

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN FINANCIAL ANALYSIS

IDAHO DEPARTMENT OF
HEALTH AND WELFARE

MAY 27, 2016

Government Human Services Consulting

CONTENTS

- 1. Introduction 1
 - Target Populations and Stakeholders 1
 - Interventions for Reducing Costs 3
 - Financial Analysis Methodology 5
 - Total Expected Cost Savings and Return on Investment 7

- 2. Actuarial Certification of the Financial Plan for Idaho’s Integrated Multi-Payer
PCMH Model 8

- 3. Appendix A: Data Request 9
 - Data Request Template Sent to Payers on July 17, 2015 9

1

Introduction

Idaho's Statewide Healthcare Innovation Plan (SHIP) is designed to lower the overall cost of healthcare for Idahoans by transforming the way healthcare is delivered. The SHIP is designed to transform payments for healthcare from volume-based payments to payments based on outcomes coinciding with the implementation of the patient-centered medical home (PCMH) model of care. The PCMH model has been described by policymakers and clinicians across the country as a cornerstone of health system transformation. Evidence of improved patient care, health outcomes, and savings from implementing PCMH models has been demonstrated across the country¹.

Target Populations and Stakeholders

Idaho's SHIP is designed to lower the overall cost of care for Idahoans, thus generating savings for the healthcare system. To determine these savings, the model classified Idaho's population by these three payer types: Medicaid, Medicare, and commercial insurance. Medicaid was further divided into dual eligible² recipients, non-dual aged/disabled recipients, children, and adults that did not fall into any other category. Commercial insurance participants were classified by the number of people on their policy: individual or family. Medicare participants were classified into dual eligibles, fee-for-service (FFS) non-duals, and non-duals with Medicare Advantage coverage (also known as Medicare Part C). These classifications were consistent with the Model Test Grant Application. A summary of base year costs can be seen below in Table 1: Populations Reported and Health Care Costs as PMPM and Total Costs.

Medicaid

Children represent 73% of Medicaid recipients in Idaho, but children represent only about 32% of the annual Medicaid expenses, or \$217.92 per member per month (PMPM) in Year 0, the base experience period. An area of particularly high costs for children is the neonatal intensive care unit (NICU) for premature and ill newborns. At an annual cost trend of 5.0% the cost of providing care to children would, without intervention, increase to \$252.29 PMPM for Year 3 of SHIP Model Test.

The highest per-person cost population among Medicaid recipients is the non-dual aged/disabled population, who typically has chronic medical conditions. Their Year 0 cost of

¹ Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012. Nielsen, Langner, Zema et al. Patient-Centered Primary Care Collaborative)

² Dual eligibles are persons with both Medicare and Medicaid coverage. Medicaid provides coverage for the cost – sharing (deductibles and coinsurance) in the Medicare benefits, as well as benefits for services not covered by Medicare, such as custodial care in nursing homes, home and community-based long-term care, and non-emergency transportation.

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN FINANCIAL ANALYSIS

\$2,293.50 PMPM is projected to grow, without intervention, at an annual rate of 4.9%, reaching \$2,648.90 PMPM in Year 3 of the Model Test.

Table 1: Populations Reported and Health Care Costs as PMPM and Total Costs

Participants	Member Months	Year 0 Total Cost	Year 0 Cost * PMPM	Without Intervention	
				Projected Year 3 Cost PMPM	Annual Rate of Increase
Medicaid		\$1.6 billion			
Children**	2,335,974	32%	\$217.92	\$252.29	5.0%
Dual Eligible	292,160	25%	\$1,378.07	\$1,572.83	4.5%
Aged/Disabled (non-dual)	198,027	28%	\$2,293.50	\$2,648.90	4.9%
Other Adult	373,261	15%	\$644.45	\$751.86	5.3%
Commercial		\$2.6 billion			
Individual	1,222,091	22%	\$472.11	\$550.72	5.3%
Family	4,560,579	78%	\$438.23	\$512.20	5.3%
Medicare		\$0.8 billion			
Dual Eligible	26,233	7%	\$2,247.63	\$2,743.74	6.9%
FFS	511,552	35%	\$576.59	\$678.90	5.6%
Medicare Advantage (Part C)	624,663	58%	\$780.38	\$931.84	6.1%

* Year 0 calendar year 2015; ** Non-Dual, Not Disabled.

The dual eligible population, which cost \$1,378.07 PMPM in Year 0, was projected to grow, without intervention, at an annual rate of 4.5%, reaching \$1,572.83 PMPM in Year 3. These groups utilize emergency department (ED) services at a higher rate than the average population and have a higher rate of hospital admissions and high-end diagnostic services. Other cost drivers for the Medicaid population in general include behavioral health drugs. Roughly one-third of the total costs of Medicaid pharmaceutical drugs are spent on behavioral health drugs.

The remaining adult Medicaid population has a Year 0 cost of \$644.45 PMPM, which is projected to grow, without intervention, at an annual rate of 4.7%, reaching \$751.86 PMPM in Year 3 of the Model Test.

Commercial Insurance

Commercial insurance costs are driven by specialty care, high-cost prescription drugs, radiology and laboratory services, outpatient care (including surgeries and ED), and inpatient maternity. Trends for both individual and family plans ran between 5.2% and 5.4% due to high ED usage, as well as high-cost diagnostics. Without intervention, individual costs are projected to grow from \$472.11 PMPM in Year 0 to \$550.72 PMPM in Year 3 and family costs from \$438.23 to \$512.20 PMPM over the same time period. The annual rate for both is 5.3%.

Medicare

Cost increases for both FFS Medicare and Medicare Advantage members are being driven by prescription drugs, home health, and inpatient hospital costs. (The available data did not have ED costs as a separate category.) Dual eligibles have a Medicare cost of \$2,247.63 PMPM in Year 0. Without intervention it is projected to grow at a 6.9% annual trend to \$2,743.74 PMPM in Year 3. FFS members have a Medicare cost of \$576.59 PMPM in Year 0, growing, without intervention, at a slightly lower annual trend rate of 5.6% to \$678.90 PMPM in Year 3. Medicare Advantage members have a cost of \$780.38 PMPM in Year 0, growing, without intervention, at an annual rate of 6.1% to \$931.84 PMPM in Year 3.

Interventions for Reducing Costs

Recent data published from the Patient-Centered Primary Care Collaborative supports the assumptions of lower ED usage, lower inpatient admissions, fewer inpatient readmissions, and increased usage of generic pharmaceuticals³. Access to PCMHs reduces ambulatory care sensitive hospital admissions and avoidable ED visits. Studies show that introducing intensive outpatient care programs (IOCP) reduced per capita spending by 20%⁴, and IMPACT⁵ treatment of depression resulted in per capita spending drop by an estimated 20%, primarily due to lower spending for ED visits and hospitalizations⁶. Coordination of care and transition management by PCMHs reduces duplicative care and decreases hospital readmission rates. In a study done for the U.S. Department of Health and Human Services, simplified hospital discharge instructions given to patients in order to help them transition from the hospital to their homes led to a 30% reduction in hospitalization readmission rates⁷. An increase in the generic prescription drug fill

³ Nielsen, Marci PhD; et al. Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of COST & QUALITY RESULTS, 2012

⁴ Schilling, Brian; Boeing's Nurse Case Managers Cut Per Capita Costs by 20 Percent; Purchasing High Performance, March 25, 2011.

⁵ IMPACT is an evidence-based depression care program developed by the University of Washington. Most IMPACT materials, training, consultation and other assistance to adapt and implement IMPACT are offered free thanks to the generous support of the John A. Hartford Foundation.

⁶ Gilbody S, Bower P, Fletcher J, et al. Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer-term Outcomes. Arch Intern Med. 2006;166:2314-2321

⁷ Koh HK1, Berwick DM, Clancy CM, Baur C, Brach C, Harris LM, Zerhusen EG.; Health Aff (Millwood). 2012 Feb;31(2):434-43. doi: 10.1377/hlthaff.2011.1169. Epub 2012 Jan 18. New federal policy initiatives to boost health literacy can help the nation move beyond the cycle of costly 'crisis care'.

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN FINANCIAL ANALYSIS

rate is also expected from an emphasis on primary care doctors prescribing generic pharmaceuticals. Studies in New Jersey and Washington both showed decreases in expense through a concerted effort to find generic equivalents by primary care doctors⁸. Specific to Medicaid, an effort to increase participation in prenatal programs to reduce preterm births and early elective deliveries is expected to reduce avoidable NICU usage as described above.

Additionally, the payers in Idaho have agreed to implement payment strategies that are alternatives to traditional FFS for primary care physicians (PCPs). Alternative payment strategies, such as incentive payments tied to performance measure improvement, are expected to reduce escalating medical costs by rewarding high quality over volume of care, while also expanding access to care. The participating payers in Idaho will work with specialists (such as orthopedists, cardiologists, oncologists, and radiologists) to implement evidence-based practice guidelines. Increasing accountability through adherence to quality of care guidelines is key to overall trend reductions.

The PCMH model is for all of Idaho's 1.6 million people. The implementation of the model, however, is a phased approach, as the population will be served by PCMHs in varying stages by payer. Beneficiaries at the end of the model test are expected to reach at least 825,000. Medicaid recipients and FFS Medicare beneficiaries are expected to engage quickly, but commercial beneficiaries will phase in based on acuity and location. Better managed care tools and cost containment for high-cost cases will drive cost savings early in the Model Test. However, through preventive activities focusing on socioeconomic and behavioral determinants of health, the PCMH model will also reduce downstream healthcare (such as, reducing the smoking rate in the population) in the future.

⁸ Nielsen; p.8, p. 13, p. 27, p. 29

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN FINANCIAL ANALYSIS

Table 2: Cost Targets, Milestones, and Savings for Public/Private Populations Combined

Issue	Year 3 Targets	Mechanism	Savings Assumptions
Early Deliveries (in weeks 37–39 of gestation)	5% reduction in expenses related to elective and non-elective preterm birth, prior to 39 weeks	1%–4% of total NICU admissions (\$40-\$70K/admit) are preventable with later deliveries	0.56% reduction in Inpatient Hospital utilization for Medicaid child per year
Appropriate Generic Drug Use	Generic fill rate of 85%	Each 1% improvement in generic fill rates reduces total pharmacy spend (0.5%-1.0% Medicaid, 0.5%-1.0% Commercial)	0.17% reduction in prescription unit costs for Medicaid and Commercial per year over 3 years
Hospital Readmissions	5%–10% reduction	20% of all hospitalizations are preventable re-hospitalizations	0.5% reduction in Inpatient Hospital utilization for Medicare and Medicaid, 0.33% reduction for Commercial
Acute Care Hospitalizations	1%–5% reduction	PCMHs reduce with IMPACT & IOCP training	0.5% reduction in Inpatient and Outpatient Hospital unit cost for Medicare and Medicaid, 0.25% reduction for Commercial
Non-Emergent ED use	5%–10% reduction in total ED use	10%–30% of ED visits are non-emergent.	1.0% reduction in ED utilization for all payers
General Primary-Care Savings	Reduction in utilization	Savings typical when moving to a care management setting	0.5% reduction for Medicare and Medicaid for Specialists, PT/OT, & Radiology; 0.25% in DME for Medicaid Duals, 0.25% for Medicare Duals

Financial Analysis Methodology

The payers were surveyed using the category of service classifications and definitions included in Appendix A. A comparison model of care was built using medical expense data supplied by the Idaho Department of Health and Welfare (IDHW) for 2013 and 2014 incurred expenses, from the Center for Medicare and Medicaid Service (CMS) for 2012 and 2013 incurred expenses, from three of the four largest commercial payers for 2014, and from Mercer's (Idaho's project management consultant) proprietary commercial claims database. Mercer also used commercial payers' public filings, as available from 2013 and 2014. The costs were trended forward using trend rates based on the U.S. Consumer Price Index (CPI) for medical care services to align reporting periods, yielding a baseline for comparison of calendar year 2015 as Year 0. Trend assumptions for each Model Test year for Medicare and Medicaid were derived from the National Health Expenditure projections from the CMS Office of the Actuary. Trend assumptions

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN FINANCIAL ANALYSIS

for commercial data for the same periods were derived from Mercer's proprietary commercial claims database. Although the Model Test years begin on February 1 and end on January 31, calendar year projections were not adjusted for the lagging month.

Table 3: PMPM Comparison of Costs by Payer After Intervention

Participants	Without Intervention		With Intervention		
	Year 0* PMPM	Annual Increase	Estimated Year 3 PMPM	Annual Increase	Estimated Year 3 PMPM
Medicaid:					
Children**	\$217.92	5.0%	\$252.29	4.5%	\$249.05
Dual Eligible	\$1,378.07	4.5%	\$1,572.83	4.5%	\$1,570.56
Aged/Disabled (Non-Dual)	\$2,293.50	4.9%	\$2,648.90	4.6%	\$2,625.11
Other Adult	\$644.45	5.3%	\$751.86	4.7%	\$739.46
Commercial:					
Individual	\$472.11	5.3%	\$550.72	5.1%	\$547.46
Family	\$438.23	5.3%	\$512.20	5.1%	\$509.41
Medicare:					
Dual Eligible	\$2,247.63	6.9%	\$2,743.74	6.7%	\$2,727.03
Fee-For-Service	\$576.59	5.6%	\$678.90	5.1%	\$668.59
Medicare Advantage	\$780.38	6.1%	\$931.84	5.7%	\$921.52

* Year 0 calendar year 2015; ** Non-Dual, Not Disabled.

Savings assumptions based on the interventions described above and calculations using data obtained from initiatives in other states and other public sources were used to estimate reductions in trend for the six areas determined to have high potential savings for Idaho as shown in Table 2. The baseline data was then projected, taking into account those savings assumptions and offset by increased costs due to expected increased utilization of PCPs. The resulting data was then compared to the baseline data to estimate cost savings over the three-year period (gain from investment).

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN FINANCIAL ANALYSIS

Table 4: Assumed Cost-Savings Over Three Years by Payer

Savings Category	Medicaid	Commercial	Medicare	Total
Generic Rx Usage	\$1,811,240	\$3,623,890	\$0	\$ 5,435,131
Re-Hospitalizations	\$10,096,525	\$12,946,745	\$8,130,252	\$ 31,173,522
Acute Care Hospitalizations	\$14,756,959	\$19,162,488	\$13,561,266	\$ 47,480,713
Non-Emergent ED Usage	\$3,810,148	\$4,708,511	\$656,227	\$ 9,174,886
Early Delivery	\$4,593,497	\$0	\$0	\$ 4,593,497
General Primary Care Savings	\$5,876,725	\$0	\$2,694,887	\$ 8,571,613
PCMH Operational Payment	(\$6,822,432)	(\$8,446,961)	(\$1,503,962)	\$(16,773,355)
Net Savings	\$34,122,662	\$31,994,674	\$23,538,670	\$ 89,656,006

Total Expected Cost Savings and Return on Investment

Return on Investment (ROI) was calculated using the following formula:

$$\text{ROI} = \frac{(\text{Gain from Investment} - \text{Cost of Investment})}{\text{Cost of Investment}}$$

Cost of investment was identified as the \$40 million model testing grant IDHW received from the Center for Medicare & Medicare Innovation. Over the three-year testing period, the Model is expected to result in projected total savings of \$89.6 million, after factoring in payments to primary care providers to coordinate care and adhere to the PCMH model. Net savings are \$34.1 million for Medicaid, \$32.0 million for commercial payers, and \$23.5 million for Medicare. Projected ROI for Medicare and Medicaid populations is 44% for the three years. The projected ROI for all populations combined is 124% for three years.


2

Actuarial Certification of the Financial Plan for Idaho’s Integrated Multi-Payer PCMH Model

Applicants for the State Innovation Model grants are required to obtain and submit an external actuarial certification with their application. The undersigned actuary is a member of the American Academy of Actuaries (MAAA) and is qualified to render this certification.

By certifying a financial plan, the actuary attests to the following:

- The data, assumptions, and projected savings outlined in the financial plan are consistent and reasonable.
- The financial plan was reviewed in compliance with the current standards of practice, as promulgated by the Actuarial Standards Board of the American Academy of Actuaries, and that the plan complies with the current Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board.
- The actuarial work supporting the applicant complies with applicable laws, rules, applicant instructions, and current CMS guidance.

Name:	F. Kevin Russell
Designation (ASA, FSA):	FSA, MAAA
Organization:	Mercer Health & Benefits
Address/City/State/Zip:	2325 E. Camelback Road, Suite 600 Phoenix, AZ 85016
Email:	kevin.russell@mercercor.com
Certification (Y/N):	Yes
Signature:	
Date:	May 27, 2016
Potential Risks or Concerns:	Savings estimates were developed from published studies and other sources. Published sources generally provide a range of potential savings. The savings percentages used in the model have been taken from the middle of the range of potential savings and are, therefore, conservative compared to the highest potential levels of saving. However, actual achievement of savings requires changing of current medical treatment practices, so it is not certain.

All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

3

Appendix A: Data Request

Data Request Template Sent to Payers on July 17, 2015

Dear Multi-payer workgroup participants,

Thank you for the opportunity to speak with you on July 8th. As we discussed, CMMI requires reports to monitor financial progress for the grant Idaho received. We finalized the financial data request needed to start the reporting process, for which the first step is to rebase the cost-savings assumptions with current data, preferably 2014 data or later for **allowed** costs. Please review the attached spreadsheet and let me know if you have any concerns providing the requested data. Costs should be aggregated based on the category of service logic provided, but split by the category of aid or contract type listed in row 4 of the Report Template tab.

I've also attached the standard Mercer Client Confidentiality Agreement for review by you and your legal teams to ensure your data is protected and kept private. Reporting to CMMI will be done in aggregate such that no individual payer data will be discernable.

Please review both documents and let me know if you have any concerns about either document by **August 5th**. If not, we'd like to start receiving data on **September 8th**. If you're unable to meet that date, please let me know when you think you can get the template completed. I appreciate your participation in the SHIP and would like to make the reporting process as simple as possible.

Thank you!

Scott Banken, CPA

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN FINANCIAL ANALYSIS

	Medicaid/CHIP				Private/Other		Medicare		
	Adult	Child	Dual Eligibles (Only)	Disabled/Elderly (Without Duals)	Individual	Family	Dual Eligible	Fee for Service/Non-Duals (Parts A and B)	Medicare Advantage Part C
Member Months									
Inpatient Hospital	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Emergency Dept	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Urgent Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Outpatient Hospital	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Primary Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Specialty Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Diagnostic Imaging/X-Ray	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Laboratory Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DME	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Dialysis Procedures	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Other (e.g., PT, OT)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Skilled Nursing Facility	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Home Health	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Custodial Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ICF/MR	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Home and Community-Based Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Behavioral Health	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Prescription Drugs (Outpatient)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Category of Service Logic

Use the following logic in order to classify claims and expenses.

Emergency Dept.

837I or UB04: Revenue codes 0450, 0451, 0452, 0459, 0981
837P or CMS1500: Procedure codes 99281-99285, G0380-G0384,
G0390

Urgent Care

837I or UB04: Revenue code 0456
837P or CMS1500: Procedure codes S9083, S9088 and/or Place of
Service code = 20

Dialysis

837I or UB04: Revenue codes 082x-088x
837P or CMS1500: Place of Service = 65 or Rendering Provider Type
= ESRD Treatment or Dialysis Facility

Inpatient Hospital

837I or UB04
Bill Type: 011x or 012x
BH is to be split out into the BH bucket by revenue codes: 0114,
0116, 0124, 0126, 0134, 0136, 0144, 0146, 0154, 0156, 0204,

Outpatient Hospital (excludes ER)

837I or UB04
Bill Type: 013x or 083x

SNF

837I or UB04: Bill Type 02xx

Professional Primary Care

837P or CMS1500: Rendering Provider Type: Family Practice,
General Practice, Internal Medicine, Pediatrics, Preventive Medicine,
Geriatrics

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2161CP.pdf>

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN FINANCIAL ANALYSIS

Professional Specialty Care

837P or CMS1500: Rendering Provider Type: Allergy&Immunology, Anesthesia, Dermatology, Emergency Medicine, Surgery, OBGYN, Ophthalmology, Orthopedics, Otolaryngology, Pathology

<http://cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/taxonomy.pdf>
Specialists are Allopathic and/or Osteopathic physicians with specialties in the attached list OTHER than the primary care specialties. Only CMS Specialty Codes 01 - 99 are to be included.

Professional Other

837P or CMS1500: Rendering Provider Type: All other specialties that do not fall into Primary Care or Specialty Care.

Diagnostic Imaging/X-Ray

837P or CMS1500: Procedure Codes 70000-79999

Lab Services

837P or CMS1500: Procedure Codes 80000-89999

DME

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html>

DME15-C is the more current file, but probably would not match data as well. File will need to be filtered to Idaho only data.

HH

837I or UB04: Bill Type 03xx or Revenue codes 0550, 0551, 0559, 057x, 0989

837P or CMS1500 Procedure Codes:T0221, S5180, S5181, S9122-S9125, T1019-T1022, G0160-G0161,
POS = 05 or Provider Type = Home Health Agency

Custodial Care

837P or CMS1500: POS = 13, 14, 32, or 33
or Procedure Code: 99324-99339

ICF/MR

837I or UB04: Bill Type 065x or 066x and
Diagnosis codes 317.x-319.x for MR

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN FINANCIAL ANALYSIS

BH

837P or CMS1500: Primary diagnosis codes 290-319 (excluding ICF claims)

837I or UB04: Inpatient BH revenue codes: 0114, 0116, 0124, 0126, 0134, 0136, 0144, 0146, 0154, 0156, 0204,

HCBS HCBS Services from Waiver Application:

Residential Habilitation
Respite
Supported Employment
Community Support Services
Financial Management Services
Support Broker Services
Adult Day Health
Behavior Consultation/Crisis Management
Chore Services
Environmental Accessibility Adaptations
Home Delivered Meals
Non-Medical Transportation
Personal Emergency Response System
Skilled Nursing
Specialized Medical Equipment and Supplies

Prescription Drugs

NCPDP or presence of NDC code.

Other

All other claims that don't fall into the above COS.



Government Human Services Consulting
Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
+1 602 522 6500