MEDICAID MODEL DATA LAB

Id: IDAHO
State: Idaho
Health Home Services Forms
(ACA 2703)

Transmital Numbers (TN) and Effective Date
Please enter the numerical part of the Transmital Numbers (TN) in the format YY-0000 where YY = the last two digits of the year for which the document relates to, and 0000 = a four digit number with leading zeros. The dashes must also be entered. State abbreviation will be added automatically.
Supersedes Transmital Number (TN)

00-0000

Transmital Number (TN)

12-0009

Please enter the Effective Date with the format MM/dd/yyyy where MM = two digit month number, dd = the two digit day of the month, and yyyy = the four digit year. Please also include the slashes (/).
Effective Date

01/01/2013

3.1 - A: Categorically Needy View
Attachment 3.1-H
Page
Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

☑ Health Home Services

How are Health Home Services Provided to the Medically Needy?
Not provided to Medically Needy
i. Geographic Limitations
Statewide Basis
If Targeted Geographic Basis,

ii. Population Criteria
The State elects to offer Health Home Services to individuals with:

☑ Two chronic conditions

☑ One chronic condition and the risk of developing another

☑ One serious mental illness

from the list of conditions below:

☑ Mental Health Condition

☐ Substance Use Disorder

☑ Asthma

☑ Diabetes

☐ Heart Disease

☐ BMI Over 25

☐ Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

To qualify for enrollment in a health home, Medicaid participants must: (1) have a chronic condition of serious persistent mental illness (SPMI) or serious emotional disturbance (SED); (2) have diabetes and asthma; or (3) have either diabetes or asthma and be at risk for another chronic condition. The risk factors for number three above will include a body mass index (BMI) greater than 25, Dyslipidemia, tobacco use, hypertension, or diseases of the respiratory system.

Medicaid participants can self-refer to a health home or be referred by any service provider. Participants who meet the criteria will be automatically enrolled into a health home, with the right or choice to opt-out.

In order to avoid duplication of services, qualifying members currently receiving Targeted Case Management (TCM) as a service will shift the delivery of this care to their health home practice.

The State assures that its Health Homes program will not duplicate payments for any other Medicaid Service, in accordance with 42 CFR 440.169.
iii. Provider Infrastructure

☑ Designated Providers as described in §ection 1945(h)(5)
The term 'designated provider' means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians).
To be qualified to be a health home, the designated provider:
(A) has the systems and infrastructure in place to provide health home services; and
(B) satisfies the qualification standard as described below.

Designated providers must be Healthy Connections providers. The designated provider will include primary care physicians, mental health care providers, nurse practitioners, or physician assistants. The designated provider will operate in coordination with health care professionals inside and outside of the particular practice that the provider feels will meet the needs of the patient. Examples of other health care professionals include, but are not limited to Registered Nurse, Medical Assistant, Dietician, Behavioral Health provider, etc.

The designated provider will identify and lead the team based care coordination approach between the clinic and specialist so the whole person's care is taken into account in both chronic disease and mental health treatment. The integration of behavioral health is a required element of the Health Home. The designated provider may use tele-health, behavioral health professionals within the clinic, referring qualified participants to a behavioral health professional (requires additional coordination of care), or other resources as the designated providers deems necessary.

Providers currently enrolled in Idaho Medicaid primary care case management program (Healthy Connections) are eligible to become designated providers. Participating providers will be required to sign a provider agreement which stipulates all Health Home requirements. Providers will be required to submit a Health Home assessment as an assurance that the necessary systems are in place prior to becoming a Health Home.

☐ Team of Health Care Professionals as described in §ection 1945(h)(6)

☐ Health Team as described in §ection 1945(h)(7), via reference to §ection 3502
iv. Service Definitions
Comprehensive Care Management
Service Definition

A care plan will be developed based on the information obtained from a health risk assessment performed by the designated provider. The assessment will identify the enrollee's physical, behavioral, and social service needs. This will ensure the patient's needs are identified, documented and addressed.
Idaho anticipates family members and other support involved in the patient's care to be identified and

included in the plan and executed as requested by the patient.
The care plan must also include outreach and activities which will support engaging the patient in their own care and promote continuity of care. The care plan will include periodic reassessment of the individual's needs, goals, and clearly identify the patient's progress towards meeting their goals. Changes in the care plan will be made based on changes in patient needs.

The designated provider's comprehensive assessment and care plan may include, but are not limited to family/social/cultural characteristics, medical history, advanced care planning, communication needs, and a depression screening for adults and children. Designated providers will identify patients/families that might benefit from additional care management support. The care coordinator in each practice will work closely with the designated provider to develop reminders for needed tests (e.g. HGA1Cs), track medical services provided out of the primary care clinic office, and streamline communication and coordination of the comprehensive care needs of each patient. Comprehensive care management functions can include, but are not limited to: Conducts pre-visit preparations, collaborates with the patient/family to develop an individual care plan (including treatment goals that are reviewed and updated at each relevant visit), gives the patient/family a written care plan, assesses and addresses barriers when the patient has not met treatment goals, and gives the patient/family a clinical summary at each relevant visit.

The care coordinator in each health home will track all referrals to ensure coordination of care between service providers. Designated providers will be responsible for obtaining and reviewing follow-up reports from medical and mental health specialists regarding services provided outside of the health home.
Ways Health IT Will Link

To facilitate the use of health information technology (HIT- electronic tools utilized to securely exchange or manage health information between two or more entities) by Health Homes to improve service delivery and coordination across the care continuum, Idaho has developed initial and final HIT standards. Providers must meet the initial HIT standard to enroll as a Health Home. Designated providers will be encouraged to utilize Idaho Health Data Exchange (IHDE) or another data repository to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals). Designated providers will be encouraged to utilize HIT as feasible to create, document, execute and update a care plan for every patient that is empanelled to the health care team. Designated providers will also be encouraged to utilize HIT as feasible to process and follow up on patient testing, treatments, services and referrals.
Care Coordination
Service Definition

Patients will choose and be assigned to a designated provider to increase continuity, and to ensure individual responsibility for care coordination functions. A person-centered plan will be developed based on the needs and desires of the patient with at least the following elements: options for accessing care, information on care planning and care coordination, names of other primary care team members when applicable, and information on ways the patient participates in this care coordination, including home and community based services(HCBS). Care coordination functions can include but are not limited to: tracking of ordered tests and result notification, tracking referrals ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and clinicians, demonstrating a process for consistently obtaining patient discharge summaries from the hospital and emergency departments, following up to obtain a specialist's reports, and direct collaboration or co-management of patients with mental health or substance abuse diagnoses. Under the direction of the designated provider, the care coordinator will help facilitate the patient's care needs. The coordinator should have knowledge and experience in the healthcare setting.
Ways Health IT Will Link

Designated providers will be encouraged to utilize the Idaho Health Data Exchange (IHDE) or another method of sharing data to access patient data and to develop partnerships that maximize the use of HIT across providers (i.e. hospitals). Designated providers will be encouraged to utilize HIT as feasible to create, document, execute and update a care plan for every patient that is accessible to the health

care professionals. Designated providers will also be encouraged to utilize HIT as feasible to monitor patient outcomes, initiate changes in care and follow up on patient testing, treatments, services and referrals.
Health Promotion
Service Definition

Idaho's Health Home plan for patient outreach and engagement will require a designated provider to actively seek to engage patients in their care by phone, letter, HIT and community outreach. Each of these outreach and engagement functions will include all aspects of comprehensive care management, care coordination, and referrals to community and social support services. All of the activities are built around the notion of relationships to care that address all of the clinical and non-clinical care needs of an individual including health promotion. The designated provider will support continuity of care and health promotion through the development of a treatment relationship with the individual and the health care professionals. The designated provider will promote evidence based wellness and prevention by linking Health Home enrollees with resources for tobacco cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on individual needs and preferences.
Ways Health IT Will Link

The designated providers will utilize HIT as feasible to promote, link, manage and follow up on enrollee health promotion activities.
Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)
Service Definition

Comprehensive transitional care will be provided to prevent enrollee avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility) and to ensure proper and timely follow up care. To accomplish this, Idaho Medicaid requires the designated provider to develop and utilize a process with hospitals and residential/rehabilitation facilities in their region to provide the Health Home care coordinator prompt notification of an enrollee's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.
The designated provider will be required to develop and have a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for timely scheduled appointments at recommended outpatient providers.
The Health Home care coordinator will be an active participant in all phases of care transition.
Ways Health IT Will Link

Designated providers will communicate with discharging/admitting facilities and use electronic health records (EHRs) as feasible. Communication will be ongoing, and may precede appointments or occur after appointments, as required to meet the needs of the patient. Communication will consist of relevant patient medical history, current complications and ongoing needs.
Designated providers will be encouraged to utilize IHDE to develop partnerships that maximize the use of HIT across providers (i.e. hospitals). The designated provider will utilize HIT as feasible to communicate with health facilities and to facilitate interdisciplinary collaboration among all providers, the patient, family, care givers and local supports.
Individual and Family Support Services (including authorized representatives)
Service Definition

Peer supports, support groups, and self-care programs will be utilized by the designated provider to increase patients' and caregivers knowledge of the individual's disease(s), promote the enrollee's engagement and self-management capabilities, and help the enrollee improve adherence to their prescribed treatment. The designated provider will ensure that communication and information shared with the patient/patient's family is understandable.
Ways Health IT Will Link

Designated providers will be encouraged to utilize IHDE or another data repository to access patient data and to develop partnerships that maximize the use of HIT across provider types. Designated providers will utilize HIT as feasible to provide the patient access to their care plan and options for accessing clinical information.
Referral to Community and Social Support Services
Service Definition

The designated provider will identify available community-based resources and actively manage appropriate referrals, access to care, engagement with other community and social supports, coordinate services and follow-up post engagement with services. Designated providers will develop policies, procedures and accountabilities to support effective collaboration with community-based resources that clearly define the roles and responsibilities of the patients. They will also assist the participant in locating individual and family supports, including referral to community, social support, and recovery services.
Ways Health IT Will Link

The designated providers will utilize HIT as feasible to initiate, manage and follow up on community-based and other social service referrals. Documentation can include, but is not limited to transformation assessments, clinical process and outcome measures, and care plans for each Health Home participant. Designated providers must be participating primary providers in Idaho's Primary Care Case Management program, Healthy Connections.

v.Provider Standards
Under Idaho State's approach to Health Home implementation, designated providers are the central point for directing patient-centered care. Designated providers are accountable for reducing avoidable health care costs (specifically preventable hospital admissions/readmissions and avoidable emergency room visits), providing timely post discharge follow-up, and improving patient outcomes by addressing primary medical, specialist and mental health care through direct provision with appropriate service providers, of comprehensive, integrated services. Designated providers will be held accountable by providing documentation of Health Home processes (transition to NCQA PCMH recognition) that ensures comprehensive care management, care coordination, comprehensive transitional care, patient and family support, referral to community and social support services, and use of HIT as feasible. Documentation can include, but is not limited to transformation assessments, clinical process and outcome measures, and care plans for each Health Home participant. Designated providers must be participating primary providers in Idaho's Primary Care Case Management program, Healthy Connections.

The designated provider will:
1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Home 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 and management of mental illness;
4. Coordinate and provide access to mental health 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; and
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.
12. Become at least level one NCQA recognized by the end of year two after initiation.
vi. Assurances

☑ A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

☑ B. The State has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

☑ C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.
vii. Monitoring
A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

Idaho Medicaid will use claims data to track avoidable readmissions.
Numerator: Any Health Home patient diagnosed with Asthma and/or Diabetes admitted within 30 days of a prior discharge.

Denominator: Total number of discharges for all patients diagnosed with Diabetes and/or Asthma.
B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

Idaho Medicaid will use claims data as their data source and will annually perform an assessment of cost savings using a pre/post-period comparison. The assessment will include total Medicaid savings for the intervention group and will be subdivided by category of service. These will be reported semi-annually. Cost measures will include:
1. Total PMPM costs
2. ED costs
3. Admission costs
4. Readmission costs
Medicaid expects to be cost neutral for the first year of implementation of Health Homes, but anticipates savings after the Health Home has been established at the practice level.
C. Describe the State's proposal for using health information technology in providing health home services under this program and improving 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).

Idaho has developed initial and final HIT requirements. Designated providers must meet the initial HIT requirement to implement a Health Home. In addition, providers must provide a plan to achieve the final requirement within twenty-four months of program initiation in order to be approved as a Health Home provider.
The initial standards (months 1-3) require designated providers to make use of available HIT for the following processes:

1. Have a structured information system in place to populate a disease management database.

2. Have a structured information system for tracking and managing the patients with chronic diseases.

The final standards require that designated providers use HIT for the following processes:

1. Have a systematic process to follow-up on tests, treatments, services, and referrals which is incorporated into the patient's care plan;

2. Utilize HIT allowing the patient health information and care plan to be accessible and allow for population management and identification of gaps in care including preventive services; and

3. Is required to make use of available HIT and access members' data through the IHDE to conduct all processes, as feasible.
3.1 - A: Categorically Needy View
Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation
viii. Quality Measures: Goal Based Quality Measures
Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.
Goal 1:
Improve Care for Diabetes among adults.
Clinical Outcomes
Measure

Diabetes: HbA1c Poor control
The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c > 9.0.
Data Source

Chart-based
Measure Specification

Numerator: Laboratory test result: HbA1c test, Most Recent value > 9.0.

Denominator: Patients 18-75 years of age who had a diagnosis of diabetes (type 1 or 2) within the past two years. Exclusions apply. Pharmacy and Diagnosis codes are provided.

NCQA
NQF # 59
How Health IT will be Utilized

Designated providers will be required to report on two to three clinical quality measures (disease of choice- if asthma is selected all three measures must be reported) and two clinical preventive measures of choice as relevant to their practice.
Providers will submit these reports directly to Idaho Medicaid using HIT.

We will use data analytics with data provided by the health home provider to calculate the results which will be shared with the health homes and will include benchmarks.
Experience of Care
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Quality of Care
Measure

Diabetes: Hemoglobin A1c Testing
Percentage of adult patients with diabetes aged 18-75 years receiving one or more A1c test(s) per year.
Data Source

Chart-based
Measure Specification

Numerator: One or more HbA1c tests performed during the measurement year.

Denominator: Patients 18-75 years of age as of December 31 of the measurement year who had a diagnosis of diabetes (type 1 or 2). Exclusions apply. Pharmacy and Diagnosis codes are provided.
NCQA
NQF # 57
How Health IT will be Utilized

Designated providers will be required to report on two to three clinical quality measures (disease of choice- if asthma is selected all three measures must be reported) and two clinical preventive measures of choice as relevant to their practice.
Providers will submit these reports directly to Idaho Medicaid using HIT.

We will use data analytics with data provided by the health home provider to calculate the results which will be shared with the health homes and will include benchmarks.
Goal 2:
Improve Care for patients with Heart Disease.
Clinical Outcomes
Measure

Controlling High Blood Pressure
The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.
Data Source

Chart-based
Measure Specification

Numerator: Physical exam finding diastolic blood pressure < 90 mmHg, and systolic blood pressure < 140 mmHg, during most recent outpatient encounter.

Denominator: Patients 18 -85 years of age that had a diagnosis of active hypertension within 6 months of the measurement date. The measurement duration is 12 months.

NCQA
NQF # 18

How Health IT will be Utilized

Designated providers will be required to report on two to three clinical quality measures (disease of choice- if asthma is selected all three measures must be reported) and two clinical preventive measures of choice as relevant to their practice.

Providers will submit these reports directly to Idaho Medicaid using HIT.

We will use data analytics with data provided by the health home provider to calculate the results which will be shared with the health homes and will include benchmarks.
Experience of Care
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Quality of Care
Measure

Hypertension: Blood Pressure Measurement
Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
Data Source

Chart-based
Measure Specification

Numerator: Physical Exam finding systolic and diastolic blood pressure.

Denominator: Patients with active hypertension who are 18 or older.

NQF # 13
How Health IT will be Utilized

Designated providers will be required to report on two to three clinical quality measures (disease of choice- if asthma is selected all three measures must be reported) and two clinical preventive measures of choice as relevant to their practice.
Providers will submit these reports directly to Idaho Medicaid using HIT.

We will use data analytics with data provided by the health home provider to calculate the results which will be shared with the health homes and will include benchmarks.
Goal 3:
Improve Outcomes for individuals with Mental Illness
Clinical Outcomes
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A

Experience of Care
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Quality of Care
Measure

1. Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment
The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.

2. Screening for Clinical Depression
Percentage of patients aged 12 and older screened for clinical depression using a standardized tool and follow-up plan documented.
Data Source

1. Chart-based

2. Chart-based
Measure Specification

1. Numerator: (a)Antidepressant
Medication dispensed = 84 days after the FIRST diagnosis of active major depression.
(b)Antidepressant
Medication dispensed = 180 days after the FIRST diagnosis of active major depression.

Denominator: Patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.

NQF # 105

2. Numerator: Patient's screening for clinical depression is documented and follow-up plan is documented.

Denominator: Patients 12 years of age and older.
NQF # 418
How Health IT will be Utilized

Designated providers will be required to report on two to three clinical quality measures (disease of choice- if asthma is selected all three measures must be reported) and two clinical preventive measures of choice as relevant to their practice.

Providers will submit these reports directly to Idaho Medicaid using HIT.

1. We will use data analytics to calculate the results which will be shared with the health homes and

will include benchmarks.

2. We will use data analytics to calculate the results which will be shared with the health homes and will include benchmarks.
Goal 4:
Improve Care for Asthma among adults and children.
Clinical Outcomes
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Experience of Care
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Quality of Care
Measure

1. Asthma Assessment
Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.

2. Asthma Pharmacologic Therapy
Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment. Report two age stratifications (5-11, 12-40), and total.

3. Management Plan for People with Asthma
Percentage of patients for whom there is documentation that a written asthma management plan was provided either to the patient or the patient's caregiver OR, at a minimum, specific written instruction on under what conditions the patient's doctor should be contacted or the patient should go to the emergency room.
Data Source

1. Chart-based

2. Chart-based

3. Chart-based
Measure Specification

1. Numerator: Symptom assessed or active: asthma daytime symptoms quantified.
Symptom assessed or active: asthma nighttime symptoms quantified.

Denominator: Patients aged 5 to 40 years with diagnosis of active asthma, and two or more office encounters to determine the physician has a relationship with the patient.
Reported separately for children and adults.

NQF # 1

2. Numerator: Medication order or medication active: Corticosteroid, inhaled or alternative asthma medication.

Denominator: Patient aged 5 through 40 years with a diagnosis of active asthma or asthma persistent, and at least two office encounters.
Reported separately for children and adults.

NQF # 47

3. Numerator: Patients for whom there is documentation, at any time during the abstraction period, that a written asthma management plan was provided either to the patient or the patient's caregiver OR at a minimum, a specific written instruction on under what conditions the patient's doctor should be contacted or the patient should go to the emergency room.

Denominator: Patients who had at least two separate Ambulatory visits to your practice site for asthma during the time period January through December.
Asthma visits are defined by claims-fields and specified ICD-9 codes.
Reported separately for children and adults.

NQF # 25
How Health IT will be Utilized

Designated providers will be required to report on two to three clinical quality measures (disease of choice- if asthma is selected all three measures must be reported) and two clinical preventive measures of choice as relevant to their practice.
Providers will submit these reports directly to Idaho Medicaid using HIT.

1. We will use data analytics with data provided by the health home provider to calculate the results which will be shared with the health homes and will include benchmarks.

2. We will use data analytics with data provided by the health home provider to calculate the results which will be shared with the health homes and will include benchmarks.

3. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks.
Goal 5:
Increase preventive care for adults.
Clinical Outcomes
Measure

N/A
Data Source

N/A

Measure Specification

N/A
How Health IT will be Utilized

N/A
Experience of Care
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Quality of Care
Measure

1. (a)Tobacco Use Assessment: Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months.
(b)Tobacco Cessation Intervention: Percentage of patients 18 and older who have been identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.

2. Adult Weight Screening and Follow-Up
Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.
Data Source

1. Chart-based

2. Chart-based
Measure Specification

1. Numerator: (a)Patient characteristic: tobacco user or non-user before or simultaneously to the encounter during past 24 months.
(b)Procedure performed: tobacco use cessation counseling during past 24 months, or tobacco cessation medication active or ordered.
Denominator: (a)Patients aged 18 and older, and 2 or more office encounter visits to determine that the PCP has a relationship with the patient.
(b) Patients 18 and older, and 2 or more office encounter visits, and who have been identified as tobacco users within the past 24 months.

NQF # 28a & 28b

2. Numerator: Physical exam finding: BMI = 22 kg/m2 and < 30 kg/m2, occurring = 6 months before or simultaneously to the outpatient encounter, OR
BMI > 30 kg/m2, occurring = 6 months before or simultaneously to the outpatient encounter
AND, Care Goal: follow-up plan BMI management, or Communication provider to provider: dietary consultation order.
OR
BMI < 22 kg/m2, occurring = 6 months before or simultaneously to the outpatient encounter

AND, Care Goal: follow-up plan BMI management, or Communication provider to provider: dietary consultation order.
Denominator: Patients age 18 and older who had one or more encounter office visits.

NQF # 421

How Health IT will be Utilized

Designated providers will be required to report on two to three clinical quality measures (disease of choice- if asthma is selected all three measures must be reported) and two clinical preventive measures of choice as relevant to their practice.
Providers will submit these reports directly to Idaho Medicaid using HIT.

1. We will use data analytics with data provided by the health home provider to calculate the results which will be shared with the health homes and will include benchmarks.

2. We will use data analytics with data provided by the health home provider to calculate the results which will be shared with the health homes and will include benchmarks.
Goal 6:
Increase preventive care for children.
Clinical Outcomes
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Experience of Care
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Quality of Care
Measure

1. Weight Assessment and Counseling for Children and Adolescents
Percentage of patients 2-17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

2. Well-Child Visits in the Third, Fifth and Sixth Years of Life
Percentage of members 3-6 years of age who received one or more well-child visits with a PCP during the measurement year.

3. Annual Risky Behavior Assessment or Counseling from age 12 to 18
Percentage of children aged 12 to 18 with documentation of assessment or counseling for risky behavior. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Abuse, Risk Assessment or Counseling for Sexual Activity.
Data Source

1. Chart-based

2. Chart-based

3. Chart-based
Measure Specification

1. Numerator: Physical exam finding BMI percentile;
Communication to patient counseling for nutrition;
Communication to patient counseling for physical activity.

Denominator: Patients aged 2 through 16 years to expect screening for patients within one year after reaching 2 until 17, and with at least one encounter with PCP or Obgyn.

NQF # 24

2. Numerator: Received one or more well-child visits with a PCP during the measurement year.

Denominator: Members age 3-6 years.

NQF # 1516

3. Numerator: Documentation of assessment or counseling for risky behavior during the past 12 months. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Abuse, Risk Assessment or Counseling for Sexual.

Denominator: Adolescents between the ages of 12 and 18.

NQF # 1507
NQF # 1406
How Health IT will be Utilized

Designated providers will be required to report on two to three clinical quality measures (disease of choice- if asthma is selected all three measures must be reported) and two clinical preventive measures of choice as relevant to their practice.
Providers will submit these reports directly to Idaho Medicaid using HIT.

1. We will use data analytics with data provided by the health home provider to calculate the results which will be shared with the health homes and will include benchmarks.

2. We will use data analytics with data provided by the health home provider to calculate the results which will be shared with the health homes and will include benchmarks.

3. We will use data analytics with data provided by the health home provider to calculate the results which will be shared with the health homes and will include benchmarks.
Goal 7:
N/A
Clinical Outcomes

Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Experience of Care
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Quality of Care
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Goal 8:
N/A
Clinical Outcomes
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Experience of Care
Measure

N/A

Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Quality of Care
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Goal 9:
N/A
Clinical Outcomes
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Experience of Care
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Quality of Care
Measure

N/A
Data Source

N/A

Measure Specification

N/A
How Health IT will be Utilized

N/A
Goal 10:
N/A
Clinical Outcomes
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Experience of Care
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A
Quality of Care
Measure

N/A
Data Source

N/A
Measure Specification

N/A
How Health IT will be Utilized

N/A

3.1 - A: Categorically Needy View
Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation
viii. Quality Measures: Service Based Measures
Service

☐ Comprehensive Care Management
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Care Coordination
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Health Promotion
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Individual and Family Support Services (including authorized representatives)
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Referral to Community and Social Support Services
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - A: Categorically Needy View
Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation
ix. Evaluations
A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):
i. Hospital admissions
Description

Idaho will compare admissions pre/post Health Homes. Idaho will also compare admissions with patients outside of a Health Home.
Data Source

Claims Data
Frequency of Data Collection

Annually
ii. Emergency room visits
Description

Idaho will compare Emergency Room utilization pre/post Health Homes. Idaho will also compare Emergency Room utilization with patients outside of a Health Home.
Data Source

Claims Data
Frequency of Data Collection

Annually
iii. Skilled Nursing Facility admissions
Description

Idaho Medicaid will compare number of skilled nursing facility admissions pre and post Health Home implementation. Additionally, Idaho will compare skilled nursing facility admissions with patients in a Health Home and patients not enrolled into a Health Home.
Data Source

Claims Data
Frequency of Data Collection

Annually

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:
i. Hospital admission rates

Idaho will compare admission rates pre/post Health Home in addition to patient's admission rates outside of a Health Home. Idaho will also stratify admission rates for each diagnosis. (e.g., mental health condition, asthma, diabetes, and hypertension).
ii. Chronic disease management

Idaho will use clinical quality data to compare pre/post Health Home to evaluate improvement in quality of clinical care. Idaho will also use standardized assessment tools and qualitative interviews with health home administrative staff and providers to evaluate the status of implementation related to chronic disease management processes.
iii. Coordination of care for individuals with chronic conditions

Idaho will use standardized assessment tools and qualitative interviews with health home administrative staff and providers to evaluate the status of implementation related to care coordination processes and HIT tools.
iv. Assessment of program implementation

Idaho will use standardized assessment tools and qualitative interviews with health home administrative staff and providers to monitor the progress and status of program implementation related to the six components of the Health Home as described in section 2703 of the ACA.
v. Processes and lessons learned

Learning Collaboratives will be developed with designated providers to identify implementation challenges as well as potential solutions. Idaho will monitor, comment, and make recommendations on implementation strategies that are working as well as those that are not based on the "plan, do, study, act" model. The group will use the Health Home patient eligibility criteria as well as the provider qualification criteria (as articulated by National Committee on Quality Assurance and as adapted by Idaho Medicaid) as guides in assessing program processes and outcome success. Idaho will use information gathered through assessments of program implementation as well as ongoing quality monitoring using administrative data to review program successes and areas for improvement.
vi. Assessment of quality improvements and clinical outcomes

As detailed in the quality measures section, Idaho has identified a list of quality and outcome measures that will be derived from Medicaid claims and provider charts. The quality measures are indicators of chronic disease management including processes and outcomes. Ongoing assessments of these quality measures will be conducted to monitor improvement in processes and outcomes.
vii. Estimates of cost savings

The State will annually perform an assessment of cost savings using a pre/post-period comparison.
3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

☐ Health Home Services
i. Geographic Limitations
If Targeted Geographic Basis,

ii. Population Criteria
The State elects to offer Health Home Services to individuals with:

☐ Two chronic conditions

☐ One chronic condition and the risk of developing another

☐ One serious mental illness
from the list of conditions below:

☐ Mental Health Condition

☐ Substance Use Disorder

☐ Asthma

☐ Diabetes

☐ Heart Disease

☐ BMI Over 25

☐ Other Chronic Conditions Covered?
Description of Other Chronic Conditions Covered.

iii. Provider Infrastructure

☐ Designated Providers as described in §ection 1945(h)(5)

☐ Team of Health Care Professionals as described in §ection 1945(h)(6)

☐ Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

iv. Service Definitions
Comprehensive Care Management
Service Definition

Ways Health IT Will Link

Care Coordination
Service Definition

Ways Health IT Will Link

Health Promotion
Service Definition

Ways Health IT Will Link

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)
Service Definition

Ways Health IT Will Link

Individual and Family Support Services (including authorized representatives)
Service Definition

Ways Health IT Will Link

Referral to Community and Social Support Services
Service Definition

Ways Health IT Will Link

v.Provider Standards
vi. Assurances

☐ A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

☐ B. The State has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

☐ C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving 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).

3.1 - B: Medically Needy View
Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Goal Based Quality Measures

Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

Goal 1:
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 2:
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 3:
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 4:
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 5:
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 6:
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 7:
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 8:
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 9:
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 10:
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View
Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation
viii. Quality Measures: Service Based Measures
Service

☐ Comprehensive Care Management
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Care Coordination
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Health Promotion
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Individual and Family Support Services (including authorized representatives)
Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Referral to Community and Social Support Services
Clinical Outcomes
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care
Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View
Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation
ix. Evaluations
A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):
i. Hospital admissions
Description

Data Source

Frequency of Data Collection

ii. Emergency room visits
Description

Data Source

Frequency of Data Collection

iii. Skilled Nursing Facility admissions
Description

Data Source

Frequency of Data Collection

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:
i. Hospital admission rates

ii. Chronic disease management

iii. Coordination of care for individuals with chronic conditions

iv. Assessment of program implementation

v. Processes and lessons learned

vi. Assessment of quality improvements and clinical outcomes

vii. Estimates of cost savings

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation
Payment Methodology
Payment Type: Per Member Per Month
Provider Type

The term "health home" means a designated provider (including a provider that operates in coordination with a team of health care professionals). The assumption is the "team" will consist of a Medical Assistant, Social Worker, Nurse, Provider (Physician or Mid-level), and Clerical staff.
Description

The payment methodology for Health Homes is in addition to the existing fee-for-service and is structured as follows:

Idaho will center the per member per month (pmpm) around a team of healthcare professionals that consist of a primary care provider, registered nurse, behavioral health professional, clerical staff, and medical assistant. The healthcare team will provide comprehensive care management for each established chronic care patient that is empanelled to the team.

This reimbursement model is designed to only fund Health Home functionalities that are not covered by any of the currently available Medicaid funding mechanisms. The coordination of care and Primary Care Provider Consultant duties often does not involve face-to-face interaction with Health Home patients. However, when these duties do involve such interaction, they are not traditional clinic treatment interactions that meet the requirements of currently available billing codes. Idaho's Health Home model includes significant support for the leadership and administrative functions that are required to transform a traditional primary care clinic service delivery system to the new data-driven, population focused, patient-centered Health Home requirements. Idaho anticipates the healthcare team will spend an additional 30 minutes per member per month on comprehensive care management for the services described in section 2703 of the ACA:

1. Comprehensive care management
2. Care coordination and health promotion
3. Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings
4. Patient and family support (including authorized representatives)
5. Referral to community and social support services, if relevant
6. Use of health information technology to link services, as feasible and appropriate

The Health Home pmpm was derived using average salaries, to include benefits, for each staff member that will assist in the comprehensive care management within the Health Home team. Average pay/hour was taken from the Bureau of Labor Statistics as reported in the state of Idaho. Staff members were given a percentage that was focused on the additional comprehensive care Idaho anticipates each team member assisting towards the chronic care patient.

The following responsibilities are in addition to duties already being accomplished within the medical practice. These roles may be interchanged with one another, but are fundamental components for practice transformation and care coordination to transpire. The medical practice may distribute these roles as they deem necessary to other personnel throughout the medical practice. Idaho assumes these responsibilities are essential to function as a Health Home.

Primary Care Provider 5%
Registered Nurse 35%
Medical Assistant 35%
Behavioral Health Professional 20%
Clerical Staff 5%
Registered Nurse Responsibilities

1. Promoting health and education through facilitation
2. Facilitate health education groups
3. Participate in the initial treatment plan development for their Health Home enrollees
4. Assist in developing treatment plan health care goals for individuals with chronic diseases
5. Consult with Community Support Staff about identified health conditions
6. Assist in contacting medical providers & hospitals for admission/discharge
7. Provide training on medical diseases, treatments & medications
8. Track required assessments and screenings
9. Monitor HIT tools & reports for treatment

Medical Assistant Responsibilities
1. Referral tracking
2. Training and technical assistance
3. Data management and reporting
4. Scheduling for Health Home Team and enrollees
5. Chart audits for compliance
6. Reminding enrollees regarding keeping appointments, filling prescriptions, etc.
7. Requesting and sending Medical Records for care coordination

Behavioral Health Professional
1. Screening/evaluation for individuals for mental health
2. Brief interventions for individuals with behavioral health problems
3. Discuss impact of interventions and decide what to change
4. Educate patients on mental health issues or concerns

Clerical Staff Responsibilities
1. Assist team with coordination of care
2. Assist in booking appointments for enrollees
3. Reminding enrollees regarding keeping appointments

Primary Care Provider Responsibilities
1. Consults with team psychiatrist and/or Mental Health Professionals
2. Consults with specialists as needed
3. Assists coordination with external medical providers

Practices will receive a $15.50 per member per month for services rendered, as described above, for qualified participants.

NCQA Costs
To cover additional NCQA (National Committee for Quality Assurance) costs of $480 per provider, which Idaho Medicaid is requiring by the end of the 2nd year in Health Homes, an additional $1.00 per member per month was added into the payment methodology. Providers will be given the discounted fee of $480.00 from NCQA through the enrollment of Health Homes. There are approximately 80 qualified patients per service location in Idaho and are approximately four providers at each service location. This equates to 20 qualified patients per provider throughout the state of Idaho. This was divided throughout a two year period over the 20 qualifying patients for each provider.

☐ Tiered?
Payment Type: Alternate Payment Methodology
Provider Type

Idaho does not have a tiered health home payment.
Description

N/A
☐ Tiered?