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State/Territory Name: Idaho

State Plan Amendment (SPA) #: 23-0001

This file contains the following documents in the order listed:

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3) Approved SPA Pages

ID - Submission Package - ID2023MS0001O - (ID-23-0001) - Health Homes

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
601 E. 12th St.
Room 355
Kansas City, MO 64106

Center for Medicaid & CHIP Services

June 23, 2023

Juliet Charron
Administrator, Division of Medicaid
Idaho Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720

Re: Approval of State Plan Amendment ID-23-0001 Intellectual Disability/Mental Illness (ID/MI) Health Home

Dear Administrator Charron,

On March 30, 2023, the Centers for Medicare and Medicaid Services (CMS) received Idaho State Plan Amendment (SPA) ID-23-0001, which proposes to implement a health home for Medicaid beneficiaries with intellectual disabilities and a diagnosis of serious mental illness or autism.

We approve Idaho State Plan Amendment (SPA) ID-23-0001 with an effective date of January 01, 2024.

For payments made to Health Homes providers under this new Health Homes Program SPA, a medical assistance percentage (FMAP) rate of 90% applies to such payments for the period 1/1/2024 to 12/31/2025.

The FMAP rate for payments made to health homes providers will return to the state's published FMAP rate at the end of the enhanced match period. The Form CMS-64 has a designated category of service Line 43 for states to report health homes services expenditures for enrollees with chronic conditions.

If you have any questions regarding this amendment, please contact Courtenay Savage at courtenay.savage@cms.hhs.gov

Sincerely,

James G. Scott

Director, Division of Program Operations

Center for Medicaid & CHIP Services

ID - Submission Package - ID2023MS0001O - (ID-23-0001) - Health Homes

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

CMS-10434 OMB 0938-1188

Package Header

Package ID ID2023MS0001O

SPA ID ID-23-0001

Submission Type Official

Initial Submission Date 3/30/2023

Approval Date 06/23/2023

Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: Idaho

Medicaid Agency Name: Idaho Department of Health and Welfare

Submission Component

(•) State Plan Amendment

(•) Medicaid

( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

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Package ID ID2023MS0001O

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Approval Date 06/23/2023

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID ID-23-0001

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	1/1/2024	New
Health Homes Geographic Limitations	1/1/2024	New
Health Homes Population and Enrollment Criteria	1/1/2024	New
Health Homes Providers	1/1/2024	New
Health Homes Service Delivery Systems	1/1/2024	New
Health Homes Payment Methodologies	1/1/2024	New
Health Homes Services	1/1/2024	New
Health Homes Monitoring, Quality Measurement and Evaluation	1/1/2024	New

Page Number of the Superseded Plan Section or Attachment (If Applicable):

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

Package Header

Package ID ID2023MS0001O

SPA ID ID-23-0001

Submission Type Official

Initial Submission Date 3/30/2023

Approval Date 06/23/2023

Effective Date N/A

Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives

The Intellectual Disability/Mental Illness (ID/MI) Health Home supports individuals who have an intellectual disability and also have a mental health diagnosis of Serious Mental Illness (SMI) or Autism and whose acuity exceeds the existing level of traditional community services and therefore struggle to have their health and safety needs met through traditional community services and need a more specialized plan of care. The ID/MI Health Home supports individuals by transitioning with them across multiple systems of care by using a comprehensive, multi-disciplinary team-based approach to crisis intervention. This allows for an individual's behavior analysis and intervention, psychiatric treatment and supports, treatment and monitoring of medical conditions as part of a comprehensive person-centered approach to care delivered in the least restrictive environment possible. This approach includes access to comprehensive care management, care coordination, health promotion and provides for comprehensive transitional care, individual and family support services, and referral to community and social support services. The ID/MI Health Home team attaches to the individual, and transitions with them across multiple systems of care, serving as the consistent bridge to treatment and supports the individual needs to be successful.

The ID/MI Health Home objective is implementing a treatment model across Idaho, which ensures individuals with the most complex and significant behaviors and other needs receive the appropriate treatment, whether they are living at a treatment center, in the community, or are transitioning from a center back into the community. The ID/MI Health Home provides person-centered, trauma-informed, services delivered in the least restrictive environment possible. The ID/MI Health Home bridges and facilitates linkages between providers and functions as the central point of contact between multiple systems of care. The ID/MI Health Home attaches to the individual navigating the different systems of care. The ID/MI Health Home focuses on directing patient-centered care across the broader health care system which allows individuals to experience improved continuity of care demonstrated through measurable improved healthcare outcomes.

The goals for the ID/MI Health Home Program are:

a. To reduce or eliminate critical health and safety issues participants might experience, working toward identifying, preventing, and/or mitigating the signs, symptoms, and/or social issues that could lead to health or safety crisis situations.

b. To provide transitional supports and continuity of care which assists in ameliorating the effects of chronic behavioral and physical health conditions and prevents repeat crisis situations for participants.

c. To improve the participants' overall medical, mental, and physical health.

d. To meet basic human needs and enhance their quality of life.

e. To improve the participants' opportunity to be successful in social situations, employment roles and typical activities of life.

f. To increase active participation in the community.

g. To partner with families, support systems and/or healthcare system providers in supporting the stabilization of participants.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2024	$3535337
Second	2025	$5011620

Federal Statute / Regulation Citation

Section 1945 of the Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

Package Header

Package ID	ID2023MS0001O	**SPA ID**	ID-23-0001
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Governor's Office Review

- (selected) No comment
- Comments received
- No response within 45 days
- Other

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ID - Submission Package - ID2023MS0001O - (ID-23-0001) - Health Homes

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

CMS-10434 OMB 0938-1188

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Superseded SPA ID	New User-Entered		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Intellectual Disability/Mental Illness (ID/MI) Health Home

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

The Intellectual Disability/Mental Illness (ID/MI) Health Home supports individuals who have an intellectual disability and also have a mental health diagnosis of Serious Mental Illness (SMI) or Autism, whose acuity exceeds the existing level of traditional community services and therefore struggle to have their health and safety needs met through traditional community services, and need a more specialized plan of care. The ID/MI Health Home supports individuals by transitioning with them across multiple systems of care by using a comprehensive, multi-disciplinary team-based approach to crisis intervention. This allows for an individual's behavior analysis and intervention, psychiatric treatment and supports, and treatment and monitoring of medical conditions, as part of a comprehensive person-centered approach to care delivered in the least restrictive environment possible. This approach includes access to comprehensive care management, care coordination, health promotion and provides for comprehensive transitional care, individual and family support services, and referral to community and social support services. The ID/MI Health Home team attaches to the individual, and transitions with them across multiple systems of care, serving as the consistent bridge to treatment and supports the individual needs to be successful.

The ID/MI Health Home objective is implementing a treatment model which ensures individuals with the most complex and significant behaviors and other needs across Idaho receive the appropriate treatment, whether they are living at a treatment center, in the community, or are transitioning from a center back into the community. The ID/MI Health Home provides person-centered, trauma-informed, services delivered in the least restrictive environment possible. The ID/MI Health Home bridges and facilitates linkages between providers and functions as the central point of contact between multiple systems of care. The ID/MI Health Home attaches to the individual navigating the different systems of care. The ID/MI Health Home focuses on directing patient-centered care across the broader health care system which allows individuals to experience improved continuity of care demonstrated through measurable improved healthcare outcomes.

The goals for the participants of the ID/MI Health Home are:
a. To reduce or eliminate critical health and safety issues that participants might experience, working toward identifying, preventing, and/or mitigating the signs, symptoms, and/or social issues that could lead to health or safety crisis situations.
b. To provide transitional supports and continuity of care which assist in ameliorating the effects of chronic behavioral and physical health conditions and prevents repeat crisis situations.
c. To improve their overall medical, mental, and physical health.
d. To meet basic human needs and enhance their quality of life.
e. To improve the opportunity to be successful in social and employment rolls and during the typical activities of life.
f. To increase active participation in the community.
g. To partner with families, support systems and/or healthcare system providers in supporting the stabilization of the participant.

General Assurances

- [x] The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- [x] The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- [x] The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- [x] The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.

- [x] The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.

- [x] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

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Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

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- (•) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

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Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

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Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

- [x] Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- [ ] Medically Needy Eligibility Groups

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

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Population Criteria

The state elects to offer Health Homes services to individuals with:

- [x] Two or more chronic conditions

Specify the conditions included:

- [x] Mental Health Condition
- [ ] Substance Use Disorder
- [ ] Asthma
- [ ] Diabetes
- [ ] Heart Disease
- [ ] BMI over 25
- [x] Other (specify):

Name	Description
Mental Health Conditions:	Serious Mental Illness (SMI): (SAMHSA Definition) Pursuant to section 1912(c) of the Public Health Service Act, adults with serious mental illness (SMI) are persons: (1) age eighteen (18) and over; and (2) who currently have, or at any time during the past year had a diagnosable mental behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness; and (3) that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities. *Federal Register Volume 58 No. 96 published Thursday May 20, 1993 pages 29422 through 29425 Autism: DSM-5 Autism Diagnostic Criteria: A. Persistent deficits in social communication and social interaction across multiple contexts B. Restricted, repetitive patterns of behavior, interests, or activities C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities or may be masked by learned strategies in later life). D. Symptoms cause clinically

Name	Description
	significant impairment in social, occupational, or other important areas of current functioning. E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.
Other Chronic Conditions:	Intellectual Disability (ID): (AAID Definition) A condition characterized by significant limitations in both intellectual functioning and adaptive behavior that originates before the age of twenty-two (22).

☐ One chronic condition and the risk of developing another

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

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Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- ○ Opt-In to Health Homes provider
- ● Referral and assignment to Health Homes provider with opt-out
- ○ Other (describe)

Describe the process used:

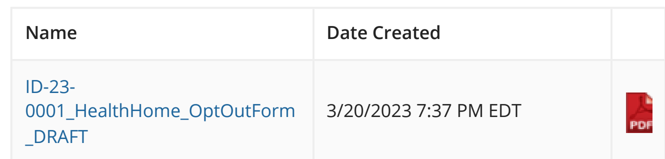
The State Medicaid Agency's Developmental Disabilities (DD) Crisis team is tasked with identifying individuals who have an intellectual disability and also have a mental health diagnosis of Serious Mental Illness (SMI) or Autism whose acuity exceeds existing community services. This team regularly works in collaboration with families, community providers, and other governmental entities including, but not limited to, the judicial system, correctional facilities, medical providers and advocacy organizations for all individual's with DD who are experiencing crisis. They also are the pathway to services for individuals with developmental disabilities when existing community services are insufficient to meet their needs. Potential ID/MI Health Home participants are identified by the DD Crisis team as the primary mechanism for referral to the ID/MI Health Home. Secondary sources can refer as well.

Participants and/or their decision making-authority are advised of the referral to the ID/MI Health Home and informed of all available options for services, so they can make an informed decision as to whether they will elect to remain in or opt out of the ID/MI Health Home.

Enrollment to the ID/MI Health Home takes place upon submission of a complete application, a signed consent for treatment and a consent for sharing information between identified Health Home linkage partners, applicable Managed Care Organizations (MCOs) and other fee for service providers. An application is considered complete when it is submitted with all relevant medical and psychiatric documentation/assessments to confirm:

- Individual meets qualifying chronic conditions population criteria.
- The individual's needs exceed traditional community-based services and requires or is at risk of requiring short term out of community placement

☑ The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit.



Name	Date Created	
ID-23-0001_HealthHome_OptOutForm_DRAFT	3/20/2023 7:37 PM EDT	PDF

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Health Homes Providers

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Types of Health Homes Providers

- [x] Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- [ ] Physicians
- [ ] Clinical Practices or Clinical Group Practices
- [ ] Rural Health Clinics
- [ ] Community Health Centers
- [ ] Community Mental Health Centers
- [ ] Home Health Agencies
- [ ] Case Management Agencies
- [ ] Community/Behavioral Health Agencies
- [ ] Federally Qualified Health Centers (FQHC)
- [x] Other (Specify)

Provider Type	Description
Health Home Team (ID/MI Health Home)	Services for ID/MI Health Home participants are provided by the ID/MI Health Home. The team must hold an active Idaho Medicaid provider agreement and comply with all provider enrollment and screening requirements as specified within the Idaho Medicaid Provider Handbook. All personnel providing Health Home services must be employed by or contracted with the ID/MI Health Home. Personnel must meet all: • Regulations specific to the Medicaid program • Requirements within the interagency agreement • Requirements specific to, Idaho's established certification and licensing standards and operate within their scope of practice.

Provider Type	Description
	Every enrolled ID/MI Health Home participant is assigned to a team based on the unique needs of the participant with services delivered through a combination of individualized intervention methods and strategies. The Health Home team pool of personnel include the following professions or disciplines: Required - • Psychiatrist • Physician Assistant or Nurse Practitioner • Licensed Practical Nurse • Board Certified Behavior Analyst • Care Coordinator May also include - • Psychologist • Social Worker • Physical Therapist • Occupational Therapist • Speech Therapist • Recreation Therapist • Education Specialist • Nutritionist • Substance Use Disorder Professional • Geriatric Specialist

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The State Medicaid Agency is responsible for providing the safety net for individuals with Intellectual/Developmental Disabilities who are experiencing crisis or whose needs cannot safely be met in a community setting. The State Medicaid Agency provides administrative oversight of the DD Crisis team and the ID/MI Health Home.

When an individual who has an intellectual disability and also has a mental health diagnosis of Serious Mental Illness (SMI) or Autism experiences a crisis, the DD Crisis team determines if the individual's needs can be met in various community treatment programs with support from the DD Crisis team, or if the individual's acuity has exceeded traditional services and should be referred to the ID/MI Health Home.

Individuals who demonstrate the need for the ID/MI Health Home are enrolled upon submission of a complete application. At that time, the ID/MI Health Home uses a comprehensive, Health Home interdisciplinary team of medical, mental health, developmental disability, and social service professionals to assess the participant. Based on a Bio-psychosocial assessment of physical, behavioral, psychological status and social functioning, along with a physical exam, the team establishes an individualized care plan and identifies the optimal setting of care. This care plan ensures the participant's prioritized needs are met by the Health Home team and/or by a Health Home partner. Operational procedures followed by the ID/MI Health Home teams when building the care plan ensure no duplication of services occurs across the multiple settings of care and when transitions occur.

An ID/MI Health Home partner is a state or community provider that has an agreement with the ID/MI Health Home team. These partners work closely with the team to ensure implementation of the participant's care plan. The team, partners, and the participant receiving care and/or their decision making-authority interact with each other daily to ensure a whole person treatment approach and coordination of care across disciplines.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services

9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

ID/MI Health Home providers and partners must participate in state-required training that addresses the above assurances and is designed to support transforming the service delivery system.

On an ongoing basis, the state will offer support to the ID/MI Health Home providers in the following ways:
a. Provide ongoing and regular technical assistance, including sufficient resources
b. Complete detailed provider manuals and protocols delineating all expectations and practice guidelines
c. Define specifications for all required quality reporting
d. Provide access to, and training on, state-specified information technology
e. Ad-hoc supports needed by the provider to ensure their effective execution of the Health Home
f. Provide ongoing monitoring and timely interventions to ensure continuous high-quality Health Home services.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

Administrative Requirements
• The Provider must meet all applicable Medicaid rule and statutory requirements.
• The Provider must have sufficient clinical and administrative infrastructure to ensure they can meet supervision, staffing and training standards.
• The Provider must utilize state specified information technology systems and will comply with all record requirements, including the use of an automated client record keeping system.
• The Provider must adhere to all requirements related to reporting and investigation of suspected abuse, neglect, mistreatment and significant injury.
• The Provider must protect and promote each patient's rights, including informed patient care, privacy, safe settings, freedom from abuse, neglect and harassment, confidentiality, access to records and resolution of grievances.

Treatment Standards
• The Provider must adhere to evidence-based practice guidelines for participants with SMI/Autism and ID.
• The Provider assures an appropriate level of supports will be provided to each participant, with frequency and duration of each contact determined by the ID/MI Health Home.
• The Provider assures a team approach is utilized in which all Health Home team members are familiar with the needs of each participant in order to provide appropriate treatment interventions that meet the unique needs of the person.
• The team maintains an effective working relationship with the State Medicaid Agency's Division of Family and Community Services, Division of Licensing and Certification, Division of Behavioral Health, Division of Medicaid, and the DD Crisis team.
• Health Home partner providers develop and implement a Quality Assurance Program designed to ensure services are consistently delivered in accordance with the Health Home service requirements and in alignment with evidence-based practice guidelines. Results of QA activities must be written and submitted to the state quarterly.
• Each Health Home provider must utilize a Quality Specialist whose responsibility includes being a liaison between the QA Program, the Health Home team and Health Home partners.

To ensure adherence to provider standards, the state operates a multi-tiered approach to oversight.
• Oversight related to administrative requirements must be provided as defined in rule and statutory requirements.
• Medicaid, as a payor of Health Home services, is responsible to assure payment for services and reimbursement requirements are met.
• As the lead for the administration of the ID/MI Health Home, the State Medicaid Agency's Division of Family and Community Services (FACS) is responsible for quality management and treatment fidelity of Health Home Services.
o FACS ensures adherence to evidence-based practices through the accreditation and/or credentialing of the Health Home by a nationally recognized association.
o FACS utilizes a Quality Improvement (QI) Committee to monitor quality assurance activities of Health Home providers and partners. QI committee findings are reported quarterly to leadership and addressed by administration.
o FACS requires quarterly reporting by Health Home providers of quality assurance measures and participant service outcomes.

Name	Date Created	
No items available		

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ID - Submission Package - ID2023MS0001O - (ID-23-0001) - Health Homes

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

CMS-10434 OMB 0938-1188

Package Header

Package ID	ID2023MS0001O	**SPA ID**	ID-23-0001
Submission Type	Official	**Initial Submission Date**	3/30/2023
Approval Date	06/23/2023	**Effective Date**	1/1/2024
Superseded SPA ID	New User-Entered		

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- [x] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care
- [ ] Other Service Delivery System

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ID - Submission Package - ID2023MS0001O - (ID-23-0001) - Health Homes

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

CMS-10434 OMB 0938-1188

Package Header

Package ID	ID2023MS0001O	**SPA ID**	ID-23-0001
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Payment Methodology

The State's Health Homes payment methodology will contain the following features

- [x] Fee for Service
  - [ ] Individual Rates Per Service
  - [ ] Per Member, Per Month Rates
  - [x] Comprehensive Methodology Included in the Plan
    - [x] Fee for Service Rates based on
      - [ ] Severity of each individual's chronic conditions
      - [ ] Capabilities of the team of health care professionals, designated provider, or health team
      - [x] Other

        Describe below

        Services and procedure codes that equate to component services under the Health Home.
  - [ ] Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided N/A

- [ ] PCCM (description included in Service Delivery section)
- [ ] Risk Based Managed Care (description included in Service Delivery section)
- [ ] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

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Agency Rates

Describe the rates used

- ○ FFS Rates included in plan
- ◉ Comprehensive methodology included in plan
- ○ The agency rates are set as of the following date and are effective for services provided on or after that date

Package Header

Package ID	ID2023MS0001O	**SPA ID**	ID-23-0001
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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
   - the frequency with which the state will review the rates, and
   - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

Cost and Data Assumptions: The State Medicaid Agency will utilize actual cost data from its MMIS. This will include services and procedure codes that equate to component services under the Health Home. The state will review the average cost and utilization of like services to determine the unit cost . This will be considered along with the anticipated hourly utilization of the component service to determine an initial per diem rate.

Reimbursable Unit of Service: Reimbursement for medically necessary Health Home services will be at the per diem rate set by the State Medicaid Agency. The per diem rate will be based, in part, on weighted averages for same or similar existing component services offered under Fee For Service (FFS).

Minimum Level of Activity: While participating in the Health Home, a participant must receive a minimum of one (1) Health Home service per month, to be documented in the member's electronic record.

Service Documentation: Any claim for Health Home services shall be supported by written documentation in the electronic record. Minimum documentation requires the Health Home provider to document under one of the six (6) core Health Home services. Documentation must include the service, duration, brief description of the specific areas addressed and the member's response to the services, including progress towards stated outcome(s). All claims for Health Home services will be subject to regular audits to ensure that Medicaid payments are consistent with efficiency, economy and quality of care.

Reviewing and Rebasing Rates: Rates will be considered for rebasing after each fiscal year, with a minimum of a rebased rate every five (5) years.

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

Package Header

Package ID ID2023MS0001O

Submission Type Official

Approval Date 06/23/2023

Superseded SPA ID New

User-Entered

SPA ID ID-23-0001

Initial Submission Date 3/30/2023

Effective Date 1/1/2024

Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved Idaho ensures non-duplication between Health Home benefits and State Plan and Medicaid HCBS services through person-centered planning practices. All underlying State plan benefits are billed separately and directly by appropriate providers. In addition, participants receiving Health Home benefits who are also enrolled in HCBS Waivers are ineligible to also receive the HCBS waiver services of behavior consultation/crisis management and skilled nursing until they have fully transitioned out of the ID/MI Health Home.

☑ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☑ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created
No items available	

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ID - Submission Package - ID2023MS0001O - (ID-23-0001) - Health Homes

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

CMS-10434 OMB 0938-1188

Package Header

Package ID	ID2023MS0001O	**SPA ID**	ID-23-0001
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Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

Comprehensive Care Management for the ID/MI Health Home includes assessment, and the identification and development of a treatment plan for service provision. This plan is based upon comprehensive assessment and ongoing monitoring of bio-psychosocial assessment of physical, behavioral, psychological status and social functioning, along with a physical exam and is individually developed to meet the participants needs and goals.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health Home team members utilize electronic health records to record all elements of the participant's care, including care management and adjust the plan as appropriate.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☑ Nurse Practitioner

Description

This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.

☐ Nurse Care Coordinators

☑ Nurses

Description

This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.

☐ Medical Specialists

☐ Physicians

☑ Physician's Assistants

Description

This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.

☐ Pharmacists

☑ Social Workers

Description

This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the

Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☑ Nutritionists

Description

This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.

☑ Other (specify)

Provider Type	Description
Psychiatrist	This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.
Board Certified Behavior Analyst	This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.
Care Coordinator	This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.
Psychologist	This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.
Physical Therapist	This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.
Occupational Therapist	This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.
Speech Therapist	This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.
Recreation Therapist	This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.
Education Specialist	This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.

Provider Type	Description
Substance Use Disorder Professional	This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.
Geriatric Specialist	This component can be completed by any Health Home team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates the assessments, Health Home functions and facilitates any necessary linkages to supports and services necessary for effective implementation.

Care Coordination

Definition

Care Coordination is the organization of activities between members of the Health Home team responsible for different components of the person-centered care plan.
Activities performed under this service include but are not limited to:

- Coordination with all ID/MI Health Home team members to ensure all objectives of treatment identified in the ID/MI plan of care are progressing
- Coordination with linkage partners to ensure all objectives of treatment identified in the ID/MI plan of care are progressing
- Scheduling and communicating treatment times for the ID/MI Health Home team
- Conducting referrals for services within the ID/MI person centered plan, facilitating linkages and following up on referrals
- Monitoring outcomes
- Participating in care setting discharge processes or care transitions

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health Home team members utilize electronic health records to record all elements of the participant's care, including care coordination and adjust the plan as appropriate.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [x] Nurse Practitioner

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation.

- [ ] Nurse Care Coordinators
- [x] Nurses

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation.

- [ ] Medical Specialists
- [ ] Physicians
- [x] Physician's Assistants

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation.

- [ ] Pharmacists
- [x] Social Workers

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [x] Nutritionists

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation.

- [x] Other (specify)

Provider Type	Description
Education Specialist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Substance Use Disorder Professional	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Geriatric Specialist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Health Home linkage providers	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Psychiatrist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Board Certified Behavior Analyst	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Care Coordinator	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Psychologist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Physical Therapist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Occupational Therapist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Speech Therapist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Recreation Therapist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.

Health Promotion

Definition

Health Promotion is the encouraging and supporting of healthy ideas and concepts to motivate participants to adopt healthy behaviors. Activities performed under this service include but are not limited to:

- Mental Health symptom education
- Teaching of coping strategies
- Evidence based nutrition and dietary management
- Anger and stress management
- Recreation activities that promote healthy living

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health Home team members utilize electronic health records to record all elements of the participant’s care, including health promotion, and adjust the plan as appropriate.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☑ Nurse Practitioner

Description

This component can be completed by any Health Home team member as most appropriate for the participant’s care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.

☐ Nurse Care Coordinators

☑ Nurses

Description

This component can be completed by any Health Home team member as most appropriate for the participant’s care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.

☐ Medical Specialists

- [ ] Physicians
- [x] Physician's Assistants

Description

This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.

- [ ] Pharmacists
- [x] Social Workers

Description

This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [x] Nutritionists

Description

This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.

- [x] Other (specify)

Provider Type	Description
Education Specialist	This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.
Substance Use Disorder Professional	This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.
Geriatric Specialist	This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.
Psychiatrist	This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.
Board Certified Behavior Analyst	This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.
Care Coordinator	This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.
Psychologist	This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.
Physical Therapist	This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.
Occupational Therapist	This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team

Provider Type	Description
	member will carry out and oversee services requiring elements specific to clinical skillsets.
Speech Therapist	This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.
Recreation Therapist	This component can be completed by any Health Home team member as most appropriate for the participant's care plan. The appropriate team member will carry out and oversee services requiring elements specific to clinical skillsets.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Transitional services focus on the movement of participants from inpatient care to long term placement in a community setting.

Activities performed under this service: Health Home team members assist in:
- Transitioning participants to less restrictive inpatient care settings (promoting step down treatment)
- The development of discharge strategies
- The identification of a community placement post discharge
- Facilitating collaboration among community treatment providers
- Creating a monitoring plan to encourage a safe transition.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health Home team members utilize electronic health records to record all elements of the participant's care, including comprehensive transition care and adjust the plan as appropriate.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☑ Nurse Practitioner

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation.

☐ Nurse Care Coordinators

☑ Nurses

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation.

☐ Medical Specialists

☐ Physicians

☑ Physician's Assistants

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation.

☐ Pharmacists

☑ Social Workers

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☑ Nutritionists

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation.

☑ Other (specify)

Provider Type	Description
Education Specialist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Substance Use Disorder Professional	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Geriatric Specialist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Psychiatrist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Board Certified Behavior Analyst	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Care Coordinator	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Psychologist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Physical Therapist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Occupational Therapist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Speech Therapist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.
Recreation Therapist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation.

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services include activities and training that ensure Health Home participants and their family/support person(s) are knowledgeable about the participant’s condition and how to support their overall treatment goals. In addition to assisting participants in accessing services that reduce barriers to treatment, care coordination, and improve health outcomes, individual and family supports may also include skills training activities related to daily life management.

Examples of Individual and Family Support Services may include:
- Skills training
- Employment/supported employment activities
- Activities related to restoration of competency
- For those persons with a representative payee, the team works with the participant and the representative payee to ensure the participant’s financial needs are met, coordinated and monitored.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health Home team members utilize electronic health records to record all elements of the participant’s care, including individual and family support services, and adjust the plan as appropriate.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [x] Nurse Practitioner

Description

This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.

- [ ] Nurse Care Coordinators
- [x] Nurses

Description

This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.

- [ ] Medical Specialists

- [ ] Physicians
- [x] Physician's Assistants

Description

This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.

- [ ] Pharmacists
- [x] Social Workers

Description

This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [x] Dieticians

Description

This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.

- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Education Specialist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.
Substance Use Disorder Professional	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.
Geriatric Specialist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.
Psychiatrist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.
Board Certified Behavior Analyst	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.
Care Coordinator	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.
Psychologist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.
Physical Therapist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.
Occupational Therpist	This component can be completed by any Health Home Team member as most appropriate for the participant’s symptom presentation. For services

Provider Type	Description
	requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.
Speech Therapist	This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.
Recreation Therapist	This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation. For services requiring clinical skillsets, the appropriate team member will carry out and oversee those specific elements.

Referral to Community and Social Support Services

Definition

Referral to community and support services includes the identification and referral of participants to available community and social support services that promote living in the least restrictive environment possible. To ensure the participant has access to formal and informal resources, the team provides linkage or direct assistance to accessible community and social support services such as:

- Housing
- Food Security/Nutrition Programs
- Employment Counseling
- Long Term Services and Supports
- School
- Faith Based Services
- Substance Use Disorder Support
- Transportation
- Geriatric Support

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Health Home team members utilize electronic health records to record all elements of the participant's care, including referral to community and social support services, and adjust the plan as appropriate.

Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☑ Nurse Practitioner

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates linkages, referral activities.

☐ Nurse Care Coordinators

☑ Nurses

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates linkages, referral activities.

☐ Medical Specialists

☐ Physicians

☑ Physician's Assistants

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates linkages, referral activities.

☐ Pharmacists

☑ Social Workers

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates linkages, referral activities.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☑ Nutritionists

Description

This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation. Typically, the

Care Coordinator coordinates linkages, referral activities.

☑ Other (specify)

Provider Type	Description
Education Specialist	This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates linkages, referral activities.
Substance Use Disorder Professional	This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates linkages, referral activities.
Geriatric Specialist	This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates linkages, referral activities.
Psychiatrist	This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates linkages, referral activities.
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Recreation Therapist	This component can be completed by any Health Home Team member as most appropriate for the participant's symptom presentation. Typically, the Care Coordinator coordinates linkages, referral activities.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

Package Header

Package ID	ID2023MS0001O	**SPA ID**	ID-23-0001
Submission Type	Official	**Initial Submission Date**	3/30/2023
Approval Date	06/23/2023	**Effective Date**	1/1/2024
Superseded SPA ID	New User-Entered		

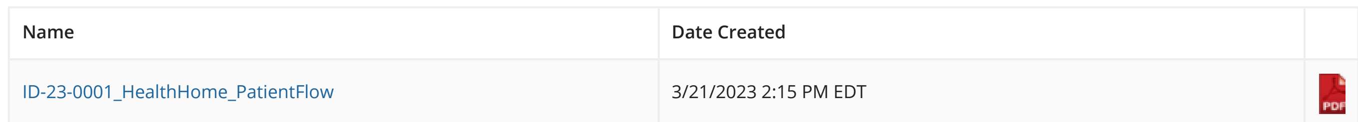
Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

Referral and Enrollment: As described above, the referral source for the ID/MI Health Home is the DD Crisis team. Through engagement with community providers, hospitals, and the court system, the DD Crisis team identifies potential participants for the ID/MI Health Home and completes a brief eligibility screening. Those individuals whose screening show their needs cannot be met in various community treatment programs or in a psychiatric hospital, are referred to the ID/MI Health Home to determine eligibility. Individuals who are eligible and who choose to participate are enrolled. The Health Home Team to complete intake activities, including assessment and care planning.

Participation: All assessments are completed within thirty (30) days of intake. The Health Home team establishes an individualized care plan and identifies the optimal setting of care. Participants and/or their decision making-authority are informed of all available options for services so that they can make an informed decision as to whether they elect to remain in or opt out of the ID/MI Health Home. Based on the identified needs of the participant, the Health Home team works with a Health Home Partner who ensures the implementation of the participant's care plan. The Health Home team and partners work together to foster a whole person treatment approach and coordination across disciplines. While participating in the Health Home, a participant receives a minimum of one (1) Health Home service per month, to be documented in the participant's electronic record.

Reassessment and Discharge: At a minimum, participant goals, psychiatric evaluations and treatment are reevaluated initially at ninety (90) days and then every six (6) months thereafter. Care plans should also be reevaluated any time a participant experiences a significant life-event to ensure the plan remains person-centered, reflects a trauma informed approach and indicates the participant's preferences and objectives. If the participant requires acute hospitalization or subacute residential care, the Health Home team actively work towards the goal of short-term inpatient treatment with a focus on movement to long term placement in a community setting. When the participant transitions from an acute or subacute care setting to a community placement, the Health Home team develops a transition plan with referrals to appropriate services and providers along with a collaborative partner plan which is used to continue the participant's care and support. When the participant no longer meets eligibility for the ID/MI Health Home and is ready to be supported through traditional services, a Health Home team member works with the participant to transition their care. A Health Home team member reports their discharge from the ID/MI Health Home to Medicaid and notes the completion of discharge planning in the participant's electronic health record.



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ID - Submission Package - ID2023MS0001O - (ID-23-0001) - Health Homes

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | ID2023MS0001O | ID-23-0001 | Intellectual Disability/Mental Illness (ID/MI) Health Home

CMS-10434 OMB 0938-1188

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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

Idaho calculates and monitors cost savings through several mechanisms. For participants with an established Medicaid claim history, cost savings data is calculated by comparing current year Medicaid and general fund dollars spent with historical Medicaid and general fund costs for participants.

For participants without established claims history, the state will determine a projected service utilization using data from participants with similar presentation and symptoms to ascertain the cost avoidance achieved through the Health Home intervention.

In addition, Idaho will include an analysis of participant outcomes to demonstrate the value provided through the Health Homes (employment, housing stability, etc.).

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

The State Medicaid Agency will require that Health Homes providers (team and partners who have a linkage agreement) use an operational automated client record keeping system to support the delivery of Health Home services. This record will be prescribed by the state and will include all elements of a participant's individualized care plan and service documentation.

The enables real time access to data and data sharing (with appropriate permissions) among the participant, the Health Home team, partner agencies and the state to ensure a comprehensive, whole-person record of support. Additionally, the system will include critical health information including pharmacology to ensure complete integration of physical health, behavioral health and long-term services and supports.

Health Homes Monitoring, Quality Measurement and Evaluation

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Quality Measurement and Evaluation

- [x] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- [x] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- [x] The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- [x] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

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