U.S. Department of Health and Human Services
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MEDICAID HEALTH HOMES IN IDAHO:

REVIEW OF PRE-EXISTING INITIATIVES AND STATE PLAN AMENDMENT FOR THE STATE'S FIRST HEALTH HOMES UNDER SECTION 2703 OF THE AFFORDABLE CARE ACT

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Idaho's Health Home Program at a Glance	
Health Home Eligibility Criteria	2 chronic conditions, or 1 chronic condition and at risk of another, serious mental illness, serious emotional disturbance
Qualifying Conditions	• Mental health condition • Asthma • Diabetes
Enrollment*	9,179
Designated Providers	Any Medicaid-enrolled primary care provider that meets health home standards.
Administrative/ Service Framework	The health home program uses the state's existing Medicaid primary care case management program, Healthy Connections. Any Healthy Connections provider who meets state qualifications can serve as a health home. To avoid duplication of services, Medicaid beneficiaries receiving targeted case management will shift the delivery of this care to their health home practice.
Required Care Team Members	The designated provider can include primary care physicians, mental health care providers, nurse practitioners, or physician assistants. The designated provider will operate in coordination with other health care professionals as deemed necessary.
Payment System	Per member per month care management fee.
Payment Level	$15.50
Health Information Technology (HIT) Requirements	The initial HIT standards require that providers have a structured information system in place that allows usage of a disease management database. An electronic medical record is not required, but providers are encouraged to have them and to use HIT tools as feasible. The final standards require that providers use HIT to systematically follow-up on patients' care, conduct population management, and access the Idaho Health Data Exchange. Providers must submit a plan to achieve the final HIT requirement to the state within 24 months of program initiation in order to be approved as a health home provider, as well as have an electronic disease registry in line with National Committee for Quality Assurance standards. Providers are also expected to report on the selected quality measures using HIT.
* January 2014 data provided to the Centers for Medicare and Medicaid Services' Health Home Information Resource Center.	

Introduction

Idaho's Section 2703 Health Home State Plan Amendment (SPA) was approved by the Centers for Medicare and Medicaid Services (CMS) on November 21, 2012, with an effective date of January 1, 2013. To be eligible for health home services, Medicaid beneficiaries must have a serious and persistent mental illness or serious emotional disturbance (SED); have diabetes and asthma; or have either diabetes or asthma and be at-risk for another chronic condition (see Table 1).

The health home initiative builds off of Idaho's Medicaid primary care case management (PCCM) program, Healthy Connections. Any Healthy Connections provider who meets state qualifications can serve as a health home, including solo or group practices, rural health clinics, community health centers, community mental health centers (CMHCs), and home health agencies. To avoid duplication of services, members currently receiving targeted case management will shift the delivery of this care to their health home practice.

Idaho Medicaid

In state fiscal year 2012, there were approximately 228,897 beneficiaries enrolled in Idaho Medicaid, all of whom are enrolled in some form of managed care.[1] Most of these are enrolled in Healthy Connections, the state's PCCM program, which is administered on a regional basis (see Figure 1). The state's three benefit plans are structured differently depending on the eligibility category. Most beneficiaries are enrolled in the Medicaid Basic Plan, which covers health, prevention, and wellness benefits for low-income children and adults with eligible dependent children. Enrollees with disabilities, special health needs, or who are dually eligible for Medicaid and Medicare are eligible for certain enhanced benefits under the Enhanced Plan or the Medicare-Medicaid Coordinated Plan (MMCP).

Implementation Context

Idaho has introduced a range of initiatives aimed at reforming the way health care is organized, financed, and delivered, many of which have implications for the health home-eligible population.

Managed Care

In February 2011, the Idaho Legislature enacted a law (HB 260) that directed the Division of Medicaid to develop and put in place risk-based managed care tools, with a special focus on enrolling high-cost populations. Medicaid has several managed care programs in place, including PCCM, dental benefits, and transportation. More recently, Medicaid began implementing additional managed care initiatives related to behavioral

health benefits, care coordination for the dually eligible, and patient-centered medical care.

CMS-approved a Section 1915(b) Waiver that authorizes the state to establish a Prepaid Ambulatory Health Plan for beneficiaries with serious mental health conditions. The state has contracted with Optum for the administration of behavioral health services, known as the Idaho Behavioral Health Plan (IBHP).[2] Under this risk-based contract, Optum manages a range of behavioral health services, including outpatient community-based mental health services, substance use disorder services, and case management. Inpatient and institutional services are not included, but the contract includes financial incentives for Optum to keep patients out of the hospital.[3] The contract term is for three years, with a possibility of two extensions of two years. IBHP began operations on September 1, 2013.[2]

Idaho had planned to participate in the CMS Financial Alignment Initiative, one of several initiatives designed to integrate and coordinate care for all dually eligible Medicare-Medicaid enrollees. The state proposed a capitation model, entailing a three-way contract between the state, CMS, and managed health care plans to provide integrated, comprehensive coverage to over 17,000 dually eligible beneficiaries.[4] The state's design calls for these services to be fully capitated, and the contracts will require health plans to ensure that all necessary Medicaid and Medicare services (including primary and acute care, pharmacy, behavioral health, and long-term services and supports) are provided, coordinated and managed. For individuals who qualify for the health home benefit, health plans will contract directly with the health home designated providers, which will provide the care management and coordination. Enrollment in these managed care plans was scheduled to begin in March 2014. As only one health plan applied to participate in the Demonstration to Integrate Care for Dual Eligibles, Idaho decided not to participate in the Demonstration and instead expanded the covered benefits in its MMCP. MMCP is a voluntary program that permits dually eligible beneficiaries to enroll in a single managed care organization (MCO) that receives capitated payments to deliver both Medicaid and Medicare services to the individual. Currently, there are more than 650 participants enrolled in the one participating Medicare Advantage plan.[5]

State Medical Home Initiatives

State Health Care Innovation Plan (SHIP): Idaho is testing several medical home initiatives, with the aim of connecting every Idahoan to a primary care provider (PCP) and implementing payment reform methodologies. Idaho is one of 16 states to receive a State Innovation Model (SIM) Design award from the CMS's Center for Medicare and Medicaid Innovation to develop a SHIP. The planning process run from June 2013 to December 2013, and the funding--up to $3 million in total--supported the ongoing development of a blueprint to fully implement patient-centered medical care and "[move] the state towards an accountable, integrated and sustainable health care delivery and payment system."[6] A range of stakeholders, including private payers, provider and health professional associations, the Governor's Office and state

legislature, the Idaho Department of Insurance, the Idaho Health Data Exchange (IHDE) and the North Idaho Health Network provided input for the SHIP. The proposed plan addressed key system transformation needs, such as the resources required to improve communication and coordination across care settings; statewide implementation of the patient-centered medical home (PCMH) model; and methods for linking the local health care system through partnerships with hospitals, PCPs, and county health and social service agencies. The state plans to develop a Model Testing grant proposal, seeking $45 million to implement the SHIP over a five-year period.[7]

Safety Net Medical Home Initiative (SNMHI): An early step in the movement toward health system transformation was the state's participation in the SNMHI, a demonstration project jointly sponsored by the Commonwealth Fund, Qualis Health, and the MacColl Institute for Healthcare Innovation at the Group Health Research Institute. The project worked with safety net primary care clinics to help them transform into high-performing PCMHs.[8] Idaho was one of five Regional Coordinating Centers (RCCs) chosen to participate in the project, which called for partnerships between safety net providers and community stakeholders to work together to improve the integration and coordination of primary care in safety net settings. Each RCC partnered with 12-15 safety net clinics in their state to provide practice coaching, peer-to-peer learning, and other forms of technical assistance on practice transformation, care coordination, quality improvement strategies, health information technology (HIT) use, and evaluating patient experience. The Idaho RCC also worked to create state health policy changes--including enhanced reimbursement for PCMH services--to support practice transformation and ensure that the PCMH model is sustainable and able to spread throughout the state. To this end, the RCC and the Idaho Primary Care Association worked with the Governor to establish the Idaho Medical Home Collaborative (IMHC).[9]

Idaho Medical Home Collaborative (IMHC): Created in 2010 by executive order 2010-10,[10] the IMHC is a collaboration of Idaho Medicaid, primary care physicians, private health insurers, and health care organizations created to make recommendations to the governor on the development, promotion, and statewide implementation of a PCMH model of care. Idaho Medicaid, BlueCross of Idaho, Pacific Source, and Regence BlueShield of Idaho are working with 21 pilot practices (family, pediatric and multi-specialty) to provide additional payment to deliver care coordination. These payments vary by payer, and range from $15.50 to $42.00 per member per month (PMPM).

In order to participate, practices must implement the 11 critical elements of a PCMH identified by IMHC, as well as meet a set of minimum standards. These common minimum standards are identical to those outlined in the state's health home SPA. Participating pilot practices must attain 2011 National Committee for Quality Assurance (NCQA) PCMH Level 1 recognition by the end of the two-year pilot; use an electronic registry with reporting functionality; attend learning collaborative and training events; and meet data reporting requirements. In addition, practices must qualify for enhanced reimbursement from two or more payers to participate in the pilot, which requires

practices to also meet any additional standards set by the insurers with whom they contract.

Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) Demonstration: In October 2011, CMS announced that 500 FQHCs had been selected for the FQHC APCP demonstration project, including four sites in Idaho. The three-year demonstration is evaluating the impact of the PCMH on improving care and lowering costs for fee-for-service (FFS) Medicare beneficiaries--including the dually eligible--who receive care at FQHCs. Participating FQHCs receive a monthly care management fee of $6.00 for each eligible beneficiary attributed to their practice, in addition to usual payment for Medicare-covered services. The management fee is intended to help defray the cost of transformation into "a person-centered, coordinated, seamless primary care practice."[11] Participating FQHCs are expected to achieve Level 3 NCQA recognition by the end of the demonstration, help patients manage chronic conditions, as well as actively coordinate care for patients, with technical assistance from CMS and the Health Resources Services Administration.

Children's HealthCare Improvement Collaboration: In February 2010, Idaho received a five-year Children's Health Insurance Program Reauthorization Act (CHIPRA) quality demonstration grant, which it is implementing in partnership with the State of Utah. The demonstration has three main goals: support three practices in becoming medical homes, with a special focus on caring for children with special health care needs; develop a quality improvement network among child-serving providers, which will identify and pursue quality improvement goals such as care integration; and facilitate automatic measures reporting and electronic health information exchange (HIE).[12]

Implications for the Idaho Section 2703 Medicaid Health Homes Evaluation

Health homes build on the state's prior experience with PCMH-type initiatives, but are just one component of much broader systems-level changes that are underway throughout Idaho. Fundamental questions to be addressed in the evaluation include the role of the enhanced federal match in development of health homes, the extent to which the health home option represents a new kind of service rather than an expansion to additional populations or continuation of medical home and advanced primary care initiatives, and how health homes are being integrated into broader systemic reforms such as the shift into risk-based managed care and the activities undertaken through the SIM planning grant.

The integration of health homes with other related initiatives represents a challenge for isolating health home effects. Eligible providers include any willing Medicaid provider who can meet the state standards; levels of experience with--and infrastructure to support--integrated service delivery and coordination may vary substantially across providers. Understanding the structures and processes that are in

place at baseline will be important in order to characterize the changes made as a consequence of becoming health homes. Participant and provider time in health homes and pre-existing initiatives also will be important factors in assessing implementation progress and for the effort to discern health home effects on outcomes.

Population Criteria and Provider Infrastructure

Idaho offers health home services to categorically needy beneficiaries who have a serious mental illness (SMI) or SED, have asthma and diabetes, or have either asthma or diabetes, and are at risk of developing another chronic condition. The identified risk factors include Body Mass Index (BMI) greater than 25, dyslipidemia, tobacco use, hypertension, or diseases of the respiratory system (see Table 1).

Any Healthy Connections provider who agrees to meet the requirements of becoming a health home is eligible to participate. The provider may be a physician, a clinical practice or clinical group practice, rural clinic, community health center, CMHC, home health agency, or any other entity or provider (including pediatricians, gynecologists, and obstetricians), but must be a Healthy Connections provider. The composition of the care team is not specified, but the health home provider will identify and lead the care coordination team, which may include other providers as necessary to meet the particular beneficiary's needs. Other provider types include, but are not limited to registered nurse, medical assistant, dietician, or behavioral health provider. The integration of behavioral health is a required element of the health home, and may be achieved through tele-health, co-location of behavioral health professionals within the clinic, or referral to a behavioral health professional.

Enrollment

Health home beneficiaries can self-refer or be referred by another provider to a health home. Health homes are responsible for generating a list of potentially eligible beneficiaries from their patient roster, which they must submit to the state for verification.[13] Eligible beneficiaries will be auto-enrolled, with the right to opt-out. Following this initial enrollment process, eligible beneficiaries must be identified on an ongoing basis by the provider, who completes and submits an enrollment form on their behalf.

Service Definitions and Provider Standards

The state's health home service definitions are reproduced in Table 2 below. The health home provider is responsible for identifying and leading the care coordination team, but no individual team member is identified as the care coordinator. The SPA allows but does not appear to require a dedicated care coordinator to be part of the health home team, though the service definitions in Table 2 describe a clear role for a care coordinator in care management, coordination, and transitions. This provides some

flexibility for smaller providers who may not be able to support a dedicated care coordinator on staff.

Aside from being enrolled in Healthy Connections, providers must achieve at least Level 1 NCQA certification by their second year of operation as a health home, and meet the 11 health home requirements detailed in the State Medicaid Director's Letter #10-024, "Health Homes for Enrollees with Chronic Conditions." To enroll, the designated provider must submit a Health Home Readiness Assessment and a signed agreement stipulating that all necessary systems are in place to provide health home services and report all required data.

Health homes are required to conduct two other assessments, the Patient-Centered Medical Home Assessment (PCMHA) and the Primary Care Development Corporation Assessment (PCDCA). The PCMHA, intended to identify strengths and weaknesses in the clinic, must be done within one month of enrollment and repeated every six months thereafter. The PCDCA must be completed within six months of enrollment, and is used to map the clinic's progress towards NCQA recognition. This assessment is conducted quarterly thereafter, until recognition is achieved.

Providers are required to report quality measures specified in the SPA (see the Quality Measures section) directly to the state Medicaid program through a web-based reporting platform, and must in addition submit a quarterly narrative progress report to the state, outlining their progress on goals, their challenges, and any technical assistance needs they have. They are also expected to conduct a baseline patient satisfaction survey, which will be repeated semi-annually. Providers may select their own, but are encouraged to use the Consumer Assessment of Healthcare Providers and Systems survey.

Use of Health Information Technology

Idaho has established initial and final HIT standards for participating providers. At the time of enrollment, providers must have a structured information system in place that will allow providers to populate a disease management database and to track and manage patients with chronic diseases. An EMR is not required, but providers are encouraged to have them, and to use HIT as feasible to create and manage care plans, monitor patient outcomes, follow-up on testing and referrals, and communicate with other providers.

The final standards require that providers use HIT in three broad processes: (1) systematic follow-up on tests, services, and referrals, which are incorporated into the patient's care plan; (2) population management and identification of care gaps; and (3) access and use of the IHDE, which is the state HIE. Providers must submit a plan to achieve the final HIT requirement to the state within 24 months of program initiation (December 31, 2014) in order to be approved as a health home provider, as well as

have an electronic disease registry in line with NCQA standards. Providers are also expected to report on the selected quality measures using HIT.

Payment Structure

Payment for health home services is made on a PMPM rate, in addition to the existing FFS payments to participating providers. To build this rate, the state assumed that the health homes care team--consisting of a PCP, nurse, medical assistant, behavioral health professional, and clerical staff--would take on defined roles within the health home (see Table 3). In practice, these roles may be distributed as the provider deems necessary, but the state sees them as essential components in care management.

The payment rate was derived from the average salaries for each member of this assumed care team, and based on and estimate about the division of labor among them, along with the additional time that the care team will spend on care management. It was assumed that the PCP and clerical staff would spend 5% time; the registered nurse and medical assistant would each spend 35%, and the behavioral health professional would spend 20%. An extra $1.00 was added to the PMPM to cover the costs of NCQA recognition. The $15.50 PMPM is paid to the provider as long as the provider remains part of Healthy Connections and offers expanded clinic hours to patients (46 hours of clinic access per week is required). No monthly contact with the patient is required in order to receive the PMPM.

Quality Improvement Goals and Measures

Participating providers are required to establish a formal quality assessment and improvement strategy, drawn from models like Six Sigma, Lean, Plan-Do-Study-Act (PDSA) cycles and the Model for Improvement.[14] Data reporting is done on a quarterly basis through the web-based Idaho Patient-Centered Medical Home Registry. The state has selected nine clinical quality measures (two measures each for diabetes, hypertension, and depression, and three for asthma), six preventive care measures, and two practice transformation measures. These measures are all from the National Quality Forum (NQF) and correspond to the six goals listed in the SPA, with the exception of the practice transformation measures. However, as the practice transformation measures are listed on the state website, they are included in Table 4.[15] Providers must report on two clinical quality measures, two preventive quality measures, and the two practice transformation measures.

Evaluation Measures and Methods

The evaluation measures and methodology described in the SPA are reproduced in Table 5. In addition to the data collected through regular provider self-assessments and the web-based registry, the state will use annual claims data and a purely pre/post health enrollment analysis of health homes enrollees to assess quality outcomes and qualitative interviews to evaluate the implementation process. The state intends to use a pre/post comparison to evaluate hospital admissions, emergency department visits, and costs. The state will also contract with an outside entity to evaluate the IMHC and develop an evaluation framework that will allow the Collaborative to assess the progress of primary care medical homes involved in the IMHC on an ongoing basis.

FIGURE 1. Idaho Healthy Connections Regions


TABLE 1. Target Population and Designated Providers--Idaho	
SPA Approval (Effective Date)	November 21, 2012 (January 1, 2013)
Designated Provider(s)	Any Medicaid-enrolled entity or provider that: (a) has the systems and infrastructure in place to provide health home services; and (b) is a Healthy Connection provider.
Health Home Team Composition	The designated provider can include primary care physicians, mental health care providers, nurse practitioners, or physician assistants. The designated provider will operate in coordination with other health care professionals as deemed necessary, including (but not limited to) a nurse care coordinator, registered nurse, nutritionist, social worker, behavior health professional, or other traditional or nontraditional health care workers.
Target Population	Beneficiaries must have a SMI, 2 chronic conditions, or 1 chronic condition and the risk of developing another. Identified risk factors include BMI greater than 25, dyslipidemia, tobacco use, hypertension, or diseases of the respiratory system.
Qualifying Chronic Conditions	• Mental health condition • Asthma • Diabetes

TABLE 2. Health Home Service Definitions--Idaho	
Care Coordination	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. 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 health care setting.
Comprehensive Care Management	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. Idaho anticipates family members and other support involved in the patient's care to be identified, included in the plan, and executed as requested by the patient. The care plan must also include outreach and activities that 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., HbA1c), 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: conducting pre-visit preparations, collaborating with the patient/family to develop an individual care plan (including treatment goals that are reviewed and updated at each relevant visit), providing the patient/family with a written care plan, assessing and addressing barriers when the patient has not met treatment goals, and giving 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 the health home.
Health Promotion	A designated provider will be required 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 nonclinical 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.

TABLE 2 (*continued*)	
Comprehensive Transitional Care	Comprehensive transitional care will be provided to prevent enrollee's 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 department, 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.
Individual and Family Support Services	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 and family support their prescribed treatment. The designated provider will ensure that communication and information shared with the patient/patient's family is understandable.
Referral to Community and Social Supports	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.

TABLE 3. Assumed Division of Care Management Responsibilities--Idaho	
Primary Care Provider	• Consults with team psychiatrist and/or mental health professionals • Consults with specialists as needed • Assists coordination with external medical providers
Registered Nurse	• Promotes health and education through facilitation • Facilitates health education groups • Participates in the initial treatment plan development for their health home enrollees • Assists in developing treatment plan health care goals for individuals with chronic diseases • Consults with Community Support Staff about identified health conditions • Assists in contacting medical providers and hospitals for admission/discharge • Provides training on medical diseases, treatments and medications • Tracks required assessments and screenings • Monitors HIT tools and reports for treatment
Medical Assistant	• Tracks referrals • Provides training and technical assistance • Conducts data management and reporting • Manages scheduling for health home team and enrollees • Conducts chart audits for compliance • Reminds enrollees regarding keeping appointments, filling prescriptions, etc. • Requests and sends medical records for care coordination
Behavioral Health Provider	• Screens/evaluates individuals for mental health • Conducts brief interventions for individuals with behavioral health problems • Discusses impact of interventions and decides what to change • Educates patients on mental health issues or concerns
Clerical Staff	• Assists team with coordination of care • Assists in booking appointments for enrollees • Reminds enrollees regarding keeping appointments

TABLE 4. Goal-Based Quality Measures--Idaho	
Improve Care for Diabetes Among Adults	Clinical outcome measures: • NQF #59: HbA1c poor control (>9.0) Quality of care measures: • NQF #57: Annual HbA1c testing
Improve Care for Patients with Heart Disease	Clinical outcome measures: • NQF #18: Controlled high blood pressure Quality of care measures: • NQF #13: Blood pressure measurement
Improve Outcomes for People with Depression	Quality of care measures: • NQF #105: Antidepressant medication management • NQF #418: Screening for clinic/practice depression
Improve Care for Asthma Among Adults and Children	Quality of care measures: • NQF #1: Asthma assessment • NQF #47: Asthma pharmacologic therapy • NQF #25: Management for people with asthma
Increase Preventive Care for Adults	Quality of care measures: • NQF #28a: Tobacco use assessment • NQF #28b: Tobacco cessation intervention • NQF #421: Adult weight screening and follow-up
Increase Preventive Care for Children	Quality of care measures: • NQF #24: Weight assessment counseling for children and adolescents ages 3-17 • NQF #1516: Percentage of members 3-6 years of age who received 1 or more well-child visits with a PCP during the measurement year • NQF #1507: Annual risky behavior assessment or counseling from age 12-18
Practice Transformation Measures (not listed in the SPA)	
• Third next available appointment • Health home participant visits that occur with the selected provider	

TABLE 5. Evaluation Methodology--Idaho	
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).
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.
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.
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.
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 PDSA model. The group will use the health home patient eligibility criteria, as well as the provider qualification criteria (as articulated by the NCQA 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.
Assessment of Quality Improvements and Clinical Outcomes	Idaho has identified a list of quality and outcome measures that will be derived from Medicaid claims and chart review. 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.
Estimates of Cost Savings	The state will annually perform an assessment of cost savings using a pre/post-period comparison.

APPENDIX: Pre-Existing Initiatives in Idaho					
	Medicaid Behavioral Health Managed Care[2,3]	**Demonstration to Integrate Care for the Dual Eligible[4]**	**SNMHI**	**IMHC**	**Children's HealthCare Improvement Collaboration[12,16]**
Timeline	3-year contract awarded to Optum in 2013; possible extension to 2020	Effective January 2014, with phased enrollment from March-July 2014	May 2008-May 2013	Created by Executive Order in October 2010. PMPM to participating practices initiated January 1, 2013	2010-2015
Geographic Area	Statewide	Statewide	Statewide	Statewide	Statewide
Sponsors	Idaho Department of Health and Welfare (IDHW)	CMS, IDHW	Idaho Primary Care Association, The Commonwealth Fund, Qualis Health, and the MacColl Center for Health Care Innovation at the Group Health Research Institute	Idaho Medicaid, BlueCross of Idaho, Regence BlueShield of Idaho, and PacificSource	CMS, IDHW, and Utah Department of Health
Scope	Optum will administer outpatient mental health, substance abuse, and case management services for all beneficiaries with a mental health diagnosis	17,735 dual eligible beneficiaries in Idaho	No data	21 Participating organizations contracted with a minimum of 2 payers, serving patients with chronic disease(s)	• 3 child-serving practices participating in a demonstration • 8 practices participating in a Quality Improvement learning collaborative

APPENDIX (*continued*)					
	Medicaid Behavioral Health Managed Care[2,3]	**Demonstration to Integrate Care for the Dual Eligible[4]**	**SNMHI**	**IMHC**	**Children's HealthCare Improvement Collaboration[12,16]**
Goals	• Reduce hospitalization and duplication of services • Improve health outcomes for people with behavioral health needs	• Ensure beneficiaries have full, streamlined access to needed services • Improve quality and continuity of care for duals • Eliminate regulatory conflicts and cost-shifting between Medicaid and Medicare	• Develop and demonstrate a replicable and sustainable model for medical home implementation in primary care safety net clinics • Through technical assistance, peer-to-peer learning, and practice transformation coaching, assist primary care safety net sites become high-performing PCMHs	• Improve health outcomes for chronic disease • Improve patient, clinician, staff satisfaction • Improve clinic flow/efficiency • Provide comprehensive and coordinated approach to patient care • Enhance provider recruitment and retention • Prepare for health reform	• Improve the child HIT infrastructure in the state • Support provider transformation into medical homes • Develop a statewide network of providers engaged in quality improvement activities
Payment Approach	Risk-based capitation payment, with a 10% withhold based on hospital utilization targets, and a shared savings component	Risk-based capitation payment, with a percentage withhold based on quality outcomes and savings shared between Medicare and Medicaid	No information found	PMPM for care coordination. Rate ranges from $15.50 to $42.00	No information found
Technical Assistance (TA)	No information found	No information found	Technical assistance in the form of: • Creation of Statewide Collaborative Learning Model • Practice Transformation Coaching • Peer-to-Peer learning	Technical assistance in the form of collaborative learning, face-to-face practice coaching, and regular webinars	Practices will participate in learning collaboratives that will assist them in quality improvement activities

APPENDIX (*continued*)					
	Medicaid Behavioral Health Managed Care[2,3]	**Demonstration to Integrate Care for the Dual Eligible[4]**	**SNMHI**	**IMHC**	**Children's HealthCare Improvement Collaboration[12,16]**
HIT Use	No information found	Contracted MCOs will use technology to track and coordinate care, avoid duplication, and catch medication errors	Implementation of a Quality Improvement Strategy by participating pilot practices	• Implementation of a patient registry • NCQA Level 1 certification by end of 2 year pilot period, including EMR implementation	Idaho is: • Testing software to extract and report quality measures from EMRs • Contributing to an on-line portal that provides resources on CSHCN • Connecting the IHDE to Utah's HIE
Evaluation Methods	No information found	No information found	No information found	Will contract with an evaluator to assess the impact and effectiveness of the Collaborative	The National CHIPRA Quality Demonstration Evaluation will collect quantitative and qualitative data to evaluate the impact of all demonstration projects, including Idaho

Endnotes

1. Idaho Department of Health and Welfare. "Facts Figures and Trends." Available from: http://healthandwelfare.idaho.gov/Portals/0/AboutUs/Publications/FFT2012-2013LR.pdf.

2. Idaho Department of Health and Welfare. "Idaho Behavioral Health Plan (IBHP) Contract Awarded." Available from: http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicaidBehavioralHealthManagedCare/tabid/1861/Default.aspx. Accessed July 3, 2013.

3. Personal communication with Idaho Department of Health and Welfare staff. June 24, 2013.

4. Idaho Department of Health and Welfare. "Idaho Division of Medicaid Demonstration Proposal to Integrate Care for Dual Eligibles." May 2012. Available from: http://www.healthandwelfare.idaho.gov/Portals/0/Medical/Managed%20Care/Proposal%20Submission%20to%20CMS.pdf. Accessed June 29, 2013.

5. Idaho Department of Health and Welfare. "Integrating Care for Dual Eligibles: Medicare-Medicaid Coordinated Plan (MMCP) Update." February 26, 2014. Available from: http://healthandwelfare.idaho.gov/Medical/Medicaid/LongTermCareManagedCare/tabid/1910/Default.aspx.

6. Center for Medicare and Medicaid Innovation. "State Innovation Models Initiative: Model Design Awards." Available from: http://innovation.cms.gov/initiatives/state-innovations-model-design/. Accessed June 29, 2013.

7. Idaho Department of Health and Welfare. "State Healthcare Innovation Plan (SHIP)." Available from: http://healthandwelfare.idaho.gov/Medical/StateHealthcareInnovationPlan/tabid/2282/Default.aspx/.

8. Safety Net Medical Home Initiative. Available from: http://www.safetynetmedicalhome.org/. Accessed June 29, 2013.

9. Idaho Medical Home Collaborative. Available from: http://imhc.idaho.gov/default.aspx. Accessed June 29, 2013.

10. Office of the Governor. "Executive Order No. 2010-10: Establishing an Idaho Medical Home Collaborative to Implement a Patient-Centered Medical Home Model of Care (Collaborative)." Executive Department of the State of Idaho. September 2010. Available from: http://imhc.idaho.gov/Docs/Executive_Order_2010_10.pdf. Accessed July 1, 2013.

11. Centers for Medicare and Medicaid Innovation. "Federally Qualified Health Center Demonstration Fact Sheet." Available from: http://innovation.cms.gov/initiatives/FQHCs/FQHC-Fact-Sheet.html. Accessed July 1, 2013.

12. Agency for Healthcare Research and Quality. "State at a Glance: Idaho." National Evaluation of the CHIPRA Quality Demonstration Grant Program. Available from: http://www.ahrq.gov/policymakers/chipra/demoeval/demostates/id.html#objectives. Accessed July 1, 2013.

13. See http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/ParticipantEnrollement.pdf.

14. Idaho Department of Health and Welfare. "Quality Improvement." Health Home Program information. Available from: http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/QualityImprovement.pdf. Accessed July 1, 2013.

15. Idaho Department of Health and Welfare. "Data Reporting." Health Home Program information. Available from: http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/DataReporting.pdf.

16. Idaho Department of Health and Welfare. "Children's Healthcare Improvement Collaboration." Available from: http://www.healthandwelfare.idaho.gov/Medical/Medicaid/ChildrensHealthcareImprovementCollaboration/tabid/1894/Default.aspx. Accessed July 3, 2013.

This paper is an attachment to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) report "***Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report - Year Two***". The full report is available at: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm.

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EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS: Annual Report - Year Two

Files Available for This Report

Full Report (including state appendices)
- Executive Summary: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2es.cfm
- HTML: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm
- PDF: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.pdf

Alabama appendix only
- HTML: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm#AL
- PDF: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2-AL.pdf

Idaho appendix only
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