IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

16.03.09 - MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-1205

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 56-257, 56-260 through 56-266, Idaho Code.

PUBLIC HEARING SCHEDULE: A Public hearing concerning this rulemaking will be held as follows:

Tuesday - October 23, 2012 - 2:00 p.m. MDT

Medicaid Central Office
Conference Room D-East and D-West
3232 Elder Street
Boise, ID 83705

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The rule amendments in this docket are being made to address the Governor's medical home initiative that has been developed over the past two years to provide better coordination of care for eligible individuals with chronic diseases and for covered services needed. The Idaho Medicaid Health Home is Medicaid's response to a multi-payer collaborative initiative in an effort to reduce ER visits, hospital admits, and prevention of co-morbid conditions. These rules implement a patient-centered medical home model of care that will coexist with the primary care case management structure called Healthy Connections.

These changes provide for the administration of the Idaho Medicaid Health Home program, which includes Home Health Services, definitions, participant eligibility including coverage and limitations, provider qualifications, procedural requirements, reimbursement structure, and quality assurance. In addition, the Healthy Connections program structure and rules have be revised and updated to describe the relationship between the Health Home program and the Healthy Connections program.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

No fiscal impact to the state general fund is expected as anticipated savings from better coordination of care and reduction in service utilization will offset any additional costs.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not initiated or feasible since the changes in this rulemaking are based on a collaborative group of stakeholders set up by the Governor for the medical home initiative. There has been extensive participation in these meetings and input has been provided on the Idaho Medicaid Health Home program.

INCORPORATION BY REFERENCE: No materials are being incorporated by reference into these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cindy Brock at (208) 364-1983.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 24, 2012.

DATED this 31st day of August, 2012.

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THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 16-0309-1205

399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.

Individuals who are eligible for Medicaid Basic Plan Benefits are eligible for the following benefits, subject to the coverage limitations contained in these rules. Those individuals eligible for services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," are also eligible for the services covered under this chapter of rules, unless specifically exempted. (5-8-09)

01. Hospital Services. The range of hospital services covered is described in Sections 400 through 449 of these rules. (5-8-09)

a. Inpatient Hospital Services are described in Sections 400 through 406. (3-30-07)

b. Outpatient Hospital Services are described in Sections 410 through 416. (3-30-07)

c. Reconstructive Surgery services are described in Sections 420 through 426. (3-30-07)

d. Surgical procedures for weight loss are described in Sections 430 through 436. (3-30-07)

e. Investigational procedures or treatments are described in Sections 440 through 446. (3-30-07)

02. Ambulatory Surgical Centers. Ambulatory Surgical Center services are described in Sections 450 through 499 of these rules. (5-8-09)

03. Physician Services and Abortion Procedures. Physician services and abortion procedures are described in Sections 500 through 519 of these rules. (5-8-09)

a. Physician services are described in Sections 500 through 506. (3-30-07)

b. Abortion procedures are described in Sections 510 through 516. (3-30-07)

04. Other Practitioner Services. Other practitioner services are described in Sections 520 through 559 of these rules. (5-8-09)

a. Midlevel practitioner services are described in Sections 520 through 526. (3-30-07)

b. Chiropractic services are described in Sections 530 through 536. (3-30-07)

c. Podiatrist services are described in Sections 540 through 545. (3-29-12)

d. Licensed midwife (LM) services are described in Sections 546 through 552. (3-29-12)

e. Optometrist services are described in Sections 553 through 556. (3-29-12)

05. Primary Care Case Management. Primary care case management services are described in Sections 560 through 5~~6~~79 of these rules**.** (5-8-09)

a. Healthy Connections services are described in Sections 560 through 566. ( )

b. Health Home services are described in Sections 570 through 576. ( )

06. Prevention Services. The range of prevention services covered is described in Sections 5~~7~~80 through 649 of these rules. ~~(5-8-09)~~( )

~~***a.*** *Health Risk Assessment services are described in Sections 570 through 576.* *(3-30-07)*~~

~~*b*~~a. Child Wellness Services are described in Sections 580 through 586. (3-30-07)

~~*c*~~b. Adult Physical Services are described in Sections 590 through 596. (3-30-07)

~~*d*~~c. Screening mammography services are described in Sections 600 through 606. (3-30-07)

~~*e*~~d. Diagnostic Screening Clinic services are described in Sections 610 through 61~~*6*~~4. ~~*(3-30-07)*~~( )

e. Additional Assessment and Evaluation services are described in Section 615. ( )

f. Health Questionnaire Assessment is described in Section 618. ( )

~~*f*~~g. Preventive Health Assistance benefits are described in Sections 620 through 626. (5-8-09)

~~*g*~~h. Nutritional services are described in Sections 630 through 636. (3-30-07)

~~*h*~~i. Diabetes Education and Training services are described in Sections 640 through 646. (3-30-07)

07. Laboratory and Radiology Services. Laboratory and radiology services are described in Sections 650 through 659 of these rules. (5-8-09)

08. Prescription Drugs. Prescription drug services are described in Sections 660 through 679 of these rules. (5-8-09)

09. Family Planning. Family planning services are described in Sections 680 through 689 of these rules. (5-8-09)

10. Substance Abuse Treatment Services. Services for substance abuse treatment are described in Sections 690 through 699 of these rules. (5-8-09)

11. Mental Health Services. The range of covered Mental Health services are described in Sections 700 through 719 of these rules. (5-8-09)

a. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. (3-30-07)

b. Mental Health Clinic services are described in Sections 707 through 71~~*8*~~9. ~~*(3-30-07)*~~( )

12. Home Health Services. Home health services are described in Sections 720 through 729 of these rules. (5-8-09)

13. **Therapy Services**. Occupational therapy, physical therapy, and speech-language pathology services are described in Sections 730 through 739 of these rules. (5-8-09)

14. **Audiology Services**. Audiology services are described in Sections 740 through 749 of these rules. (5-8-09)

15. **Durable Medical Equipment and Supplies**. The range of covered durable medical equipment and supplies is described in Sections 750 through 779 of these rules. (5-8-09)

a. Durable Medical Equipment and supplies are described in Sections 750 through 756. (3-30-07)

b. Oxygen and related equipment and supplies are described in Sections 760 through 766. (3-30-07)

c. Prosthetic and orthotic services are described in Sections 770 through 776. (3-30-07)

16. **Vision Services**. Vision services are described in Sections 780 through 789 of these rules. (5-8-09)

17. **Dental Services**. The dental services covered under the Basic Plan are covered under a selective contract as described in Section 800 through 819 of these rules. (3-29-12)

18. **Essential Providers**. The range of covered essential services is described in Sections 820 through 859 of these rules. (5-8-09)

a. Rural health clinic services are described in Sections 820 through 826. (3-30-07)

b. Federally Qualified Health Center services are described in Sections 830 through 836. (3-30-07)

c. Indian Health Services Clinic services are described in Sections 840 through 846. (3-30-07)

d. School-Based services are described in Sections 850 through 856. (3-30-07)

19. **Transportation**. The range of covered transportation services is described in Sections 860 through 879 of these rules. (5-8-09)

a. Emergency transportation services are described in Sections 860 through 866. (3-30-07)

b. Non-emergency medical transportation services are described in Sections 870 through 876. ~~(3-30-07)~~( )

20. **EPSDT Services**. EPSDT services are described in Sections 880 through 889 of these rules. (5-8-09)

21. **Specific Pregnancy-Related Services**. Specific pregnancy-related services are described in Sections 890 through 899 of these rules. (5-8-09)

(BREAK IN CONTINUITY OF SECTIONS)

413. OUTPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. **Review Prior to Delivery of Outpatient Services**. Failure to obtain a timely review from the Department or its quality improvement organization (QIO) prior to delivery of outpatient services, listed on the select procedure and diagnosis list in the QIO Idaho Medicaid Providers Manual and the Hospital Provider Handbook, as amended, for participants who are eligible at the time of service, will result in a retrospective review. The Department

will assess a late review penalty, as outlined in Subsection 405.05 of these rules, when a review is conducted due to an untimely request. ~~*(3-30-07)*~~(____)

02. Follow-Up for Emergency Room Patients with Chronic Conditions. Hospitals must establish procedures to refer Medicaid participants with targeted chronic diseases defined in Section 560 of these rules to an Idaho Medicaid Health Home provider, if one is available within a reasonable distance of the participant's residence. Hospitals must coordinate care of patients who already have a Health Home provider with that PCP. (____)

(BREAK IN CONTINUITY OF SECTIONS)

SUB AREA: PRIMARY CARE CASE MANAGEMENT
(Sections 560 -- 5~~*6*~~79)

560. HEALTHY CONNECTIONS AND IDAHO MEDICAID HEALTH HOME: DEFINITIONS.
For purposes of this Sub Area that includes Sections 560 through 579 of these rules, ~~*unless the context clearly requires otherwise,*~~ the following ~~*words and*~~ terms ~~*have the following meanings*~~ and definitions apply: ~~*(3-30-07)*~~(____)

01. Best Practices Protocol. A regimen of proven, effective and evidence-based practices. (4-2-08)

02. Care Plan. A patient specific document that identifies health care orders for the patient and serves as a guide to care. It can either be written for an individual patient or be retrieved from a computer and individualized. (____)

0~~*2*~~3. Chronic Disease Management. The process of applying best practices protocol to manage a chronic disease in order to produce the best health outcomes for a participant with the targeted chronic disease. (4-2-08)

0~~*3*~~4. Clinic. Two (2) or more qualified medical professionals who provide services jointly through an organization for which an individual is given authority to act on its behalf. It also includes Federally Qualified Health Centers (FQHCs), Certified Rural Health Clinics, and Indian Health Clinics. (3-30-07)

0~~*4*~~5. Covered Services. Those medical services and supplies for which reimbursement is available under the State Plan. (3-30-07)

0~~*5*~~6. Grievance. The formal process by which problems and complaints related to Healthy Connections are addressed and resolved. Grievance decisions may be appealed as provided herein. (3-30-07)

07. Health Home. A primary care provider organization contracted with Medicaid to lead a team approach for chronic disease management. The Health Home provides comprehensive patient centered care management and health promotion services to patients with chronic conditions in accordance with the requirements described in section 560 through 579 of these rules and Section 1945 of the Social Security Act. (____)

08. Health Information Technology. Electronic tools utilized to securely exchange or manage health information between two or more entities. (____)

0~~*6*~~9. Healthy Connections. The provision of health care services through a single point of entry for the purposes of managing participant care with an emphasis on preventative and primary care and reducing inappropriate utilization of services and resulting costs. This is sometimes referred to as managed care. Healthy Connections is a primary care case management model. (4-2-08)

10. Individual or Family Supports. Community based social supports or recovery services available to assist individuals or families in need. (____)

11. National Committee for Quality Assurance (NCQA). Accrediting organization which develops health care performance measurements and provides certifications of quality to health care providers. ( )

~~**07. Pay-for-Performance**. *The use of incentives to encourage and reinforce the delivery of evidence-based practices that promote better outcomes as efficiently as possible.* (4-2-08)~~

12. Preventive Care. Medical care that focuses on disease prevention and health maintenance. ( )

~~*08*~~**13. Primary Care Case Management**. The process in which a primary care provider is responsible for direct care of a participant, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the participant. (4-2-08)

~~*09*~~**14. Primary Care Provider (PCP)**. A qualified medical professional who contracts with Medicaid to coordinate the care of certain participants enrolled in the Healthy Connections program. ~~*(4-2-08)*~~( )

1~~*0*~~5. Qualified Medical Professional. A duly licensed physician in the following specialties: Pediatrics, Internal Medicine, Family Practice, General Practice, General Surgery, Obstetrics/Gynecology, or a physician in any other specialty who chooses to assume the function of primary care case management. It also includes nurse practitioners, and physician assistants. Licenses must be held in the state(s) where services are being rendered. (3-30-07)

16. Quality Improvement Program. A program of organized, ongoing, and systematic efforts to improve and assess the quality of care within a primary care provider practice or organization. ( )

17. Quality Measures. A measure of health care performance based on specified dimensions of care and service. ( )

~~*1*~~**18. Referral**. ~~*The process by which*~~ A documented communication from a participant's primary care provider (PCP) to another Medicaid provider authorizing ~~*participants gain access to those*~~ specific covered services subject to primary care case management~~, *but*~~ that are not provided by the ~~*primary care provider*~~ participant's PCP. ~~*It is the authorization for such services.*~~ ~~*(3-30-07)*~~( )

19. Risk Factor. A characteristic, condition, or behavior that increases the possibility of disease or injury. ( )

~~*1*~~**20. Targeted Chronic Disease**. ~~*One (1) of the diseases included in the chronic disease management pay-for-performance program. The specific targeted chronic diseases are diabetes, asthma, hypertension, hyperlipidemia, and depression. The Department may change the diseases included in the program after appropriate notification to PCPs.*~~ A disease identified by the Department for management under the Idaho Medicaid Health Home program. Specific conditions are identified in the Medicaid Provider Handbook available at www.idmdedicaid.com. ~~*(4-2-08)*~~( )

21. Transitional Care. The care or services provided by a health care provider to ensure care of the patient as they move between health care settings or between healthcare providers. ( )

561. HEALTHY CONNECTIONS: PARTICIPANT ELIGIBILITY.

~~**01. Voluntary County**. *In a county where participation in Healthy Connections is voluntary, the participant will be given an opportunity to choose a PCP. If the participant is unable to choose a provider but wishes to participate, a provider will be assigned by the Department. If a voluntary county subsequently becomes a mandatory county, provider selection and assignment will remain unchanged where possible.* (4-2-08)~~

0~~*2*~~1. ~~***Mandatory County**. In a county where participation*~~ **Primary Care Case Management Enrollment**. Each participant in Idaho Medicaid is enrolled in Healthy Connections ~~*is mandatory*~~, unless the participant is granted an exemption by the Department described in Subsections 561.02.a. through 561.02.h. of this rule. Each participant must choose a PCP within the Healthy Connections program. If a participant fails to choose a PCP, one will be assigned ~~*if the participant fails to choose a participating provider after given the opportunity to do*~~

~~*so*~~ to the participant by the Department. ~~*Members*~~ Participants of the same family ~~*do not have to*~~ may choose ~~*the same*~~ different Healthy Connections providers. ~~*All participants in the county are required to participate unless individually granted an exception.*~~ ( )

02. **~~*Exceptions*~~ Exemption from Participation**. An exemption from participation in ~~*a mandatory county are available*~~ Healthy Connections may be granted on a individual basis by the Department for a participant~~*s*~~ who: ~~*(4-2-08)*~~( )

a. ~~*Have to travel more than*~~ Is unable to access a Healthy Connections provider within a distance of thirty (30) miles, or within thirty (30) minutes to obtain primary care services; ~~*(3-30-07)*~~( )

b. Ha~~*ve*~~s an eligibility period that is less than three (3) months; ~~*(3-30-07)*~~( )

c. Ha~~*ve*~~s an eligibility period that is only retroactive; ~~*(3-30-07)*~~( )

d. ~~*Are*~~ Is eligible only as a Qualified Medicare Beneficiary; ~~*(3-30-07)*~~( )

e. Ha~~*ve*~~s an existing relationship with a primary care physician or clinic who is not participating ~~*with the*~~ in Healthy Connections; ~~*or*~~ ~~*(3-30-07)*~~( )

~~***f.***~~ ~~*Has incompatible third party liability.*~~ ~~*(3-30-07)*~~

~~*g*~~f. ~~*Are*~~ Is enrolled in the Medicare/Medicaid Coordinated Plan~~.~~; ~~*(4-2-08)*~~( )

g. Resides in a nursing facility or an ICF/ID; or ( )

h. Resides in a county where there are not an adequate number of providers to deliver primary care case management services. ( )

562. HEALTHY CONNECTIONS: COVERAGE AND LIMITATIONS.

01. **Exempted Services**. All services are subject to primary care case management unless specifically exempted. The following services are exempt: (3-30-07)

a. Family planning services; (3-30-07)

b. Treatment for ~~*E*~~emergency ~~*care (as defined by the Department for the purpose of payment and performed in an emergency department)*~~ medical conditions defined in Subsection 010.23 of these rules; and ~~*(3-30-07)*~~( )

c. Hospital admissions subsequent to an emergency room visit provided that the patient's discharge is coordinated with a PCP; ( )

~~*c*~~d. Dental care; (4-2-08)

~~*d*~~e. Podiatry (performed in the office); (3-30-07)

~~*e*~~f. Audiology (hearing tests or screening, does not include ear/nose/throat services); (3-30-07)

~~*f*~~g. Optical/Ophthalmology/Optometrist services (performed in the office); (3-30-07)

~~*g*~~h. Chiropractic (performed in the office); (3-30-07)

~~*h*~~i. Pharmacy (prescription drugs only); (3-30-07)

~~*i*~~j. Nursing home; (3-30-07)

~~j~~k. ICF/ID services; (3-30-07)

~~k~~l. Immunizations (not requiring an office visit); (4-2-08)

~~l~~m. Flu shots and/or pneumococcal vaccine (not requiring an office visit); (3-30-07)

~~m~~n. Diagnosis and/or treatment for sexually transmitted diseases; (3-30-07)

~~n~~o. One screening mammography per calendar year for women age forty (40) or older; (3-30-07)

~~o~~p. Indian Health Clinic/638 Clinic services provided to individuals eligible for Indian Health Services; (4-2-08)

~~p~~q. In-home services, known as Personal Care Services and Personal Care Services Case Management; (4-2-08)

~~q~~r. Laboratory services, including pathology; (4-2-08)

~~r~~s. Anesthesiology services; (3-29-12)

~~s~~t. Radiology services; ~~*and*~~ ~~*(3-29-12)*~~( )

~~t~~u. Services rendered at an Urgent Care Clinic when the participant's PCP's office is closed~~.~~; ~~*(3-29-12)*~~( )

v. School-based services; ( )

w. Services managed directly by the Department, as defined in the provider handbook for those services at www.idmedicaid.com; and ( )

x. Pregnancy related services provided by an obstetrician or gynecologist not enrolled as a Healthy Connections provider. ( )

02. Change in Services That Require a Referral. The Department may change the services that require a referral after appropriate notification of Medicaid eligible individuals and providers. (3-30-07)

563. HEALTHY CONNECTIONS: PROCEDURAL REQUIREMENTS.

01. Primary Care Case Management. Under the Healthy Connections model of managed care, each participant obtains medical services through a PCP. This provider either provides the needed service, or makes a referral for needed services. This management function neither reduces nor expands the scope of covered services. (4-2-08)

a. Referrals. The primary care provider is responsible for making all reasonable efforts to monitor and manage the participant's care, providing primary care services, and making referrals for services when medically necessary. All services not specifically exempted in Section 562 of these rules require receipt of a referral prior to delivery of services. Services that require a referral, but are provided without a referral ~~*will*~~ are not ~~*be paid*~~ covered. All referrals must be documented in the participant's patient record. ~~*(3-30-07)*~~( )

b. Changing PCP~~*s*~~. If a participant is dissatisfied with his PCP, he may change providers ~~*effective the first day of any month*~~ by contacting his designated Healthy Connections Representative ~~*to do so no later than fifteen*~~ at least ten (1~~5~~0) days ~~*in advance*~~ prior to the end of the month. The change is effective the first day of the following month. This advance notice requirement may be waived by the Department. ~~*(4-2-08)*~~( )

c. Changing Service Areas. A ~~P~~participant~~*s*~~ who moves from the area where ~~*they are*~~ he is enrolled must ~~*disenroll in the same manner as provided in the preceding paragraph for changing PCPs, and may obtain a referral from their PCP pending the transfer. Such referrals are valid not to exceed thirty (30) days*~~ contact his

designated Healthy Connections Representative to disenroll from his current PCP and enroll with a new PCP in the area where moving. Enrollment with the new PCP is effective the first day of the month following the request. ~~(4-2-08)~~(____)

02. Problem Resolution. (3-30-07)

a. ~~*Intent.*~~ To help assure the success of Healthy Connections, the Department ~~*intends to*~~ provides a mechanism for timely and personal attention to problems and complaints related to the program. ~~(3-30-07)~~(____)

b. ~~*Local Program Representative.*~~ To facilitate problem resolution, ~~*each area*~~ the Department will have a designated representative who will receive and attempt to resolve all complaints and problems related to the program and function as a liaison between participants and providers. It is anticipated that most problems and complaints will be resolved informally at this level. ~~(4-2-08)~~(____)

c. ~~*Registering a Complaint. Both*~~ A participant~~*s and*~~ or a provider~~*s*~~ may register a complaint or notify the Department of a problem related to Healthy Connections either ~~*by*~~ in writing, electronically, or by telephon~~*ing*~~e to the ~~*local program*~~ designated representative. The ~~*health*~~ designated representative will attempt to resolve conflicts and disputes whenever possible and refer the complainant to alternative forums where appropriate. ~~(3-30-07)~~(____)

d. ~~*Grievance.*~~ If a participant or provider is not satisfied with the resolution of a problem or complaint addressed by the ~~*program*~~ designated representative, he may file a formal grievance in writing to the representative. The manager of the managed care program may, where appropriate, refer the matter to a review committee designated by the Department to address issues such as quality of care or medical necessity. However, such decisions are not binding on the Department. The Department will respond in writing to grievances within thirty (30) days of receipt. ~~(3-30-07)~~(____)

e. ~~*Appeal.*~~ Decisions in response to grievances may be appealed. Appeals ~~*by participants*~~ are ~~*considered as fair hearings and appeals by providers as contested cases under the Rules Governing Contested Case Proceedings and Declaratory Rulings,*~~ governed by the requirements of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," and must be filed ~~*in accordance with*~~ according to the provisions of that chapter. ~~(3-30-07)~~(____)

~~***03. Chronic Disease Management Registration**. A participating PCP must initially register each participant eligible for chronic disease management reimbursement with the Department. (4-2-08)*~~

~~***04. Chronic Disease Management Reporting**. A participating PCP must annually report on all identified quality indicators for each targeted chronic disease that he seeks reimbursement as specified in the provider agreement. The reporting schedule is established by the Department in the provider agreement. (4-2-08)*~~

564. HEALTHY CONNECTIONS: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Participation Qualifications. Primary care case management services may be provided by qualified medical professionals, licensed to practice in the state where services are being rendered. (3-30-07)

02. Provider Participation Conditions and Restrictions. (3-30-07)

a. Quality of Services. Each ~~*P*~~provider must: (____)

i. ~~*m*~~Maintain and provide services in accordance with community standards of care~~*. Provider must*~~; (____)

ii. ~~*e*~~Exercise his best efforts to effectively control utilization of services~~*. Providers must*~~; and (____)

iii. ~~*p*~~Provide twenty-four (24) hour coverage by telephone to assure participant access to services. ~~(3-30-07)~~(____)

b. Provider Agreements. Each ~~*P*~~provider~~*s*~~ participating in primary care case management must:

( )

i. sSign an agreement. Clinics may sign an agreement on behalf of their qualified medical professionals.; ( )

ii. Enroll with the Department all primary care clinic locations as Healthy Connections service locations; and ( )

iii. Providers participating in the chronic disease management pay-for-performance program must sSign an addendum to the primary care case management provider agreement when participating in the Idaho Medicaid Health Home program. (4-2-08)( )

c. Patient Limits. A Pproviders may limit the number of participants they wish to manage. Subject to this limit, the provider must accept all participants who either elect or are assigned to the provider, unless disenrolled in accordance with Subsection 564.02.d. of this rule. A Pproviders may change their participant limit effective the first day of any month. by written request The PCP must make the request in writing to the Department thirty (30) days prior to the effective date of the change. This advance notice Rrequirement maybe waived by the Department. (3-30-07)( )

d. Disenrollment. Instances may arise where When the provider-patient relationship breaks down due to failure of the participant to follow the plan of care plan or for other reasons. Accordingly, a provider may choose to withdraw as the participant's primary care provider effective the first day of any month. by written notice to The PCP must notify in writing, both the participant and the Department thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department. (3-30-07)( )

e. Record Retention. Each Pproviders must: ( )

i. rRetain patient and financial records and provide the Department access to those records for a minimum of six (6) years from the date of service.; ( )

ii. Upon the reassignment of a participant to another PCP, the provider must transfer (if a request is made) a copy of the patient's medical record to the new PCP. Provider must also; and ( )

iii. dDisclose information required by Subsection 205.01 of these rules, when applicable. (4-2-08)( )

f. Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in Subsection 205.03 of these rules. An agreement may be amended for the same reasons. (3-30-07)

565. HEALTHY CONNECTIONS: PROVIDER REIMBURSEMENT.

01. Case Management Fee. Reimbursement is as follows: (4-2-08)

a. A PCPs will be is paid a case management fee for primary care case management services based on the level of each participant's health care needs and the PCP's availability. (3-29-12)( )

b. A PCPs enrolled in the chronic disease management pay-for-performance Idaho Medicaid Health Home program will be is paid an enhanced chronic disease case management fee. (4-2-08)( )

c. The amount of the fees is determined by the Department. (3-29-12)( )

d. The amount of the fee is fixed and the same for all participating PCPs. (4-2-08)

02. Primary Care Case Management. Reimbursement is based on: (3-29-12)

a. The number of participants enrolled under with the provider on the first day of each month

multiplied by the amount of the case management fee established for participants enrolled in the Basic Plan Benefit package; ~~*(3-29-12)*~~( )

b. The number of participants enrolled ~~*under*~~ with the provider on the first day of each month, multiplied by the amount of the case management fee established for participants enrolled in the Enhanced Plan Benefit package; and ~~*(3-29-12)*~~( )

c. ~~*The amount of the case management fee is increased by fifty cents ($.50) per participant*~~ An incentive payment is added per participant to the primary care case management fee in Subsection 565.01.a. of this rule when the PCP's ~~*office*~~ offers extended hours of service in one (1) of the following ways: ( )

i. The number of hours the PCP's office is available for delivery of service to participants equals ~~*to*~~ or exceed~~*ing*~~s forty-six (46) hours per week. The ~~*amount of*~~ extended hours must be verified by and on file with the Department prior to an increase to the monthly case management fee~~*generation for the increase to be paid.*~~; or ~~*(3-29-12)*~~( )

ii. The PCP has electronic health records available and accessible for delivery of services at a nearby service location that is within the same Healthy Connections provider organization and makes services available to the participant at lease forty-six (46) hours per week. The alternate location and extended hours must be verified by and on file with the Department prior to an increase to the monthly case management fee. ( )

d. The number of participants enrolled with an Idaho Medicaid Health Home provider on the first day of the month for services described in Section 572 these rules, multiplied by the case management fee established per participant enrolled in that program. ( )

~~***03.*** ***Chronic Disease Management****. Reimbursement is based on:*~~ ~~*(4-2-08)*~~

~~***a.*** *The number of participants who have a targeted chronic disease multiplied by the amount of the enhanced case management fee for patient identification; and*~~ ~~*(4-2-08)*~~

~~***b.*** *The number of instances that the PCP achieved Department specified best practices protocol for the disease being managed multiplied by the amount of the enhanced case management fee for reported quality indicators.*~~ ~~*(4-2-08)*~~

566. HEALTHY CONNECTIONS: QUALITY ASSURANCE.

The Department will establish performance measurements to evaluate the effectiveness of ~~*Chronic Disease Management*~~ the primary care case management programs. The performance measurements will be reviewed at least annually and adjusted as necessary to provide quality assurance. ~~*(4-2-08)*~~( )

567. -- 569. (RESERVED)

SUB AREA: PREVENTION SERVICES
(Sections 570 -- 649)

[SECTION 570 MOVED TO SECTION 618]

570. IDAHO MEDICAID HEALTH HOME: DEFINITIONS.

For purposes of the Idaho Medicaid Health Home program, the terms and definitions in Section 560 of these rules apply. ( )

571. IDAHO MEDICAID HEALTH HOME: PARTICIPANT ELIGIBILITY.

01. Eligibility. A Medicaid participant diagnosed with two (2) targeted chronic diseases, or one (1) targeted chronic disease and one (1) or more risk factors is eligible for enrollment in the Idaho Medicaid Health Home program. ( )

02. Eligibility Determination. A participant who meets the diagnostic criteria for health home eligibility is identified by the PCP to the Department. The Department will utilize claims data and other documentation as needed to verify the participant is eligible for Idaho Medicaid Health Home services. (   )

572. IDAHO MEDICAID HEALTH HOME: COVERAGE AND LIMITATIONS.
The following services are covered for an eligible participant assigned to a Health Home provider: (   )

01. Comprehensive Care Management. A Health Home provider must develop and implement a patient-centered care plan based on an individual's health risk assessment. The care plan must describe how the Health Home provider will coordinate clinical care with other providers as well as non-clinical health care related needs and services. (   )

02. Care Coordination and Health Promotion. A Health Home provider must: (   )

a. Coordinate the participant's care by sharing clinical information relevant to patient care with other providers; (   )

b. Provide educational information and information about health care resources to the participant; (   )

c. Have ongoing communication with the participant to encourage compliance with prescribed treatment; and (   )

d. Other activities necessary to facilitate improved health outcomes for the participant. (   )

03. Comprehensive Transitional Care. A Health Home provider must: (   )

a. Receive relevant medical information from and share relevant medical information with inpatient facilities to foster a coordinated approach to preventing avoidable readmissions; and (   )

b. Review and update care plans after unplanned admissions to adjust care coordination and management activities to address identifiable causes for the admission. (   )

04. Individual, Family, Community, and Social Support Services. A Health Home provider must: (   )

a. Coordinate care in a manner that effectively utilizes available individual and family supports to improve and maintain the health of the participant; and (   )

b. Provide information on available community and social support services that aid in promoting healthy behaviors and reducing physical and mental health risk factors. (   )

573. IDAHO MEDICAID HEALTH HOME: PROCEDURAL REQUIREMENTS.

01. Provider Agreement. A Health Home provider must sign an addendum to the primary care case management provider agreement which identifies the location of the Health Home and other requirements necessary to meet the Health Home service requirements in these rules. (   )

02. Data Reporting. Health Home providers must report data to the Department on a periodic basis in keeping with schedules outlined in the provider handbook and the terms of the Health Homes provider agreement. (   )

03. Quality Improvement Program. A provider must establish a continuous quality improvement program directed towards improving care for patients with chronic conditions. (   )

574. IDAHO MEDICAID HEALTH HOME: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Infrastructure and Health Home Assessment. A prospective Health Home provider must complete a Health Home practice assessment in cooperation with the Department to determine the ability of the provider to provide the required services in keeping with a patient-centered medical home model. This assessment must demonstrate that the provider; ( )

a. Has identified the qualified medical professionals and other resources available to provide Health Home services; ( )

b. Has the ability to utilize health information technology to coordinate and facilitate communication of health information and to link to services; ( )

c. Is able to submit clinical and practice transformation data within six (6) months of the date the provider agreement is signed; and ( )

d. Has a chronic disease patient registry in place within three (3) months of the date the provider agreement is signed. ( )

02. Qualifications. An Idaho Medicaid Health Home provider must: ( )

a. Possess a current NCQA patient-centered medical home level one (1) certification, or demonstrate that the provider is actively pursuing that recognition. A provider that does not achieve this NCQA certification within two (2) years of the initiation date of their Idaho Medicaid Health Home provider agreement will be terminated as a Health Home provider for non-compliance with the provider agreement; ( )

b. Be enrolled as a Healthy Connections primary care provider (PCP); ( )

c. Sign an addendum to their primary care provider agreement which identifies the location of the enrolled site and indicates reporting schedule and quality measurement requirements;. ( )

d. Have qualified medical professionals, licensed to practice in the state where services are being rendered; and ( )

e. Maintain office hours that allow enhanced access to care as described in Section 565.02 of these rules. ( )

03. Provider Duties. A Health Home provider must provide or coordinate the following elements of Health Home services: ( )

a. Care Plan. Develop a patient-centered care plan for each participant that coordinates and integrates both clinical and non-clinical health care related needs and services; ( )

b. Chronic Disease Management. Provide access to chronic disease management, including self-management support to the participant and the participant's family; ( )

c. Individual, Family, and Community Supports. Facilitate access to individual, family, and community supports outlined in the provider's agreement. ( )

d. Mental Health & Substance Abuse Services. Facilitate access to mental health and substance abuse services. ( )

e. Preventive Care. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance abuse disorders. ( )

f. Quality Improvement Program. Establish a continuous quality improvement program and report on quality improvement measures outlined in the provider agreement. ( )

g. Quality of Services. Maintain and provide quality services for each Home Health participant.

( )

h. Transitional Care. Coordinate and provide access to comprehensive care management and transitional care from and to inpatient settings and from a pediatric to an adult system of health care. ( )

575. (RESERVED)

576. IDAHO MEDICAID HEALTH HOME: QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of the Idaho Medicaid Health Home program through the collection and reporting of quality measures as specified in Section 1945 of the Social Security Act. ( )

57~~1~~7. -- 579. (RESERVED)

SUB AREA: PREVENTION SERVICES
(Sections 5~~7~~80 -- 649)

(BREAK IN CONTINUITY OF SECTIONS)

616. -- 61~~9~~7. (RESERVED)

~~570~~618. HEALTH QUESTIONNAIRE.
The Health Questionnaire assesses the general health status and health behaviors of a participant. The information collected is used to provide customized health education to the participant. The Health Questionnaire is administered at initial program entry and at periodic intervals thereafter. Participant responses to the issues addressed in the Health Questionnaire may identify a participant's interest in the Preventive Health Assistance benefits described in Section 620 of these rules. (3-30-07)

619. (RESERVED)