the participant a Notice of Decision (NOD). The NOD will contain a voucher that specifies the amount approved and designated weight management provider. The participant must then take the NOD and voucher to their weight management program to receive services.

### **9.13.2. Participants Under 21**

Participants between five (5) and twenty-one (21) years of age may qualify for weight management services if they have a body mass index (BMI) that falls into either the overweight, obese or underweight category as determined by the Centers for Disease Control and Prevention's (CDC) [Child and Teen BMI Calculator](#).

### **9.13.3. Participants Over 21**

Participants twenty-one (21) years of age and older with a body mass index (BMI) of 30 or higher, or 18½ or lower, may qualify for the weight management program.

### **9.13.4. References: Eligible Participants – Weight Management Services**

#### ***a) State Regulations***

"Behavioral PHA." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 621.01 Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

### **9.13.5. Provider Qualifications: Weight Management Services**

Providers of weight management services include, but are not limited to, life style coaches and other suppliers in the National Diabetes Prevention program, gyms, health clubs and registered dietitians. Providers, including those that are already enrolled as another provider type, must enroll as an atypical provider with Idaho Medicaid prior to providing weight management services under the Preventive Health Program (PHA). Providers must be enrolled independently as the direct/pay-to and cannot bill as a rendering under a group NPI.

Registered dietitians, however, enrolled with Medicaid do not have to complete a separate enrollment to provide weight management services within the scope of their licensure. A registered dietitian can bill for their services as a rendering provider under a group NPI or be a direct/pay-to provider. If the dietitian offers services beyond nutrition and diet, such as operating a gym or health club, then the dietitian would need to enroll as an atypical provider type for those services.

Providers must follow the Idaho Medicaid Provider Handbook and all applicable state, and federal, rules and regulations including county and local business licensing requirements. They must also be established as a business that serves the general public. In addition, medication



and pharmaceutical supply vendors must be a licensed pharmacy and meet the requirements under section 664 of [IDAPA 16.03.09](#), "Medicaid Basic Plan Benefits."

See the [Provider Enrollment](#) section for more information on enrolling as an Idaho Medicaid provider.

### **9.13.6. References: Provider Qualifications – Weight Management Services**

#### ***a) State Regulations***

"Preventive Health Assistance (PHA): Provider Qualifications and Duties." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 624. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

### **9.13.7. Covered Services and Limitations: Weight Management Services**

The behavioral benefit of the Preventive Health Program (PHA) awards points to enrolled Medicaid participants to redeem for weight management services. All services must be prior authorized by the Medical Care Unit (MCU) through a voucher and notice of decision. Weight management services must either address physical fitness, balanced diet or personal health education. These can include services under the National Diabetes Prevention Program, gym fees, healthy lifestyle classes or nutrition classes. Participants can request coverage from the Department for an unidentified service. Participants can earn up to 200 points under the behavioral benefit during each benefit period. An initial one hundred (100) points are earned upon approval into the program. An additional one hundred (100) points are earned by completing the chosen program or one of the goals established with their primary care provider. The weight management services provider must verify the program or goal was completed and provide documentation to the MCU.

Benefit periods last twelve months from when the participant is approved for the program. Participants may reapply after or near the end of their benefit period if they still meet criteria for the program. Benefit periods cannot overlap. Points cannot be transferred to another participant. Any points not utilized during their issued benefit period, expire. Points can be redeemed by voucher with a Medicaid enrolled provider at a rate of one-point to one-dollar towards eligible services.

Weight management providers must verify eligibility when they receive the voucher. Providers can only verify eligibility for PHA weight management services by calling Gainwell Technologies customer service at 1 (866) 686-4272.

### **9.13.8. References: Covered Services and Limitations – Weight Management Services**

#### ***a) State Regulations***

"Behavioral PHA." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 623. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Benefit Year." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 620.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Preventive Health Assistance (PHA): Coverage and Limitations." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 622. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

"Prior Authorization." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 624.02. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

### 9.13.9. Reimbursement: Weight Management Services

Services must meet all Medicaid requirements to be eligible for reimbursement. Idaho Medicaid reimburses weight management services on a fee-for-service basis. Services are reimbursed at 100% of the invoiced amount up to the maximum on the participant's voucher, so long as the participant has points remaining to redeem. Once a participant has exhausted their benefit, the participant is liable for any remaining balance due from services provided under the PHA behavioral benefit that are not otherwise covered by Idaho Medicaid. See the [Participant Financial Responsibility](#) section for requirements on billing a participant.

Claims must be submitted on a CMS-1500 form to Gainwell Technologies via mail or the provider portal for reimbursement. Covered services and the corresponding billing codes are found in the table below. Reimbursement is only available for participants with one of the diagnoses listed in the [Eligible Participants: Weight Management Services](#) section billed as the primary diagnosis on the claim. See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook regarding policy on billing, prior authorization and requirements for billing all other third-party resources before submitting claims to Medicaid.

PHA Weight Management Covered Codes	
HCPCS	Description
S9449	Weight management classes, non-physician provider, per session. Weight management classes are training and education related to nutrition, physical activity, stress management, and lifestyle and how they relate to health.
S9451	Exercise classes, non-physician provider, per session. Exercise classes are formal programs of bodily activities that maintain physical fitness and overall health. They are usually performed in a group. There are generally three types of exercise: flexibility, such as stretching; aerobic, such as cycling, tennis, and swimming; and anaerobic, such as weight lifting.
S9452	Nutrition classes, non-physician and non-physician practitioner provider, per session. Nutrition classes provide organized instruction in the food and foodstuffs necessary for life. Classes are usually group activities that discuss generalities.
S9970	Health club membership, annual. This code represents the annual fees for a health club, also known as a fitness club or gym. The club or gym is a location that houses exercise equipment, may offer exercise classes, and other educational opportunities.

### 9.13.10. References: Reimbursement – Weight Management Services

#### a) State Regulations

"Preventive Health Assistance (PHA): Provider Reimbursement." IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sec. 625. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

### **9.13.11. References: Weight Management Services**

#### ***a) State Regulations***

"Preventive Health Assistance (PHA)." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 620 – 626. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

## **9.14. CHIP Wellness Incentive**

Children enrolled in the Children's Health Insurance Program (CHIP) are subject to a monthly premium of \$10 or \$15 per month. The Preventive Health Assistance (PHA) program as part of its wellness benefit provides ten (10) points a month to participants, who keep up-to-date on their well child exams and immunizations. Points are then converted into a \$10 credit towards the participant's monthly CHIP premium. Preventive care including well child exams, vaccines and their administration (immunizations) are not subject to copayments.

Points accumulated through the PHA wellness benefit are only redeemable towards CHIP premiums. A participant can only receive 120 points in a twelve-month period. Points cannot be transferred to another participant. Any points not utilized during their issued twelve-month period, expire.

Statements are mailed to parents on a monthly basis. If a parent knows their child is up-to-date on their well checks and immunizations, they may ask their primary care provider (PCP) to fax verification of the checkup or immunizations to the Medical Care Unit at 1 (877) 845-3956. If you have questions about the PHA program, please call the Medical Care Unit toll free at 1 (877) 364-1843.

See the Wellness Examinations section of the [Physician and Non-Physician Practitioner](#), Idaho Medicaid Provider Handbook for more information.

### **9.14.1. References: CHIP Wellness Incentive**

#### ***a) State Regulations***

"Premiums for Participation Under the State Children's Health Insurance Program (SCHIP)." *IDAPA 16.03.18, "Medicaid Cost-Sharing,"* Sec. 200. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160318.pdf>.

"Preventive Health Assistance (PHA)." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 620 – 626. Department of Administration, State of Idaho, <https://adminrules.idaho.gov/rules/current/16/160309.pdf>.

## Appendix A. Provider Agreement Example

### Idaho Department of Health and Welfare (IDHW) Medicaid Provider Agreement

Name and address of individual or entity applying to provide these items or services:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current or previous Provider number for this provider type and specialty: \_\_\_\_\_  
(Does not apply if this is an initial application)

As a condition of participation in Medicaid, the Provider agrees as follows:

#### TERMS AND CONIDITIONS

##### 1. Compliance.

This Provider Agreement ("AGREEMENT") is entered into by and between the Department of Health and Welfare ("DEPARTMENT"), as the State of Idaho's administering agency with authority under Idaho Code, Title 56, Chapter 2, to enter into agreements with individuals or entities ("PROVIDER"). This AGREEMENT is entered into for the purpose of defining the DEPARTMENT's expectations of providers who provide medical care, services, medical equipment, supplies or items to persons eligible for medical assistance and who submit claims for reimbursement in accordance with all applicable provisions of Idaho Statute, administrative code and federal regulations under the Medical Assistance Program ("MEDICAID"). This AGREEMENT and the terms herein are conditions of payment as used in Section 56-§209h(5) of Idaho Code. Failure to comply with any of the Terms and Conditions, or applicable ADDENDUMS incorporated herein, may affect PROVIDER's ability to continue participation in MEDICAID or may result in recovery of payments made by the DEPARTMENT to the PROVIDER, assessment of civil monetary penalties, suspension or payments and/or exclusion from the Medicaid program.

This AGREEMENT and any applicable ADDENDUMS attached hereto and hereby incorporated by reference; are subject to modification, revisions, or termination in accordance with changes in federal or state laws, administrative code or regulations. The DEPARTMENT reserves the right to amend this AGREEMENT by providing the PROVIDER twenty-eight (28) day notice, as published within an Information Release (IR), and PROVIDER is deemed to accept, following such notice period. This AGREEMENT will be deemed modified, revised, or terminated to comply with any change on the effective date of such change.

This AGREEMENT delineates the responsibilities of the PROVIDER and any subcontractor, agent or employee of the PROVIDER, in regard to the MEDICAID Program. The PROVIDER certifies and agrees to the Terms and Conditions set forth below.

##### 2. Regulations, Rules, Policies and Procedures.

2.1 PROVIDER certifies that items and services provided will be available without discrimination as to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, disability, or national origin in accordance with Title VI and VII of the Civil Rights Act of 1964, as amended, the Age Discrimination Act of 1975, as amended;

2.2 PROVIDER additionally certifies compliance with Section 504 of the Rehabilitation Act of 1973, as amended; the Americans with Disabilities Act of 1990 as amended; and 45 CFR Parts 91 and 92, as amended, specific to discrimination.

Revised November 2020

2.3 PROVIDER shall comply with all applicable provisions of 45 CFR Part 88, consistent with applicable court orders or as amended; the Health Insurance Portability and Accountability Act (HIPAA); Sections 262 and 264 of Public Law 104-191, 42 USC Section 1320d, and applicable federal regulations at 45 CFR Subchapter C specific to Administrative Data Standards and 45 CFR Subchapter D - Health Information Technology and Related Requirements; 170.215. PROVIDER shall additionally be responsible for protecting the confidentiality of participant information that is collected, used, or maintained according to IDAPA 16.05.01, "Use and Disclosure of Department Records," and 42 CFR § 431. Subpart F, specific to unauthorized disclosure of applicant and beneficiary information.

2.4 PROVIDER shall comply with 42 USC § 1396A(a)(68) if PROVIDER receives or makes annual payments of MEDICAID funds of at least five million dollars (\$5,000,000).

2.5 PROVIDER shall ensure any individual providing interpretive services related to the provision of a health-related service, is a minimum of 18 years of age and meets the definition of qualified interpreter consistent with 28 CFR § 35.104.

2.6 Pursuant to 42 CFR § 431.107(b)(4), hospitals, nursing facilities, and PROVIDERs of home health care and personal care services, and hospice services shall comply with the requirements for Advance Directives as specified in 42CFR § Part 489, Subpart I and 42 CFR § 417.436(d), as amended.

2.7 PROVIDER acknowledges the responsibility to comply with all applicable parts of the False Claims Act (31USC §§3729-3733) including, but not limited to, educating employees about federal and State laws pertaining to civil or criminal penalties for false claims, false statements and whistleblower protections under such laws.

2.8 Pursuant to federal regulations at 42 CFR § 455.105, PROVIDER shall if requested, furnish to the DEPARTMENT and/or the U.S. Department of Health and Human Services, within thirty-five (35) days of the date of the transaction or the date of the written request, full and complete information related to certain business transactions, specifically:

2.8.1 ownership of any subcontractor with whom the PROVIDER has had business transactions totaling more than \$25,000 during the 12-month period preceding the most recent business transaction or ending on the date of the request; and

2.8.2 pursuant to 42 CFR 455 Subpart B, any significant business transaction, between the PROVIDER and any wholly owned supplier, or between the PROVIDER and any subcontractor, during the 5-year period preceding the most recent business transaction or ending on the date of the request.

### **3. Administrative Code.**

PROVIDER shall comply with all applicable provisions of the Idaho Administrative Code, as amended, including but not limited to: IDAPA 16.03.01 - "Eligibility for Health Care Assistance for Families and Children", IDAPA 16.03.05 - "Eligibility for Aid to the Aged, Blind, and Disabled", IDAPA 16.03.09 - "Medicaid Basic Plan Benefits", IDAPA 16.03.10 - "Medicaid Enhanced Plan Benefits", IDAPA, 16.03.13 - "Consumer Directed Services", IDAPA 16.03.17 - "Medicare/Medicaid Coordinated Plan Benefits", and IDAPA 16.03.18 - "Medicaid Cost Sharing", IDAPA - 16.05.03 "Contested Case Proceedings and Declaratory Rulings", IDAPA 16.05.06 "Criminal History and Background Checks", IDAPA 16.05.07 - "The Investigation and Enforcement of Fraud, Abuse and Misconduct."

### **4. Policy Guidance.**

PROVIDER shall conduct operations in accordance with all applicable provisions of policy documents and guidance accessible to them via the internet at [www.idmedicaid.com](http://www.idmedicaid.com), including, but not limited to, policy documents and guidance contained within the Medicaid newsletter, IR's and the Idaho Medicaid Provider Handbook (Provider Manual), as amended.

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**5. Employee Training.**

PROVIDER acknowledges responsibility to ensure employees, subcontractors and agents of the PROVIDER receive training specific to the usage and adherence of all applicable provisions of this AGREEMENT including but not limited to, all applicable IDAPA rules, policy documents and guidance contained within the Medicaid newsletter, IR's, and the Idaho Medicaid Provider Handbook (Provider Manual), as amended.

**6. Provider Enrollment Process**

6.1 PROVIDER shall comply with the DEPARTMENT's enrollment processes and acknowledges the DEPARTMENT's authority to make provider enrollment decisions, which may include but is not limited to, mandatory denial of a Provider Agreement in accordance with IDAPA 16.03.09.200.06. PROVIDER acknowledges and agrees PROVIDER and its principals will be held responsible for violations of this AGREEMENT through any acts or omissions by the PROVIDER, its employees, its subcontractors or its agents specific to the provider enrollment process, including but not limited to, failure to disclose the revocation, termination or voluntary termination of an enrollment or if any party specified within 42 CFR § 455.106(c) has been convicted of a criminal offense.

6.1.1 PROVIDER understands this includes disclosure of relationships between those who have an ownership interest, a control interest, or managerial control of the PROVIDER organization.

6.1.2 Pursuant to federal regulations at 42 §CFR Part 455, Subpart B, "Disclosure of Information by Providers and Fiscal Agents", PROVIDER shall comply with the disclosure of ownership requirements; and agrees that for the purposes of this AGREEMENT, principal of the PROVIDER includes all owners, corporate officers, directors, all general or limited partnership interests, and all shareholders of a legal entity, including a professional corporation, association, or limited liability company with a direct or indirect ownership or control interest, regardless of percentage of ownership.

6.2 PROVIDER acknowledges this AGREEMENT is not transferable or assignable. PROVIDER also acknowledges that at any time during the course of this AGREEMENT, PROVIDER shall notify the DEPARTMENT of any change in information contained in this AGREEMENT or their Provider Enrollment application thirty-five (35) days prior to the change. Changes PROVIDERs are required to report include, but are not limited to, changes (or impending changes) in ownership; indirect ownership, changes to licensure, federal tax information, bankruptcy; physical, mailing or electronic addresses, phone number; or the addition or removal of Licensed Medical Service Providers.

**7. Professionalism.**

7.1 PROVIDER shall provide medical care, services, equipment, and supplies or items, in accordance with Idaho state statutes and the Idaho Administrative Code.

7.2 PROVIDER shall maintain licensure, certification and registration with the applicable state and/or federal authorities.

7.3 PROVIDER agrees to uphold professionally recognized standards of care and if applicable, retain Non-Physician practitioners or paraprofessionals who have appropriate qualifications, licensing and certification. PROVIDER additionally agrees to provide appropriate supervision of such individuals.

7.4 PROVIDER shall verify and ensure that all employees, subcontractors and agents meet the fingerprint-based Criminal History Background Check provisions, as required by the DEPARTMENT under IDAPA 16.05.06 - "Criminal History and Background Checks."

7.5 PROVIDER shall abide by all applicable laws regarding the Medicaid participant's right to privacy, dignity, and free choice of providers and agrees to comply with 42 CFR, Chapter I, Subchapter A, Part 2 and CFR, Part 5b specific to access to medical, dental, psychological and

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substance use disorder treatment records.

7.6 PROVIDER shall abide by this AGREEMENT and any applicable Addendums.

#### **8. Records Management.**

8.1 PROVIDER agrees to legibly document all services, including but not limited to, medical, psychological, transportation, or dental treatment services, equipment, orthotics, prosthetics and supplies or items in accordance with professionally recognized standards to support each claim for reimbursement by MEDICAID, at the time it is provided, in compliance with the requirements specified in Idaho Code, §56-209h(3), as amended, applicable DEPARTMENT rules and this AGREEMENT. Such documentation shall be maintained for at least five years after the date of service, in accordance with IDAPA 16.05.07.101 or as required by other DEPARTMENT rule. Failure to comply with documentation requirements may result in the recoupment of Medicaid payments.

8.2 PROVIDER shall ensure their cooperation with the DEPARTMENT's Medicaid Program Integrity Unit (MPIU) and the U.S. Department of Health and Human Services, or their agents by providing immediate access in accordance with Idaho Code § 56-209h and IDAPA 16.05.07, to all records, documents, material, and data in any medium which supports services billed to MEDICAID, at the time the MPIU makes its request

8.2.1 PROVIDER also agrees to comply with Quality Assurance audits specific to IDAPA 16.03.10, if applicable, and as provided by any ADDENDUM to this AGREEMENT.

#### **9. Accurate Billing.**

9.1 PROVIDER shall certify by their signature or through their designee, including electronic signatures on a claim form or transmittal document, that the services, including but not limited to medical care, transportation, dental, equipment, prosthetics, orthotics and supplies or items claimed were actually provided in accordance with professionally recognized standards of health care, all applicable DEPARTMENT rules, and this AGREEMENT.

9.2 PROVIDER agrees to be solely responsible for the accuracy of claims submitted to the DEPARTMENT.

9.3 PROVIDER ensures services claimed were not claimed under another program, provider type or managed care organization and to immediately repay the DEPARTMENT for any services, including but not limited to medical care, transportation, dental, equipment, prosthetics, orthotics, supplies or items the DEPARTMENT or the PROVIDER determines were not properly provided, properly documented, or properly claimed.

9.4 Pursuant to 42 USC § 1320a-7 and 42 USC § 1320c-5, PROVIDER shall bill only for services, including but not limited to medical care, transportation, dental, equipment, prosthetics, orthotics, supplies or items delivered by individuals not excluded from MEDICAID; and additionally, assures all payments are correctly applied to participant accounts and credited timely

#### **10. Secondary Payor or Third-Party Liability.**

10.1 PROVIDER agrees to comply with 42 CFR § 433.- Subpart D. specific to third party liability and agrees to seek payment first from all other sources, before billing MEDICAID; Additionally, PROVIDER also acknowledges MEDICAID as the payer of last resort and agrees to comply with 42 CFR § 447.20(b).

10.2 PROVIDER acknowledges that if a secondary payor or third party pays the participant for the medical care, service, equipment, supply or item, the PROVIDER may bill the participant for that amount if written notice of financial responsibility was provided prior to the delivery of the service.

10.3 PROVIDER agrees to not bill the DEPARTMENT if a secondary payor or third-party payment is made to the PROVIDER, unless the secondary payor or third-party payment is less than the amount MEDICAID would pay.

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**11. Reimbursement.**

11.1 PROVIDER agrees to complete the appropriate claim form and submit it to the MEDICAID or the DEPARTMENT's agent for reimbursement.

11.2 PROVIDER agrees to submit a request for prior authorization, if one is required, and to receive an approval for that request, prior to providing the requested medical care, service, equipment, supply or item to the participant except where allowed by MEDICAID.

11.3 PROVIDER understands that reimbursement for the services, including but not limited to, medical care, transportation, dental, equipment, prosthetics, orthotics, supplies or items by MEDICAID is contingent on the PROVIDER being correctly enrolled, and licensed; conducting a determination of medical necessity for the service, including but not limited to, medical care, transportation, dental, equipment, prosthetic, orthotic, supply or item that meets all DEPARTMENT requirements under MEDICAID; eligibility of the participant for the service, including but not limited to, medical care, transportation, dental, equipment, prosthetic, orthotic, supply or item at the time it is rendered; coverage limitations at the time provided; timely submittal of prior authorization when applicable; and the PROVIDER billing per all applicable administrative code, policies and requirements specified by the National Correct Coding Initiative.

**12. Payment in Full.**

12.1 Pursuant to 42CFR §447.15 PROVIDER agrees to accept MEDICAID payment, as payment in full, for any medical care, services, equipment, supplies or items.

12.1.1 PROVIDER also agrees that prior to delivering a non-covered or excluded MEDICAID service to a participant, PROVIDER will provide written notice to the participant of their responsibility to pay for the service or item they are receiving, prior to rendering the service or item and require the participant to affix their signature as acknowledgement of their financial responsibility.

a) If the participant qualifies for a period of retroactive eligibility for Medicaid, 12.1.1 does not apply.

12.1.2 PROVIDER agrees to comply with the billing requirements specific to participant financial responsibility as provided within the Provider Handbook or administrative code.

**13. Officers and Employees of the State.**

PROVIDER acknowledges that no official, employee, or agent of the DEPARTMENT shall be in any way personally liable or responsible for any term of this AGREEMENT, whether express or implied, nor for any statement, representation, or warranty made in connection with this AGREEMENT. A guarantee of payment for services cannot be made by an official, employee or agent of the DEPARTMENT.

**14. Provider Liability.**

PROVIDER agrees if their organization is any type of business entity, the entity and all general or limited partnership interests and all shareholders, with a direct or indirect ownership or control interest, regardless of the percentage of ownership, are jointly and severally liable for any breach of this AGREEMENT, and that action by the DEPARTMENT against the PROVIDER may result in action against any or all such individuals in the entity.

**15. Provider Revalidation.**

15.1 PROVIDER acknowledges that the DEPARTMENT requires all enrolled providers to revalidate enrollment information at least every five years, in accordance with 42 CFR 455.414 and the DEPARTMENT may conduct off-cycle revalidations for certain program integrity purposes as allowed by 42 CFR §455.452 to ensure compliance with these requirements. Upon the DEPARTMENT's request to revalidate its enrollment, the PROVIDER has ninety (90) days from the postmark on the Revalidation Notice to submit the completed enrollment to the

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DEPARTMENT for approval.

15.2 PROVIDER also acknowledges all information disclosed by the PROVIDER is subject to verification. Any deliberate omission, misrepresentation or falsification of any information contained in the Provider Enrollment Application, this AGREEMENT (if applicable) and Disclosure Statement or contained in any communication supplying information to the DEPARTMENT may be punishable to the full extent allowed under the law, including but not limited to, revocation of the PROVIDER AGREEMENT, recovery of payments made, and assessment of civil monetary penalties.

**16. Breach.**

In addition to any breaches specified in other sections of this AGREEMENT, the failure of the PROVIDER to perform any of its obligations hereunder in whole or in part or in a timely or satisfactory manner constitutes a breach. A breach in this AGREEMENT may result in termination, suspension or recoupment of any or all PROVIDER payments and/or assessment of civil monetary penalties.

**17. Duration and Termination of Agreement.**

17.1 PROVIDER acknowledges this AGREEMENT shall be effective from the date the applicant is enrolled as a PROVIDER or from the date the PROVIDER is approved for continued enrollment and will remain in effect until terminated in writing.

17.2 This AGREEMENT may be terminated by either party, without cause, by giving twenty-eight (28) days' notice in writing to the other party.

17.2.1 DEPARTMENTS's sole obligation, in the event of termination, shall be to pay for services provided prior to the effective date of the termination.

17.3 DEPARTMENT may at its discretion, terminate this AGREEMENT in writing in the event the PROVIDER has failed to submit a claim for reimbursement to Medicaid within a twenty-four (24) month period.

17.4 DEPARTMENT may terminate this AGREEMENT if judicial interpretation of federal or state laws, regulations, or rules renders fulfillment of this AGREEMENT infeasible or impossible.

17.5 DEPARTMENT shall immediately terminate this AGREEMENT if the PROVIDER's license or certification, required by law or rule, is revoked, not renewed or is otherwise not in effect at the time service is provided.

17.6 DEPARTMENT may, at its discretion terminate this AGREEMENT if it determines the PROVIDER did not fully and accurately make any disclosure, including but not limited to board actions, or if the PROVIDER failed to notify the DEPARTMENT of any change as specified in "6. Provider Enrollment Process" of this AGREEMENT. All correspondence sent to the mailing or electronic address on file with the DEPARTMENT's fiscal agent shall be deemed to have been received by the PROVIDER.

17.7 DEPARTMENT may, at its discretion, terminate this AGREEMENT in writing when the PROVIDER fails to comply with any applicable regulations, statutes, administrative code, guidance, policy or provision of this AGREEMENT, either immediately or upon such notice as the DEPARTMENT deems appropriate in accordance with IDAPA 16.03.09.205 or IDAPA 16.05.07.230.

17.8. PROVIDER understands and agrees its conduct may be subject to additional penalties or sanctions under Idaho Code §§ 56-209h, 56-227, 56-227A, 56-227B, and 56-227E, and IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse and Misconduct", of the Idaho Administrative Rules, as amended and PROVIDER also understands there are federal penalties for false reporting and fraudulent acts committed during the course and scope of this AGREEMENT. Notice of these sanctions shall in no way imply they represent an exclusive or exhaustive list of available actions concerning fraud and abuse.

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**18. Additional terms,**

PROVIDER agrees to abide by any applicable terms if any, are attached.

**19. Construction, Severability, and Venue.**

This AGREEMENT shall be governed, construed, and enforced in accordance with the laws and regulations of the state of Idaho and appropriate federal statutes and regulations. The provisions of this AGREEMENT are severable and independent, and if any such provision shall be determined to be unenforceable, in whole or in part, the remaining provisions and any partially enforceable provision shall, to the extent enforceable in any jurisdiction, nevertheless be binding and enforceable. Any action to enforce the provisions of this AGREEMENT shall be brought in State District Court in Ada County, Boise, Idaho.

**20. Interpretation.**

In the event of inconsistency or ambiguity between the provisions of IDAPA and this AGREEMENT, the provisions of IDAPA shall be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, in which case such federal or state law shall be determinative of the obligations of the parties. In the event IDAPA is silent with respect to any ambiguity or inconsistency, the AGREEMENT (including Appendices) shall be determinative of the obligations of the parties. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the AGREEMENT and the budgetary and statutory constraints of DEPARTMENT.

**21. Headings.**

The headings in this AGREEMENT have been inserted for convenient reference only and shall not be considered in any questions of interpretation or construction of this AGREEMENT.

Printed name of individual practitioner or individual authorized to sign on behalf of the Provider:

\_\_\_\_\_

Position: \_\_\_\_\_

By my signature, I declare, under penalty of perjury, that I have the legal authority to enter into this Agreement and hereby bind all entities and individuals that comprise the Provider.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## Appendix B. General Information and Requirements for Providers, Provider Handbook Modifications

This table lists the last three years of changes to this handbook as of the publication date.

General Information and Requirements for Providers, Provider Handbook Modifications				
Version	Section	Update	Publish Date	SME
91.0	All	Published version	02/01/2024	TQD
90.20	9.14. CHIP Wellness Incentive	Added info about co-pays for wellness visits and immunizations.	01/31/2024	W Deseron E Garibovic
90.19	9.12.3. Virtual Care Services – Reimbursement	Updated policy.	01/31/2024	W Deseron E Garibovic
90.18	9.12.2. Virtual Care Services – Documentation	Updated policy.	01/31/2024	W Deseron E Garibovic
90.17	9.12. Virtual Care Services	Updated policy.	01/31/2024	W Deseron E Garibovic
90.16	9.10.3. Interpretive Services – Reimbursement	Terminology change for virtual care services.	01/31/2024	W Deseron E Garibovic
90.15	9.9.7. Payment for Services	Updated terminology for virtual care services.	01/31/2024	W Deseron E Garibovic
90.14	7.3.6. Services Not Requiring an HC PCP Referral	Clarified immunizations referrals.	01/31/2024	W Deseron E Garibovic
90.13	7.3.1. Important Referral Policy Reminders	Updated referral requirement for non-VCO provider networks.	01/31/2024	W Deseron E Garibovic
90.12	7.2.9. Participant Disenrollment by the Provider	Removed language around participant responsibilities.	01/31/2024	W Deseron E Garibovic
90.11	7.1.5. Healthy Connections Coordinated Care Agreement and Tier Compliance by Tier	Updated terminology for virtual care services.	01/31/2024	W Deseron E Garibovic
90.10	7.1.4. Healthy Connections Tier Requirements	Updated terminology for virtual care services.	01/31/2024	W Deseron E Garibovic
90.9	7.1. Healthy Connections Provider Enrollment	Technical correction.	01/31/2024	W Deseron E Garibovic
90.8	5.6.3. High Risk Providers	Added Skilled Nursing Facility and Hospice.	01/31/2024	W Deseron E Garibovic
90.7	5.6.2. Moderate Risk Providers	Removed Hospice.	01/31/2024	W Deseron E Garibovic
90.6	5.6.1. Limited Risk Providers	Removed Skilled Nursing Facility.	01/31/2024	W Deseron E Garibovic
90.5	5.1. Non-billing Ordering, Referring and Prescribing Providers	Clarified Pharmacist billing.	01/31/2024	W Deseron E Garibovic
90.4	4.2. Eligibility Checks	New section.	01/31/2024	W Deseron E Garibovic
90.3	2.1.2.2. Co-payments	Non-substantive word changes.	01/31/2024	W Deseron E Garibovic
90.2	2. Participant Financial Responsibility	Clarified inability to refuse services for TPL.	01/31/2024	W Deseron E Garibovic
90.1	1.3. Ordering, Referring and Prescribing Providers	Clarified Pharmacist enrollment.	01/31/2024	W Deseron E Garibovic
90.0	All	Published version	08/16/2023	TQD
89.9	9.12.4.d) State Regulations	Updated references.	08/02/2023	W Deseron E Garibovic
89.8	7.3.9. Urgent Care Services	Add allowance for Health Districts.	08/02/2023	W Deseron E Garibovic

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Version	Section	Update	Publish Date	SME
89.7	7.3.6. Services Not Requiring an HC PCP Referral	Clarify Speech language pathology requires coordination with pcp.	08/02/2023	W Deseron E Garibovic
89.6	7.1. Healthy Connections Provider Enrollment	Update provider termination and recontract requirements.	08/02/2023	W Deseron E Garibovic
89.5	6.10.1.b) Idaho State Plan	New section.	08/02/2023	W Deseron E Garibovic
89.4	6.10.1.a) Federal Regulations	New section.	08/02/2023	W Deseron E Garibovic
89.3	6.10. Katie Beckett Medicaid Eligibility	Clarified copayment and premium requirements.	08/02/2023	W Deseron E Garibovic
89.2	2.1.1.c) State Regulations	Updated references.	08/02/2023	W Deseron E Garibovic
89.1	1.3. Ordering, Referring and Prescribing Providers	Updated to reflect additional eligible physician types.	08/02/2023	W Deseron E Garibovic
89.0	All	Published version	06/02/2023	TQD
88.29	5.6 Provider Relations Consultants (PRC)	Updated contact phone numbers for PRCs – brought into existing version. Previously approved change on 11/18/2022.	06/02/2023	A Boparai M Payne J Kennedy-King
88.28	9.12.4.	References: Telehealth Services renamed section References: Virtual Care Services. Updated.	05/26/2023	W Deseron K Duke
88.27	9.12.3.	Telehealth Services -- Reimbursement renamed section Virtual Care Services -- Reimbursement. Updated with new policy.	05/26/2023	W Deseron K Duke
88.26	9.12.2.	Telehealth Services -- Documentation renamed section Virtual Care Services -- Documentation.	05/26/2023	W Deseron K Duke
88.25	9.12.1.	Telehealth Services -- Technical Requirements renamed section Virtual Care Services -- Technical Requirements.	05/26/2023	W Deseron K Duke
88.24	9.12. Telehealth Services	Renamed section Virtual Care Services. Updated to incorporate new policy.	05/26/2023	W Deseron K Duke
88.23	9.8. Dental	Note about ASC coverage.	05/26/2023	W Deseron K Duke
88.22	9.7.3. References: Non-Covered and Excluded Services	Updated.	05/26/2023	W Deseron K Duke
88.21	9.7. Non-Covered and Excluded Services	Clarify codes not on fee scheduled are non-covered. Non-covered codes can't be billed under revenue codes that don't require HCPCS.	05/26/2023	W Deseron K Duke
88.20	9.6.1. References: Informational Codes	New section.	05/26/2023	W Deseron K Duke
88.19	9.6. Informational Codes	New section. Incorporating newsletter article.	05/26/2023	W Deseron K Duke
88.18	9.3.1. References: Qualifying Clinical Trials	New section.	05/26/2023	W Deseron K Duke
88.17	9.3. Qualifying Clinical Trials	New section. Incorporating newsletter article.	05/26/2023	W Deseron K Duke

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Version	Section	Update	Publish Date	SME
88.16	9.2.1. References: Non-Covered and Excluded Services	Section renamed References: Experimental/Investigational Services.	05/26/2023	W Deseron K Duke
88.15	a) References: School Based Health Centers	New section.	05/26/2023	W Deseron K Duke
88.14	7.3.8. School Based Health Centers	Inclusion of newsletter article.	05/26/2023	W Deseron K Duke
88.13	7.3.6. Services Not Requiring an HC PCP Referral	Updated service list.	05/26/2023	W Deseron K Duke
88.12	7.3.1. Important Referral Policy Reminders	Minor technical change and adding historical note.	05/26/2023	W Deseron K Duke
88.11	6.9. Incarcerated Persons	Clarify eligibility may be for basic or enhanced plan.	05/26/2023	W Deseron K Duke
88.10	5.10.1. References: Change in Ownership or Tax Identification Information	New section.	05/26/2023	W Deseron K Duke
88.9	5.10. Change in Ownership (CHOW) or Tax Identification Information	Updated name to Change in Ownership or Tax Identification Information. Clarified when providers must enter a new provider agreement.	05/26/2023	W Deseron K Duke
88.8	1.3. Ordering, Referring and Prescribing Providers	Adds residents as ORPs.	05/26/2023	W Deseron K Duke
88.7	1.2.6. References: Documentation	Updated references.	05/26/2023	W Deseron K Duke
88.6	1.2.5. Retention of Records	New section. Clarifies requirements.	05/26/2023	W Deseron K Duke
88.5	1.2.4. Electronic Signatures	New section. Clarifies acceptable format and requirements.	05/26/2023	W Deseron K Duke
88.4	1.2.3. Signatures	New section. Integrates previous language.	05/26/2023	W Deseron K Duke
88.3	1.2.2. Amendments or Corrections	New section. Integrates previous language.	05/26/2023	W Deseron K Duke
88.2	1.2.1. Additional Documentation	New section. Notes that additional documentation is throughout handbook.	05/26/2023	W Deseron K Duke
88.1	1.2. Documentation	Clarified requirements.	05/26/2023	W Deseron K Duke
88.0	All	Published version	11/04/2022	TQD
87.6	8.3.5. Follow-up Communication Requirements for Referrals	Clarification	11/01/2022	C Beal E Garibovic
87.5	8.3.1. Important Referral Policy Reminders	Policy Update	11/01/2022	C Beal E Garibovic
87.4	8.2.4. Mandatory Participant Enrollment in Healthy Connections	Policy Update	11/01/2022	C Beal E Garibovic
87.3	8.2. Participant Enrollment	Policy Update	11/01/2022	C Beal E Garibovic
87.2	8.1.3. Healthy Connections Clinic Panel Limit Guidelines	Policy Update	11/01/2022	C Beal E Garibovic
87.1	8.1. Healthy Connections Provider Enrollment	Clarification of definitions	11/01/2022	C Beal E Garibovic
87.0	All	Published version	07/22/2022	TQD

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Version	Section	Update	Publish Date	SME
86.2	6.10 Change in Ownership (CHOW) or Tax Identification Information	New section	07/20/2022	Policy Team J Kennedy-King M Payne
86.1	6.9 Provider File Updates	Updated to add	07/20/2022	Policy Team J Kennedy-King M Payne
86.0	All	Published version	06/7/2022	TQD
85.6	9.4.5 Excluded Participant Categories	Update to reflect performance year 1	06/1/2022	C Beal E Garibovic
85.5	9.2 General Value Care Terms and Conditions	Update to reflect performance year 1	06/1/2022	C Beal E Garibovic
85.4	9.1 Guidelines for HC Organization Affiliation with VCOs	Updated language based on change in policy	06/1/2022	C Beal E Garibovic
85.3	9. Healthy Connections Value care	Update dates based on change in policy	06/1/2022	C Beal E Garibovic
85.2	8.3.6 Services Not Requiring an HC PCP Referral	Updated to new policy on Chiropractic services	06/1/2022	C Beal E Garibovic
85.1	8.1 Healthy Connections Provider Enrollment	Updated language for the Terming of the HC Contract	06/1/2022	C Beal E Garibovic
85.0	All	Published version	02/16/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.25	9.5.4. Quality Performance Payment Distribution	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.23	9.5.3. Annual Improvement Targets	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.22	9.5.2. Common Set of Quality Measures	Timelines, clarifications	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.21	9.5. Quality Performance Program	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic

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Version	Section	Update	Publish Date	SME
84.20	9.4.5. Excluded Participant Categories	Timelines	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.19	9.4. Total Cost of Care (TCOC)	Clarifications	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.18	9.2. General Value Care Terms and Conditions	Timelines, clarifications	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.17	9.1. Guidelines for HC Organization Affiliation with VCOs	Timelines, clarifications	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.16	9. Healthy Connections Value Care	Timelines, clarifications	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.15	8.3.9. Urgent Care Services	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.14	8.3.7. Reimbursement for Services Requiring a Referral	New subsection	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.13	8.3.6. Services Not Requiring an HC PCP Referral	Multiple changes to align handbook with statewide HC value care project	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic



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84.12	8.2.5. Changing Enrollment in Healthy Connections	Timelines	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.11	8.2.2. Participant Enrollment Guidelines	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.10	8.2.1. Voluntary Participant Enrollment in Healthy Connections	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.9	8.2. Participant Enrollment	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.8	8.1.7. Healthy Connections Case Management Payment	Copy-editing, timelines	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.7	8.1.6. Healthy Connections Corrective Action Process (CAP)	New subsection	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.6	8.1.5. Healthy Connections Coordinated Care Agreement and Tier Compliance by Tier	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.5	8.1.4. Healthy Connections Tier Requirements	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic

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84.4	8.1.2. Healthy Connections Clinic Panel Limit Entry	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.3	8.1.1. Healthy Connections Primary Care Provider Network Directory	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.2	8.1. Healthy Connections Provider Enrollment	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.1	8. Healthy Connections	Copy-editing; Statewide Value Care project updates	02/07/2022	M Hamso A Williams K Huff S Knigge J Riener C Beal E Garibovic
84.0	All	Published version	06/14/2021	TQD
84.42	8.10. References: Healthy Connections Value Care	New section.	06/09/2021	W Deseron E Garibovic
84.41	8.9. Contract Compliance	New section.	06/09/2021	W Deseron E Garibovic
84.40	8.8. Advisory Groups	New section.	06/09/2021	W Deseron E Garibovic
84.39	8.7. Cost Settlement Process	New section.	06/09/2021	W Deseron E Garibovic
84.38	8.6. Data Deliverables	New section.	06/09/2021	W Deseron E Garibovic
84.37	8.5.5. Quality Measures Under Consideration for Future Years	New section.	06/09/2021	W Deseron E Garibovic
84.36	8.5.4. Quality Performance Payment Distribution	New section.	06/09/2021	W Deseron E Garibovic
84.35	8.5.3. Annual Improvement Targets	New section.	06/09/2021	W Deseron E Garibovic
84.34	8.5.2. Common Set of Quality Measures	New section.	06/09/2021	W Deseron E Garibovic
84.33	8.5.1. Quality Measure Targets	New section.	06/09/2021	W Deseron E Garibovic
84.32	8.5. Quality Performance Program	New section.	06/09/2021	W Deseron E Garibovic
84.31	8.4.5. Excluded Participant Categories	New section.	06/09/2021	W Deseron E Garibovic
84.30	8.4.4. Excluded Costs	New section.	06/09/2021	W Deseron E Garibovic
84.29	8.4.3. Included Costs	New section.	06/09/2021	W Deseron E Garibovic

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84.28	8.4.2. VCO Gross Target Per Member Per Month (PMPM)s	New section.	06/09/2021	W Deseron E Garibovic
84.27	8.4.1. Trend Factor	New section.	06/09/2021	W Deseron E Garibovic
84.26	8.4. Total Cost of Care (TCOC)	New section.	06/09/2021	W Deseron E Garibovic
84.25	8.3. HCVC Participant Attribution Model	New section.	06/09/2021	W Deseron E Garibovic
84.24	8.2. General Value Care Terms and Conditions	New section.	06/09/2021	W Deseron E Garibovic
84.23	8.1. Guidelines for HC Organization Affiliation with VCOs	New section.	06/09/2021	W Deseron E Garibovic
84.22	8. Healthy Connections Value Care	New section.	06/09/2021	W Deseron E Garibovic
84.21	7.4.9 Reimbursement for Services Requiring Referral	Section deleted.	06/09/2021	W Deseron E Garibovic
84.20	7.3.2. Referral Elements	Clarify diagnosis goes in Notes.	06/09/2021	W Deseron E Garibovic
84.19	7.2.6. Exceptions & Exemptions to HC Enrollment	Clarifying language added.	06/09/2021	W Deseron E Garibovic
84.18	7.2.5. Changing Enrollment in Healthy Connections	Updated annual enrollment period.	06/09/2021	W Deseron E Garibovic
84.17	7.2.4 Mandatory Assignment	Renamed Mandatory Participant Enrollment in Healthy Connections. How participants will be assigned.	06/09/2021	W Deseron E Garibovic
84.16	7.2.3. Enrollment to clinic with panel limitations	New section.	06/09/2021	W Deseron E Garibovic
84.15	7.2.2. Participant Enrollment Guidelines	New section.	06/09/2021	W Deseron E Garibovic
84.14	7.2.1. Enrollment in Healthy Connections	Renamed Voluntary Participant Enrollment in Healthy Connections. Non-substantive language change.	06/09/2021	W Deseron E Garibovic
84.13	7.2.4 Provider Network Lists	Section deleted.	06/09/2021	W Deseron E Garibovic
84.12	7.1.7. Healthy Connections Participant Rosters	Updated information available on HC report.	06/09/2021	W Deseron E Garibovic
84.11	7.1.6. Healthy Connections Case Management Payment	Updated payment rate and processing time frame.	06/09/2021	W Deseron E Garibovic
84.10	7.1.5. Healthy Connections Coordinated Care Agreement and Tier Compliance by Tier	New section.	06/09/2021	W Deseron E Garibovic
84.9	7.1.4. Healthy Connections Tier Requirements	Updated tier requirements.	06/09/2021	W Deseron E Garibovic
84.8	7.1.3. Healthy Connections Clinic Panel Limit Guidelines	New section.	06/09/2021	W Deseron E Garibovic
84.7	7.1.2. Healthy Connections Clinic Panel Limit Entry	New section.	06/09/2021	W Deseron E Garibovic
84.6	7.1.1. Healthy Connections Primary Care Provider Network Directory	New section.	06/09/2021	W Deseron E Garibovic
84.5	7.1. Healthy Connections Provider Enrollment	Add provider requirements to maintain information and re-enrolling after cancellation.	06/09/2021	W Deseron E Garibovic

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Version	Section	Update	Publish Date	SME
84.4	7.1 Importance of Verifying Medicaid Eligibility and Healthy Connections Enrollment	Section deleted.	06/09/2021	W Deseron E Garibovic
84.3	7. Healthy Connections (HC)	Clarify primary care provider team.	06/09/2021	W Deseron E Garibovic
84.2	6.2.2. Trading Partner Account (TPA)	Clarify healthy connections information available.	06/09/2021	W Deseron E Garibovic
84.1	6.2. Verifying Participant Eligibility	Clarify checking healthy connections status.	06/09/2021	W Deseron E Garibovic
84.0	All	Published version	03/11/2021	TQD
83.1	Appendix A. Provider Agreement Example	Updated to current Provider Agreement version, revised November 2020	03/11/2021	T Humpherys M Payne
83.0	All	Published version	03/05/2021	TQD
82.4	6.2.3.1. Electronic Visit Verification (EVV) Software	New section.	03/02/2021	W Deseron E Garibovic
82.3	1.2. Documentation	Added allowance for EVV signatures.	03/02/2021	W Deseron E Garibovic
82.2	1. Provider Responsibilities	Added 21st Century Cures Act.	03/02/2021	W Deseron E Garibovic
82.1	General Information and Requirements for Providers	Added description of references.	03/02/2021	W Deseron E Garibovic
82.0	All	Published version	01/19/2021	TQD
81.1	5.6.1 Limited Risk Providers	Added Pharmacist	01/19/2021	M Payne K Duke
81.0	All	Published version	12/31/2020	TQD
80.1	All	Removed DXC references, rebranded to Gainwell Technologies	12/31/2020	TQD
80.0	All	Published version	11/10/2020	TQD
79.1	1.6 Payment Error Rate Measurement (PERM) Audits	Updated State PERM contact email address	11/04/2020	M Payne J Kennedy-King
79.0	All	Published version	10/30/2020	TQD
78.1	4.6 Provider Relations Consultants (PRC)	Updated PRC contact information to include local numbers	10/28/2020	M Payne E Garibovic
78.0	All	Published version	09/18/2020	TQD
77.1	4.6 Provider Relations Consultants (PRC)	Updated PRC contact information	09/18/2020	M Payne E Garibovic
77.0	All	Published version	07/23/2020	TQD
76.4	1.3. Ordering, Referring and Prescribing Providers	Approval for changes related to CCF 10857B1 provided	07/23/2020	T Humpherys M Payne
76.3	7.3.1 Enrollment in Healthy Connections	Added information for clinics in Healthy Connections to restrict participant enrollment.	07/22/2020	W Deseron E Garibovic
76.2	7.2.4 Primary Care Provider Listing	Renamed section to Provider Network Lists. Clarified where changes should be submitted.	07/22/2020	W Deseron E Garibovic
76.1	1.3. Ordering, Referring and Prescribing Providers	Added Pharmacist specialty per CCF 10857B1.	05/28/2020	M Payne