iv Operational Plan (REVISED 9/8/14)

ORGANIZATIONAL CAPACITY

The Idaho Department of Health and Welfare (IDHW) is Idaho's umbrella agency for all health and welfare programs. The department reports to Governor Butch Otter and is responsible for an annual budget of $2.5 billion dollars including management of $1.6B in federal funds. IDHW manages numerous federal grants and has extensive experience in grant reporting, fiscal and program management. The DHW provides programs with added resources to manage grants. Each program is required to meet quarterly with a Budget Analyst from the Bureau of Financial Services, Bureau Chief and Section Manager to review program budgets and monitor expenditures. Each program is also supported by the Department's Contracting and Procurement Services Unit which ensures all contracts are legal, binding, and meets DHW and state standards.

Key personnel in this proposal include:

Dick Armstrong has served as Director of IDHW since June of 2006. He has a very strong insurance background, is a member of the Idaho Healthcare Coalition (IHC) and a strong voice for healthcare system transformation in Idaho.

Denise Chuckovich has served as the IDHW Deputy Director since September 2012. Denise has extensive experience in primary care management, health policy and program development. Denise has been directly involved with the Idaho transformation plans since inception and has overall executive responsibility for Idaho's Model Test project at IDHW.

Ted Epperly, MD, serves as Chair of the IHC. Dr. Epperly is a family physician and CEO of the Family Medicine Residency of Idaho. He is past president of the American Academy of Family Physicians. Dr. Epperly is a highly respected physician in Idaho and nationally and has provided visionary leadership to the IHC.

Other IDHW administrators who will be actively involved in executing the model in Idaho include the Medicaid Division Administrator, the Public Health Division Administrator and the Behavioral Health Division Administrator. In addition, the Deputy Attorney General assigned to IDHW provides legal staff support to the IHC.

Since his election in 2007 Governor Otter has provided strong support to Idaho's healthcare transformation efforts. He created the Idaho Medical Home Collaborative in 2010 and the Idaho Healthcare Coalition in 2014. Governor Otter supports the work of the IHC and his health policy staff participates as a member of the IHC. He has strongly endorsed Idaho's MTP and committed to support of the IHC's efforts in the future.

CMS Comment (Item 17): Please describe the role of cabinet level officials (other than the senior health official) in the successful implementation of the state's plan, such as cabinet-level officials responsible for housing, education, corrections, etc.

IDAHO'S RESPONSE:

Idaho's small population is truly an advantage when working within the state system for change. Cabinet members in a small state often work together on initiatives, and the governor is also well-versed in emerging initiatives such as the SHIP. The Director of the Department of Health and Welfare has been deeply involved in the development of the SHIP, and is an active member of the Idaho Healthcare Coalition.

As the SHIP evolves over the next four years other cabinet members will become involved as healthcare system transformation touches on their areas of responsibility. For example, the Director of the Dept of Insurance will become involved as we work to align payment models of Idaho's major private payers and address insurance payment models. The Director of Corrections and the Director of Juvenile Corrections will become involved as we address how best to coordinate healthcare delivery for individuals moving between the corrections system and the private healthcare system. This will be especially critical for those individuals who suffer from chronic conditions including behavioral health diagnoses. The State Superintendent of Education will become involved in strategies to promote coordinated healthcare delivery in school settings. In addition, local members of these fields of responsibility will be encouraged to participate in the Regional Collaboratives, representing their areas of expertise. For example, the superintendent of a rural school district with access to care challenges could be a key member of the Regional Collaborative, identifying linkages to school personnel and opportunities others would not be aware of.

CMS Comment (item 11): Identify the recruitment process – including hiring entity – and training along with timeframes for staff the state will hire to implement the proposal.

IDAHO'S RESONSE:

State Hiring Process: The State of Idaho utilizes a competitive hiring process. Interested applicants apply through the Idaho Division of Human Resources. Job announcements include the job responsibilities as well as the minimum qualifications for that classification. Applicants demonstrate meeting those minimum qualifications by completing an online exam. The exam allows the applicants to provide supporting documentation to verify the education and/or experience required of the position.
All applications are scored by a Subject Matter Expert (SME), someone who has either been in that position or supervised such. Their identity is kept confidential and they are not involved in the hiring process. The SME scores the exams based on pre-determined grading criteria and an exam score is identified. Once all exams are scored, a hiring list is created, which includes those who passed the exam and are ranked in order of their exam score. The hiring list is used by the hiring managers to identify candidates for consideration. The new hire must have been an applicant who scored within the top 25 ranked applicants.

Recruiting Resources: Additional recruitment may be needed for positions that are determined difficult in filling, particularly those with very specific skill-sets. Recruiting resources may include numerous online, free or paid sources including universities, local or national websites, professional organizations and/or other industry specific entities such as CareerBuilder.
Required Training Courses: There are a number of standard training courses that all Department employees must take. They include:

(1) *New Employee Orientation* (classroom session 3-1/2 hours)
(2) *IDHW Employee Benefits for NEW and CURRENT Staff* (online version approx. 1 hour)
(3) Respectful Workplace for New Employees (classroom session 2 hours)
(4) Privacy and Confidentiality Course (online version approx. 30-45 minutes)
(5) IDHW Strategic Plan Orientation (online version approx. 30-45 minutes)
(6) IDHW Customer Service Plan (online version approx. 30-45 minutes)

(7) Region IV Programs & Services Orientation (classroom session 3-1/2 hours)
(8) Emergency & Evacuation Procedures (online version approx. 1 hour)
(9) User and Approver I-Time Training (online version approx. 1 hour)
(10) Securing the Human (online version approx. 1-1/2 hours)
In addition, during New Employee Orientation policies and procedures are covered and employees are advised to read and have an understanding of such. A few of the required include: Nondiscrimination policy, Employee conduct, Use of Department Resources, Employee Internet Use, Discipline, Due Process and Appeals.

Recruitment Timeframe

- IDHW publishes announcements for a minimum of five business days, with the ability to extend. However; depending on the position and additional recruitment that may occur, the announcement may run longer to allow for additional candidates to apply.
- Typically, from the time the announcement is posted to the time a hiring manager receives a hiring list is 2 – 3 weeks, depending on the number of candidates and how long it takes the SME to review and score the exams.
- The hiring manager receives the hiring list, completes a thorough review and schedules interviews.
- Interviews are conducted, selections are made and offers are accepted.

PRE-IMPLEMENTATION ACTIVITIES (8/1/2014 – 12/31/2015)

Idaho will implement its State Healthcare Innovation Plan under the management of IDHW. As shown in the Organizational Chart (page 9), staff will be hired to work for the full grant performance period. They will be responsible for facilitating work teams, program development, project management and grant and contract monitoring. Oversight will be provided by IDHW, and the Idaho Healthcare Coalition will be advisory, and will serve on work teams. During the first 8 months of the pre-implementation period, the teams and staff will develop a continuing stakeholder education plan, vendor contracts, and the Model requirements that will direct how the program is implemented. The operational plan for the Model Test will be completed before the Model Test begins (see Roles and Responsibilities, page 10).

Currently, the IHC meets monthly, and is staffed by the Deputy Director, Denise Chuckovich, the Medically Indigent Administrator, and a Research and Development Analyst. Working with the Idaho Medical Home Collaborative, IDHW, the IHC and IHC work groups will meet regularly to develop requirements and contract scopes of work that will contribute to the acquisition of necessary contracts early in the pre-implementation period.

Requirements Development (8/1/2014 – 1/1/2015)

- PCMH requirements and standards, including Virtual PCMHs, the incentive structure and PCMH Mentoring Program.
- Community Health Worker (CHW) and Community EMS (CHEMS) standards and certification requirements.
- Regional Collaborative roles and responsibilities, standards and expectations.
- Requirements for contracts listed below.
- PCMH Payment Structure – enrollment and attribution processes. The payers will set parameters for their patient population risk stratification methodology, and build their PMPM

amounts. Payers will consider and/or develop a value-based payment methodology for primary care and Behavioral Health integration, and whether payments may expand to shared savings for more complex clients as PCMHs reach higher levels of accreditation.

Contract Procurement (1/1/2015 - 10/01/2015)

Vendors will have a significant role in establishing the implementation processes and supports consistent with the plan requirements. The contracts will be developed in stages, beginning prior to grant award. The Procurement process can take up to five months for contracts that are procured through IDHW's competitive bid process. Early Requests for Proposals will be posted with communication that contracts are contingent on the grant award. Non-bid contracts will include the IHDE contract, which will require an amendment to the State's current Sole Source contract, the Program Evaluation contract, and the CHW and CHEMS Training Contracts, which will be secured with educational institutions, and the contract with Public Health Districts to establish Regional Collaborative teams.

Non-Bid Contract-Facilitated work (1/1/2015 – 12/31/2015)

1. Establish Program Evaluation Plan for the Model Test.
2. Develop HIT Infrastructure and Technical Assistance Supports.
3. Develop Virtual PCMH Staff Training (CHW & CHEMS).
4. Develop RC's roles and responsibilities and on-board the RCs.

Bidded Contract-Facilitated work (1/1/2015 – 12/31/2015)

5. **With Project Implementation Contractor:** The project implementation plan & Financial Analysis model will be refined.
6. **With the PCMH Technical Assistance, Training and Coaching Contractor:** The PCMH transformation support plan will be developed.
7. **With the PCMH Performance Reporting Training and Technical Assistance Contractor:** The training and TA program to help PCMHs prepare for data reporting and data-driven quality improvement activities will be developed.
8. **With the Incentive Distribution Contractor**: Mechanisms and controls will be developed to ensure proper distribution of start-up, expansion and recognition incentives to practices.
9. **With Telehealth Contractor:** The Telehealth Implementation Plan will be developed.
10. **With the Data Collection & Analysis Contractor:** The infrastructure for collecting and analyzing data for performance reporting will be developed.

Ramp-Up Activities (1/1/2015 – 12/31/2015)

Objectives (by the end of the Pre-implementation period):

1. Recruit and designate, with the initial PCMH designation, 60 primary care practices (60 clinic sites/addresses), and provide them with technical assistance and incentives to support their

PCMH transformation efforts. This will involve:

a) Identifying and reaching out to practices. From previous and ongoing efforts (e.g., Safety Net Medical Home Initiative, Governor's Idaho Medical Home Collaborative Pilot, ACA Health Homes, Children's PCMH Demonstration Project), Idaho has a number of practices that are working towards PCMH recognition, or are already PCMH recognized. PCMH supports and incentives will be a draw for these practices. During the life of the Model Test, a number of these practices will become mentors to newly designated practices.

b) Provide PCMH outreach, education and technical assistance to practices desiring to become PCMHs. Through the support provided by the contractors, 2, 3, 4, &6 above, 180 Idaho primary care practices (60 clinic sites/addresses per year) will have access to resources to help them transform to Patient Centered Medical Homes (PCMH). These supports will be operational on or before the day the Model Test begins until the Model Test ends.

c) Provide financial incentives to support transformation efforts and support quality outcomes. A PCMH Designation incentive will be distributed to these practices. Start-up, technology and PCMH transformation incentives will be available as soon as the Technical Assistance supports are operational, on or before the Model Test period begins.

2. Build supports for the integration of each PCMH with the local Medical Neighborhood.

a) Build support through the Regional Collaborative Infrastructure. By July 1, 2015, each of Idaho's 7 public health districts will establish a Regional Collaborative (contracts under # 4 above), consisting of a team of 4.25 FTE, including a public health integrator, QA/QI specialist, RC Liaison and administrative and fiscal support staff.

MODEL TESTING ACTIVITIES (1/1/2016 – 12/31/2018)

- IDHW, IHC and the work teams will begin to monitor and evaluate the implementation of the Model Test elements according to the approved operational plan.
- IDHW staff will be responsible for monitoring the contracts associated with their assigned teams and disbursement of grant funds, and regular reporting to CMS.
- Contractors will implement their plans under IDHW oversight.

Model Test Goals, Activities & Milestones (1/1/2016 – 12/31/2018)

Idaho proposes to improve the quality of health care and health outcomes for all Idahoans, and to reduce healthcare costs:

<u>Goal 1:</u> Accelerate establishment of the PCMH model of care throughout the State by building 180 PCMH primary care practices (a practice is defined as a clinic site) that have

reached at least level-1 PCMH recognition or accreditation within their first year of participation in the Model Test.

a) Provide PCMH outreach, education and technical assistance to practices desiring to become PCMHs. Through the support provided by the contractors listed above, 180 Idaho primary care practices (60 clinic sites per year) will have access to resources to help them transform to Patient Centered Medical Homes (PCMH). These supports will be operational on or before the day the Model Test begins until the Model Test ends.

b) Provide financial incentives to support transformation efforts and support quality outcomes. Distribution of incentives through contractor # 8 will be operational on or before the day the Model Test begins until the Model Test ends.

c) Provide PCMH Incentives: Each year, for three years, $30,000 in start-up incentives will be distributed to 60 PCMH-designated practices for a total of 1,800,000 per year. Practices will also receive one time incentive payments at each level of national PCMH recognition as an incentive to further enhance their PCMH capacity. The recognition payment will be $10,000 per each level of recognition achieved (assumes 3 tiers), and Idaho assumes 60 practices per year (includes practices already on path to accreditation through the IMHC) will receive this payment in Year 1, 90 practices in Year 2, and 120 practices in Year 3. It is assumed that not all practices participating in the MTP will reach Level 3 recognition within the model test period. The total requested for recognition payments over the three project years is $3,600,000.

Reaching Beneficiaries: The IHC estimates that the number of patients served by nationally recognized or accredited PCMHs will be 1,282,500 (80% of the population). This is based upon an average of 180 transformed practices with 5 providers per practice, each with a patient panel size of 1425. Broken out quarterly, 106,875 patients would be served by 15 practices newly designated as PCMHs each quarter for 12 quarters. Annually, 427,500 patients will be impacted.

Goal 1: Establish the PCMH model of care throughout the State by building 180 PCMH primary care practices (including Virtual PCMHs) that have reached at least level-1 PCMH recognition or accreditation within their first year of participation in the Model Test. Practices are defined as a clinic site. The total number of PCP's will reach about 900 primary care providers serving 1.3 Million Idahoans based on an estimated panel size of 1425 (80% of the population) by the end of the Model Test Period.

CMS Comment (item 7): Identify quarterly accountability targets and thresholds the state will use to measure the success of the innovation project. Specifically, identify discrete metrics (include numerator/denominator, where possible) and corresponding timelines that will gauge the success of the state's initiatives and allow for CMS to monitor the award throughout the SIM performance period.

IDAHO'S RESPONSE: Below are quarterly accountability targets and thresholds the state will use to measure the success of the innovation project for this activity. The number and proportion of health care providers, hospitals and beneficiaries engaged by each component are indicated.

Discrete metrics have been identified, including numerators and denominators. The timeline for meeting each related milestone is shown in the table. [Green indicates a milestone.]				
Measures	**Pre-Implementation Year – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of primary care practices recruited to transform to PCMH. ***Model Test Target 180.***	No activity yet	30 (17%)	60 (33%)	75 (42%)
CUM # (%) of Practices designated PCMH – ***Model Test Target 180.***	No activity yet	No activity yet	30 (17%)	60 (33%)
CUM # (%) designated PCMHs that have completed a PCMH readiness assessment and goals for transformation. ***Model Test Target 180***	No activity yet	No activity yet	30 (17%)	60 (33%)
CUM # (%) of designated or recognized PCMHs receiving PCMH Technical Support and transformation incentives. ***Model Test Target 180***	No activity yet	No activity yet	30 (17%)	60 (33%)
CUM # (%) of designated PCMHs that have achieved Level 1 National PCMH recognition – ***Model Test target 180.***	No activity yet	No activity yet	10 (6%)	10 (6%)
CUM # (%) of designated PCMHs that have achieved Level 2 National PCMH recognition. ***Model Test target 75 (42%).***	No activity yet	No activity yet	3 (2%)	3 (2%)
CUM # (%) of designated PCMHs that have achieved Level 3 National PCMH recognition. ***Model Test target 62 (33%).***	No activity yet	No activity yet	2 (1%)	2 (1%)
CUM # (%) of Idahoans who enroll in a recognized PCMH (each practice estimated to have 5 providers, each with panel of 1425). ***Model Test Target – 1,282,500 (80% of Idahoans).***	No activity yet	No activity yet	106,875 (8%)	106,875 (8%)
CUM # (%) of enrolled PCMH patients reporting they are an active participant in their healthcare. ***Model Test Target –***	No activity yet	No activity yet	106,875 (8%)	106,875 (8%)

1,282,500 (80% of Idahoans).				
CUM # (%) of hospitals that have an established protocol for follow up communications with designated PCMHs regarding hospitalizations. ***Model Test Target – 52 (100%)***	No activity yet	No activity yet	26 (50%)	52 (100%)
Measures	**Model Test Year 1 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
CUM # (%) of primary care practices recruited to transform to PCMH.	90 (50%)	105 (58%)	120 (67%)	135 (75%)
CUM # (%) of practices designated PCMH.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) designated PCMHs that have completed a PCMH readiness assessment and goals for transformation.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of designated or recognized PCMHs receiving PCMH Technical Support and transformation incentives.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of designated PCMHs that have achieved Level 1 National PCMH recognition	10 (6%)	10 (6%)	15 (8%)	45 (25%)
CUM # (%) of designated PCMHs that have achieved Level 2 National PCMH recognition.	3 (2%)	3 (2%)	10 (6%)	10 (6%)
CUM # (%) of designated PCMHs that have achieved Level 3 National PCMH recognition.	2 (1%)	2 (1%)	5 (3%)	5 (3%)
CUM # (%) of Idahoans who enroll in a recognized PCMH (each practice estimated to have 5 providers, each with panel of 1425).	106,875 (8%)	106,875 (8%)	213,750 (17%)	427,500 (33%)
CUM # (%) of enrolled PCMH patients reporting they are an active participant in their healthcare.	106,875 (8%)	106,875 (8%)	213,750 (17%)	427,500 (33%)
# (%) of hospitals that are using established protocol for follow up communications with	52 (100%)	52 (100%)	52 (100%)	52 (100%)

designated PCMHs re: hospitalizations.				
Measures	**Model Test Year 2 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
CUM # (%) of primary care practices recruited to transform to PCMH.	150 (83%)	165 (92%)	180 (100%)	No further recruitment
CUM # (%) of practices designated PCMH.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) designated PCMH practices that have completed a PCMH readiness assessment and goals for transformation.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of designated or recognized PCMHs receiving PCMH Technical Support and transformation incentives.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of designated PCMH practices that have achieved Level 1 National PCMH Recognition.	60 (33%)	75 (42%)	75 (42%)	60 (33%)
CUM #/% of designated PCMHs that have achieved Level 2 National PCMH recognition.	10 (6%)	10 (6%)	15 (8%)	45 (25%)
CUM # (%) of designated PCMHs that have achieved Level 3 National PCMH recognition.	5 (3%)	5 (3%)	15 (8%)	15 (8%)
CUM # (%) of Idahoans who enroll in a recognized PCMH (each practice estimated to have 5 providers, each with panel of 1425).	534,375 (42%)	641,250 (50%)	748,125 (58%)	855,000 (67%)
CUM # (%) of enrolled PCMH patients reporting they are an active participant in their healthcare.	534,375 (42%)	641,250 (50%)	748,125 (58%)	855,000 (67%)
# (%) of hospitals that are using established protocol for follow up communications with designated PCMHs re: hospitalizations.	52 (100%)	52 (100%)	52 (100%)	52 (100%)
Measures	**Model Test Year 3 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
CUM # (%) of primary care	Activity	Activity	Activity	Activity

practices recruited to transform to PCMH.	Completed	Completed	Completed	Completed
CUM # (%) of practices designated PCMH.	Activity Completed	Activity Completed	Activity Completed	Activity Completed
CUM # (%) designated PCMH practices that have completed a PCMH readiness assessment and goals for transformation.	Activity Completed	Activity Completed	Activity Completed	Activity Completed
# (%) of designated or recognized PCMHs receiving PCMH Technical Support and transformation incentives.	180 (100%)	180 (100%)	180 (100%)	180 (100%)
CUM # (%) of designated PCMH practices that have achieved Level 1 National PCMH Recognition.	60 (33%)	60 (33%)	60 (33%)	45 (25%)
CUM #/% of designated PCMHs that have achieved Level 2 National PCMH recognition.	60 (33%)	75 (42%)	75 (42%)	75 (42%)
CUM # (%) of designated PCMHs that have achieved Level 3 National PCMH recognition.	15 (8%)	15 (8%)	30 (17%)	60 (33%)
CUM # (%) of Idahoans who enroll in a recognized PCMH (each practice estimated to have 5 providers, each with panel of 1425).	961,875 (75%)	1,068,750 (83%)	1,175,625 (92%)	1,282,500 (100% of target; 80% of population)
CUM # (%) of enrolled PCMH patients reporting they are an active participant in their healthcare.	961,875 (75%)	1,068,750 (83%)	1,175,625 (92%)	1,282,500 (100% of target; 80% of population)
# (%) of hospitals that are using established protocol for follow up communications with designated PCMHs re: hospitalizations.	52 (100%)	52 (100%)	52 (100%)	52 (100%)

<u>Goal 2:</u> Improve care coordination by improving real-time communication between PCMHs, their patients, and other entities across the healthcare system (e.g., hospitals and specialty care) through adoption and use of EHRs and HIE connections among the 180 PCMHs, as well as building statewide capacity for data exchange across the system.

a) Increase Health Information Technology Adoption and Use. Over the three-year Model Test period, Idaho Health Data Exchange (Contractor # 2 above) will engage 180

PCMH-designated clinic sites statewide to both adopt and use EHR technology and to connect to the IHDE. Up to 120 designated practices will be connected during the Model Test. The initial 60 practices will have been connected in 2015.

b) As the model matures, the IHDW and IHC will determine the most appropriate ongoing HIT infrastructures to provide aggregation and analytic support to facilitate Idaho's population health management functions.

Goal 2: Improve care coordination by improving real-time communication between PCMHs, their patients, and other entities across the healthcare system (e.g., hospitals and specialty care) through adoption and use of EHRs and IHDE connections among the 180 PCMHs, as well as building statewide capacity for data exchange across the system. The model requires PCMHs to obtain and use an Electronic Health Record. Practice is defined as a clinic site with an estimated averages provider size of 5 and an estimated panel size of 1425.

CMS Comment: Identify quarterly accountability targets and thresholds the state will use to measure the success of the innovation project. Specifically, identify discrete metrics (include numerator/denominator, where possible) and corresponding timelines that will gauge the success of the state's initiatives and allow for CMS to monitor the award throughout the SIM performance period.

IDAHO'S RESPONSE: Below are quarterly accountability targets and thresholds the state will use to measure the success of the innovation project for this activity. The number and proportion of health care providers, hospitals and beneficiaries engaged by each component are indicated. Discrete metrics have been identified, including numerators and denominators. The timeline for meeting each related milestone is shown in the table. [Green indicates a milestone.]

Measures	**Pre-Implementation Year – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated PCMH practices with active Electronic Health Records. ***Model Test Target is 180.***	No Activity	No Activity	52 (29%)	60 (33%)
CUM # (%) of patients having an electronic medical record in participating PCMH designated practices. ***Model Test Target is 1,282,500 (80% of Idahoans).***	No Activity	No Activity	370,500 (29%)	427,500 (33%)
CUM # (%) of designated PCMHs with an active connection to the Idaho Health Data Exchange (IHDE) and utilizing the clinical portal to obtain patient summaries, etc. ***Model Test Target is 180.***	No Activity	No Activity	52 (29%)	60 (33%)
CUM # (%) hospitals connected	No Activity	No Activity	15 (29%)	19 (37%)

to the IHDE. ***Model Test Target is 52.***				
Measures	**Model Test Year 1 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated PCMH practices with active Electronic Health Records.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of patients having an electronic medical record in participating PCMH designated practices.	534,375 (42%)	641,250 (50%)	748,125 (58%)	855,000 (67%)
CUM # (%) of designated PCMHs with an active connection to the Idaho Health Data Exchange (IHDE) and utilizing the clinical portal to obtain patient summaries, etc.		75 (42%)	90 (50%)	105 (58%)
CUM # (%) hospitals connected to the IHDE.	23 (44%)	27 (52%)	31 (60%)	35 (67%)
Measures	**Model Test Year 2 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated PCMH practices with active Electronic Health Records.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of patients having an electronic medical record in participating PCMH designated practices.	961,875 (75%)	1,068,750 (83%)	1,175,625 (92%)	1,282,500 (100%)
CUM # (%) of designated PCMHs with an active connection to the Idaho Health Data Exchange (IHDE) and utilizing the clinical portal to obtain patient summaries, etc.	120 (67%)	135 (75%)	150 (83%)	165 (92%)
CUM # (%) hospitals connected to the IHDE.	39 (75%)	43 (83%)	47 (90%)	52 (100%)
Measures	**Model Test Year 3 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated PCMHs with active Electronic Health Records.	180 (100%)	180 (100%)	180 (100%)	180 (100%)
CUM # (%) of patients having an electronic medical record in participating PCMH designated	1,282,500 (100%)	1,282,500 (100%)	1,282,500 (100%)	1,282,500 (100%)

practices.				
CUM # (%) of designated PCMHs with an active connection to the Idaho Health Data Exchange (IHDE) and utilizing the clinical portal to obtain patient summaries, etc.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) hospitals connected to the IHDE.	52 (100%)	52 (100%)	52 (100%)	52 (100%)

<u>Goal 3:</u> Support the integration of each PCMH with the local Medical Neighborhood.

a) Provide support through the Regional Collaborative infrastructure. On or before January 1, 2016, each of Idaho's 7 public health districts will have established RC's available to provide support to PCMHs.

Goal 3: Support the integration of each PCMH with the local Medical Neighborhood by creating the Regional Collaborative Infrastructure. RCs will support practices in PCMH transformation and will link the PCMHs to the Medical Neighborhood to facilitate coordinated patient care through the entire provider community.

CMS Comment: Identify quarterly accountability targets and thresholds the state will use to measure the success of the innovation project. Specifically, identify discrete metrics (include numerator/denominator, where possible) and corresponding timelines that will gauge the success of the state's initiatives and allow for CMS to monitor the award throughout the SIM performance period.

IDAHO'S RESPONSE: Below are quarterly accountability targets and thresholds the state will use to measure the success of the innovation project for this activity. The number and proportion of health care providers, hospitals and beneficiaries engaged by each component are indicated. Discrete metrics have been identified, including numerators and denominators. The timeline for meeting each related milestone is shown in the table. [Green indicates a milestone.]

Measures	**Pre-Implementation Year – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
# (%) of RC's established and providing regional quality improvement and medical neighborhood integration services. ***Model Test Target, one RC team in each of the 7 health districts.***	No Activity Yet	No Activity Yet	7 (100%)	7 (100%)
Cumulative (CUM) # (%) of PCMH designated or recognized primary care practices that can receive assistance through an RC. ***Model Test Target – 180.***	No Activity Yet	No Activity Yet	30 (17%)	60 (33%)

CUM # (%) of designated or recognized PCMHs who are using established protocols for referrals and follow up communications with service providers in their medical neighborhood to manage care transitions. ***Model Test Target – 180.***	No Activity Yet	No Activity Yet	30 (17%)	60 (33%)
CUM # (%) of patients enrolled in a designated or recognized PCMH whose health needs are coordinated across their local medical neighborhood as needed. ***Model Test Target – 1,282,500 (80% of Idahoans).***	No Activity Yet	No Activity Yet	213,750 (17%)	427,500 (33%)
# (%) of Hospitals providing information regarding enrolled patient hospitalizations to designated or recognized PCMHS. ***Model Test Target – 52.***	No Activity Yet	No Activity Yet	52 (100%)	52 (100%)
Measures	**Model Test Year 1 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
# (%) of RC's established and providing regional quality improvement and medical neighborhood integration services.	7 (100%)	7 (100%)	7 (100%)	7 (100%)
CUM # (%) of PCMH designated Primary Care practices that can receive assistance through an RC.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of designated or recognized PCMHs who are using established protocols for referrals and follow up communications with service providers in their medical neighborhood to manage care transitions.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of patients enrolled in a designated or recognized PCMH whose health needs are coordinated across their local medical neighborhood as needed.	535,375 (42%)	641,250 (50%)	748,125 (58%)	855,000 (67%)
# (%) of Hospitals providing information regarding enrolled patient hospitalizations to designated or recognized	52 (100%)	52 (100%)	52 (100%)	52 (100%)

PCMHS.				
Measures	**Model Test Year 2 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
# (%) of RC's established and providing regional quality improvement and medical neighborhood integration services.	7 (100%)	7 (100%)	7 (100%)	7 (100%)
CUM) # (%) of PCMH designated or recognized primary care practices that can receive assistance through an RC.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of designated or recognized PCMHs who are using established protocols for referrals and follow up communications with service providers in their medical neighborhood to manage care transitions.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of patients enrolled in a designated or recognized PCMH whose health needs are coordinated across their local medical neighborhood as needed.	961,875 (75%)	1,068,750 (83%)	1,175,625 (92%)	1,282,500 (100% of target; 80% of population)
# (%) of Hospitals providing information regarding enrolled patient hospitalizations to designated or recognized PCMHS.	52 (100%)	52 (100%)	52 (100%)	52 (100%)
Measures	**Model Test Year 3 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
# (%) of RC's established and providing regional quality improvement and medical neighborhood integration services.	7 (100%)	7 (100%)	7 (100%)	7 (100%)
# (%) of PCMH practices that can receive assistance through an RC.	180 (100%)	180 (100%)	180 (100%)	180 (100%)
# (%) of PCMH practices that are using established protocols for referrals and follow up communications with service providers in their medical neighborhood to manage care transitions.	180 (100%)	180 (100%)	180 (100%)	180 (100%)
# (%) of patients enrolled in a	1,282,500	1,282,500	1,282,500	1,282,500

designated or recognized PCMH whose health needs are coordinated across their local medical neighborhood as needed.	(100%)	(100%)	(100%)	(100%)
# (%) of Hospitals providing information regarding enrolled patient hospitalizations to designated or recognized PCMHS.	52 (100%)	52 (100%)	52 (100%)	52 (100%)

<u>Goal 4:</u> Improve patient access to PCMH –based care in geographically remote area of Idaho by supporting a Virtual PCMH Model through provider incentives and training community health workers, as well as integrating Telehealth into HIT plans for these areas.

a) Pay a one-time provider incentive payment of $5,000: Beginning in January, 2016, this payment will be available for up to 75 practices (from the 180 PCMHs) that meet the requirements of the virtual PCMH Model. Recruitment of Virtual PCMHs will begin in year 1 of the Model Test.

b) Train Community Health EMS (CHEMS) staff: Through training contracts (Contractor # 3 above), community paramedic staff will be trained in three regions to provide essential services as part of the virtual PCMH in geographically isolated and medically under-resourced areas. Outreach events to educate stakeholders about CHEMS will be conducted to ensure that three regional programs (each with 4 staff) are implemented each year of the Model Test, for a total of 52 CHEMS staff providing services in 13 rural communities by the end of the Model Test period. Program fees will be waived during the Model Test year, paid for by the grant funds. In Years 3 and 4, a one-day continuing education conference will be held for trained staff.

c) Train Community Health Workers (CHWs): Through training contracts (Contractor # 3 above), CHW training will begin as a two-day in-person training in regional locations with support from the RCs at 7 locations per year, reaching up to 525 CHWs providing essential services as part of the virtual PCMH in geographically isolated and medically under-resourced areas by the end of the Model Test. In Years 3 and 4, one-day continuing education conferences will be held for CHW trained staff, in conjunction with the CHEMS continuing education conference.

d) Improve Telehealth Usage & Integration of Behavioral Health and Physical Health: The Telehealth Contractor (contractor # 9 above) will help IDHW expand Telehealth technology, to include training and technical assistance, in rural communities, enhancing access to behavioral health and other specialty services. Telehealth services will also be used to support CHW and community EMS staff participation in virtual PCMHs.

Goal 4: Improve patient access to PCMH – based care in geographically remote areas of Idaho by developing 75 Virtual PCMHs; the model includes training of Community Health Workers and Integrating Telehealth infrastructure.

CMS Comment: Identify quarterly accountability targets and thresholds the state will use to measure the success of the innovation project. Specifically, identify discrete metrics (include numerator/denominator, where possible) and corresponding timelines that will gauge the success of the state's initiatives and allow for CMS to monitor the award throughout the SIM performance period.

IDAHO'S RESPONSE: Below are quarterly accountability targets and thresholds the state will use to measure the success of the innovation project for this activity. The number and proportion of health care providers, hospitals and beneficiaries engaged by each component are indicated. Discrete metrics have been identified, including numerators and denominators. The timeline for meeting each related milestone is shown in the table. [Green indicates a milestone.]

Measures	Pre-Implementation Year – Quarterly Targets			
	Q1	Q2	Q3	Q4
CUM # (%) of Virtual PCMHs established in rural communities following assessment of need. ***Model Test Target - 75***	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
CUM # (%) of regional Community Health EMS Services (CHEMS) programs established. ***Model Test Target – 13.***	No Activity Yet	No Activity Yet	No Activity Yet	2 (15%)
CUM # (%) of CHEMS program personnel trained for Virtual PCMH coordination. ***Model Test Target – 52 (4 per program)***	No Activity Yet	No Activity Yet	No Activity Yet	8 (15%)
CUM # (%) 2-day Virtual PCMH training events for Community Health Workers. ***Model Test Target – 21 regional locations.***	No Activity Yet	No Activity Yet	No Activity Yet	1 (5%)
CUM # (%) of new community health workers trained for Virtual PCMH coordination. ***Model Test Target – 525 (25 per training).***	No Activity Yet	No Activity Yet	No Activity Yet	25 (5%)
CUM # (%) of continuing education conferences held for CHW and CHEMS Virtual PCMH Staff. ***Model Test Target – 2 for 577 community health workers.***	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
CUM # (%) of designated or recognized Virtual PCMH practices that have completed	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet

training and technical assistance for using Telehealth tools. ***Model Test Target – 75.***				
CUM # (%) of designated or recognized Virtual PCMH practices that routinely use Telehealth tools to provide specialty and behavioral health services to rural patients. ***Model Test Target – 75.***	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
Measures	**Model Test Year 1 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
CUM # (%) of Virtual PCMHs established in rural communities following assessment of need.	6 (8%)	12 (16%)	18 (24%)	24 (32%)
CUM # (%) of regional Community Health EMS Services (CHEMS) programs established.	3 (23%)	4 (31%)	5 (38%)	6 (46%)
CUM # (%) of CHEMS program personnel trained for Virtual PCMH coordination.	12 (23%)	18 (31%)	20 (38%)	24 (46%)
CUM # (%) 2-day Virtual PCMH training events for Community Health Workers.	2 (10%)	3 (14%)	5 (24%)	7 (33%)
CUM # (%) of new community health workers trained for Virtual PCMH coordination.	50 (10%)	75 (14%)	125 (24%)	175 (33%)
CUM # (%) of continuing education conferences held for CHW and CHEMS Virtual PCMH Staff.	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
CUM # (%) of designated or recognized Virtual PCMH practices that have completed training and technical assistance for using Telehealth tools.	No Activity Yet	6 (8%)	12 (16%)	18 (24%)
CUM # (%) of designated or recognized Virtual PCMH practices that routinely use Telehealth tools to provide specialty and behavioral health services to rural patients.	No Activity Yet	6 (8%)	12 (16%)	18 (24%)
Measures	**Model Test Year 2 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
CUM # (%) of Virtual PCMHs established in rural communities	30 (40%)	36 (48%)	42 (56%)	48 (64%)

following assessment of need.				
CUM # (%) of regional Community Health EMS Services (CHEMS) programs established.	7 (54%)	8 (62%)	9 (69%)	10 (77%)
CUM # (%) of CHEMS program personnel trained for Virtual PCMH coordination.	28 (54%)	32 (62%)	36 (69%)	40 (77%)
CUM # (%) 2-day Virtual PCMH training events for Community Health Workers.	9 (43%)	11 (52%)	13 (62%)	15 (71%)
CUM # (%) of new community health workers trained for Virtual PCMH coordination.	225 (43%)	275 (52%)	325 (62%)	375 (71%)
CUM # (%) of continuing education conferences held for CHW and CHEMS Virtual PCMH Staff.	1 (50%)	No Activity	No Activity	No Activity
CUM # (%) of designated or recognized Virtual PCMH practices that have completed training and technical assistance for using Telehealth tools.	24 (32%)	30 (40%)	36 (48%)	42 (56%)
CUM # (%) of designated or recognized Virtual PCMH practices that routinely use Telehealth tools to provide specialty and behavioral health services to rural patients.	24 (32%)	30 (40%)	36 (48%)	42 (56%)
Measures	**Model Test Year 3 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
CUM # (%) of Virtual PCMHs established in rural communities following assessment of need.	55 (73%)	62 (83%)	69 (92%)	75 (100%)
CUM # (%) of regional Community Health EMS Services (CHEMS) programs established.	11 (85%)	12 (92%)	13 (100%)	13 (100%)
CUM # (%) of CHEMS program personnel trained for Virtual PCMH coordination.	44 (85%)	48 (92%)	52 (100%)	52 (100%)
CUM # (%) 2-day Virtual PCMH training events for Community Health Workers.	17 (81%)	19 (90%)	21 (100%)	21 (100%)
CUM # (%) of new community health workers trained for Virtual PCMH coordination.	425 (81%)	475 (90%)	525 (100%)	525 (100%)
CUM # (%) of continuing	1 (100%)	No Activity	No Activity	No Activity

education conferences held for CHW and CHEMS Virtual PCMH Staff.				
CUM # (%) of designated or recognized Virtual PCMH practices that have completed training and technical assistance for using Telehealth tools.	48 (64%)	55 (73%)	62 (83%)	75 (100%)
CUM # (%) of designated or recognized Virtual PCMH practices that routinely use Telehealth tools to provide specialty and behavioral health services to rural patients.	48 (64%)	55 (73%)	62 (83%)	75 (100%)

Goal 5: Build a statewide system for collecting, analyzing and reporting quality and outcome data at the PCMH, regional and state levels. This will provide critical feedback at the practice, regional and state levels:

a) Provide PCMH performance reporting training and technical assistance: Through the PCMH TA vendor (Contract # 7 above), education and technical assistance for performance reporting capacity will be provided to ensure that 60 practices are prepared to report on identified measures in the second year of the Model Test, and up to 120 practices are able to report on identified measures in the third year. 180 practices will report in 2019. In year 2 of the Model Test, the RC's will conduct regional needs assessments and will develop strategies and activity recommendations to address regional improvement.

b) Support data collection and analytics for targeted performance reporting: The data collection and analytics consultant (contractor # 10 above) will collect, and analyze selected quality and cost data for the baseline and each subsequent year through the Model Test. The contractor will provide data analytics feedback at the practice level for improving the care of the patient population; at the regional level for identification of quality indicators to focus on at the regional level, and at the state level to provide direction in evaluating the overall success of the Model Test.

Goal 5: Build a statewide data analytics system to measure and improve performance and population health.

CMS Comment: Identify quarterly accountability targets and thresholds the state will use to measure the success of the innovation project. Specifically, identify discrete metrics (include numerator/denominator, where possible) and corresponding timelines that will gauge the success of the state's initiatives and allow for CMS to monitor the award throughout the SIM performance period.

IDAHO'S RESPONSE: Below are quarterly accountability targets and thresholds the state will use to measure the success of the innovation project for this activity. The number and proportion of health care providers, hospitals and beneficiaries engaged by each component are indicated. Discrete metrics have been identified, including numerators and denominators. The timeline for meeting each related milestone is shown in the table. [Green indicates a milestone.]

Measures	**Pre-Implementation Year – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated or recognized PCMH practices that have received technical assistance to establish performance reporting capacity. ***Model Test Target - 180 by 2020. 60 prepared to report on measures in year 2, 120 in year 3 and 180 in 2019***	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
CUM # (%) of % of designated or recognized PCMH practices that report on identified measures. ***Model Test Target - 180 by 2020.***	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
CUM # (%) of % of designated or recognized PCMH practices that receive from an RC the results of their community health needs assessment, which can be used to guide their quality improvement initiatives. ***Model Test Target – 180.***	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
Measures	**Model Test Year 1 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated or recognized PCMH practices that have received technical assistance to establish performance reporting capacity.	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
CUM # (%) of % of designated or recognized PCMH practices that report on identified measures.	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
# (%) of % of designated or recognized PCMH practices that receive from an RC the results of their community health needs assessment, which can be used to guide their quality improvement initiatives.	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
Measures	**Model Test Year 2 – Quarterly Targets**			

	Q1	Q2	Q3	Q4
Cumulative (CUM) # (%) of designated or recognized PCMH practices that have received technical assistance to establish performance reporting capacity.	15 (8%)	30 (17%)	45 (25%)	60 (33%)
CUM # (%) of % of designated or recognized PCMH practices that report on identified measures.	No Reporting	No Reporting	30 (17%)	60 (33%)
# (%) of % of designated or recognized PCMH practices that receive from an RC the results of their community health needs assessment, which can be used to guide their quality improvement initiatives.	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
Measures	**Model Test Year 3 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated or recognized PCMH practices that have received technical assistance to establish performance reporting capacity.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of % of designated or recognized PCMH practices that report on identified measures.			90 (50%)	120 (67%)
# (%) of % of designated or recognized PCMH practices that receive from an RC the results of their community health needs assessment, which can be used to guide their quality improvement initiatives.	Assessment being conducted.	Assessment being conducted.	Assessment being conducted.	180 (100%)
Measures	**Post- Model Test Year 4 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated or recognized PCMH practices that have received technical assistance to establish performance reporting capacity.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of % of designated or recognized PCMH practices that report on identified measures.	No Reporting	No Reporting	150 (83%)	180 (100%)
# (%) of % of designated or recognized PCMH practices that receive from an RC the results of	Completed	Completed	Completed	Completed

their community health needs assessment, which can be used to guide their quality improvement initiatives.				

<u>Goal 6:</u> Test transformation from a fee-for-service system to one that incentivizes value, rather than volume, by aligning value-based payment mechanisms across payers.

a) Implement a phased payment model that will include consideration of PMPM payments for reaching certain recognition levels to support ongoing PCMH activities (e.g., coordination of care), payments for quality performance, and potential shared savings arrangements. As the PCMH model matures during the first years of the Model Test implementation, and the infrastructure for performance reporting is established, and population health targets identified, the new payment model will be introduced in phases that will incentivize for increasing quality of care.

Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value. Practice is defined as a clinic site with an estimated averages provider size of 5 and an estimated panel size of 1425.

CMS Comment: Identify quarterly accountability targets and thresholds the state will use to measure the success of the innovation project. Specifically, identify discrete metrics (include numerator/denominator, where possible) and corresponding timelines that will gauge the success of the state's initiatives and allow for CMS to monitor the award throughout the SIM performance period.

IDAHO'S RESPONSE: Below are quarterly accountability targets and thresholds the state will use to measure the success of the innovation project for this activity. The number and proportion of health care providers, hospitals and beneficiaries engaged by each component are indicated. Discrete metrics have been identified, including numerators and denominators. The timeline for meeting each related milestone is shown in the table. [Green indicates a milestone.]

Measures	**Pre-Implementation Year – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) Payers representing at least 80% of the beneficiary population that adopt new reimbursement models. ***Model Test Target – 4 (100%).***	4 (100%)	4 (100%)	4 (100%)	4 (100%)
CUM # (%) of recognized PCMH Practices who are under contract with one to 4 payers to receive alternative (non-volume based) reimbursements. ***Model Test Target – 180.***	No Activity Yet	No Activity Yet	15 (8%)	15 (8%)
CUM # (%) of beneficiaries attributed for purposes of	No Activity Yet	No Activity Yet	106,875 (8%)	106,875 (8%)

alternative reimbursement payments. ***Model Test Target – 1, 282,500 (80% of Idahoans).***				
Measures	**Model Test Year 1 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) Payers representing at least 80% of the beneficiary population that adopt new reimbursement models.	4 (100%)	4 (100%)	4 (100%)	4 (100%)
CUM # (%) of recognized PCMH Practices who are under contract with one to 4 payers to receive alternative (non-volume based) reimbursements.	15 (8%)	15 (8%)	30 (17%)	60 (33%)
CUM # (%) of beneficiaries attributed for purposes of alternative reimbursement payments.	106,875 (8%)	106,875 (8%)	213,750 (17%)	427,500 (33%)
Measures	**Model Test Year 2 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) Payers representing at least 80% of the beneficiary population that adopt new reimbursement models.	4 (100%)	4 (100%)	4 (100%)	4 (100%)
CUM # (%) of recognized PCMH Practices who are under contract with one to 4 payers to receive alternative (non-volume based) reimbursements.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of beneficiaries attributed for purposes of alternative reimbursement payments.	534,375 (42%)	641,250 (50%)	748,125 (58%)	855,000 (67%)
Measures	**Model Test Year 3 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) Payers representing at least 80% of the beneficiary population that adopt new reimbursement models.	4 (100%)	4 (100%)	4 (100%)	4 (100%)
CUM # (%) of recognized PCMH Practices who are under contract with one to 4 payers to receive alternative (non-volume based) reimbursements.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of beneficiaries attributed for purposes of	961,875 (75%)	1,068,750 (83%)	1,175,625 (92%)	1,282,500 (100% of

alternative reimbursement payments.				target; 80% of population)

<u>Goal 7:</u> Determine the cost savings and return on investment of the model, and progress toward meeting implementation goals throughout the Model Test period, as well as health outcomes predicted by the Model.

a) Monitor cost savings from the Model and return on investment (ROI): The contractor (# 5 above) will help IDHW develop the financial models and monitor costs.

b) Evaluate progress toward goals of the Model Test against annual targets, and the success of the Model Test to reach the goals of the project by the end of the Model Test: Beginning on or before January, 2016, Idaho will implement the Model Test evaluation plan as defined in the evaluation plan, with the help of the State Evaluator (Contractor # 1 above).

CMS Comment (item 2): Explain how the individual elements described in the proposal will scale to statewide implementation during the SIM period of performance. Include a timeline for scaling specific elements of the proposal.

IDAHO'S RESPONSE:

Idaho's PCMH Model Test proposes to build 60 Nationally Recognized PCMH practices each year of the program implementation period (including 75 Virtual PCMHs), culminating in 180 practices by the end of the Model Test. Practices are defined as practice sites with an estimated average of 5 providers each of whom serves a panel of 1425 patients, on average. From the beginning to the end, practices will be selected representationally from each of the 7 Health Districts in Idaho. Therefore, the program will be Statewide from the beginning, building to capacity in a steady rate throughout the Model Testing period. By the fourth quarter of each year, including the pre-implementation period, an additional 60 PCMHs at minimum (25% of the target) will have joined the program by becoming designated as a PCMH for purposes of transformation and recognition. PCMHs will be recruited and designated at a rate of 15 per quarter beginning on January 1 of 2016. To the extent possible, the rate of recruitment will vary only in the pre-implementation year, when the initial 60 are recruited between July 1 and December 31, 2015. The initial 60 will be recruited from among a known group of practices currently striving for, or having achieved, PCMH recognition status (see the Timeline for Statewide Scale-Up below).

As PCMHs become level 1 recognized, the proportion of Idahoans who become attributed patients of a recognized patient-centered medical home will increase by the same rate. The initial group of recognized practices is expected to be small (about 15). However, by the fourth quarter of the first Model Test year, the first 60 PCMHs will meet the milestone of at least level 1 recognition. Note that practices will be able to use a variety of Idaho Healthcare Coalition (IHC)-approved national PCMH recognition/accreditation programs to achieve these goals.

Because an additional 15 practices enter the program every quarter of each Model Test year, 15 additional practices are expected to be recognized every quarter beginning in Model Test Year 2. By the end of Model Test Year 3, 180 practices (100% of target) will have reached at least level-1 recognition; 75% will have reached recognition status greater than level 1. 50% of Idaho's beneficiaries (641,250) will be attributed to PCMHs by quarter 1 of Model Test Year 2. 80% of Idaho's beneficiaries, 1,282,500 Idahoans, will be attributed to PCMHs by the last quarter of Model Test Year 3.

Upon designation, and until the end of the Model Test period, PCMHs will receive technical assistance from PCMH contractors, from Idaho Health Data Exchange, and from the Regional Collaboratives. The PCMH contractors will help the initial 60 practices during the pre-implementation year and 15 new practices each quarter during the Model Test years, to complete a PCMH readiness assessment within the first quarter following designation, and establish transformation goals and business plans that will guide their activities for the program during the Model Test. The PCMH contractor will be responsible for distributing appropriate technical assistance financial incentives. Beginning in the first quarter of each designated PCMHs participation, IHDE and its sub-contractors will provide technical assistance to practices to establish EMR's and to connect those to the IHDE. The group from which the initial 60 practices will be recruited in the pre-implementation year are already mostly connected, but some additional work will be done then as needed. Connecting 15 new PCMHs per quarter beginning January 1, 2016 is expected to be a reasonable goal. As such 50% of designated PCMH's are expected to have active EMR's by quarter 2 of 2016, and all PCMH's are expected to have EMRs by the fourth quarter of 2017. Essentially, HIT connectivity in PCMHs will keep pace with PCMH designation.

The permanent Regional Collaborative infrastructure will be established in each of 7 regional health districts by July 1, 2015. They will begin to provide medical neighborhood integration and quality improvement services to the initial 60 practices during the pre-implementation year. The goal will be to ready the initial 60 practices to be fully engaged in transformation by January 1, 2016. Every practice that is designated as a PCMH will immediately be able to utilize the services of the local/regional RC. Thus, 50% of designated PCMHs will have access to RC services by the second quarter of Model Test Year 1. All of the PCMH designees (100% of target) will have continuing access to their RCs by quarter 4 of Model Test Year 2. Within the quarter that they are designated, each PCMH practice will be expected to establish a protocol for communicating with the other medical services within their medical neighborhood, including hospitals, in order to coordinate care transitions.

As PCMHs are designated and begin transformation, 75 practices will be recruited to become Virtual PCMHs at a planned rate of 6 per quarter beginning in January 2017, and finishing up in quarter 4, 2018. At that same rate, Virtual PCMH practices will be trained on use of Telehealth technology and standards, the infrastructure of which will be established in 2015 and 2016. They will be expected to be using Telehealth practices routinely within the quarter in which they are

trained. Virtual PCMH practices will be established in remote and rural communities where the medical workforce is sparse.

By the end of 2018, the preparation of Community Workers (Community Health EMS (CHEMS) workers & Community Health Workers (CHWs)) will be well underway, with 54% (28 CHEMS workers) and about 52% (275 CHW workers) trained. The workers will serve on Virtual PCMH care coordination teams. The remaining community health workers will be trained by the third quarter of Model Test year 3, and will be able to work on PCMH teams established during the Model Test, and those established after the Model Test. The PCMH training for Community workers will be provided by the RCs as needed beyond the Model Test.

During the second Model Test Year, 2017, designated and recognized PCMH practices will begin to receive technical assistance for performance reporting. The first practices, the 60 which were designated in 2015, will be expected to report on identified quality measures by quarter four of that year. By quarter 3 in 2018, 50% of the PCMHs will be reporting, and by the end of the Model Test (2018), 75% of the PCMHs will be reporting. Reporting will continue for the model test into 2019; 180 (100%) of the recognized PCMHs will be reporting in quarter 4. In sum, there will be three rounds of performance reporting, with greater numbers of providers reporting each time.

In summary, all of the elements of Idaho's Model Test will be in place by the end of the Model Test, with only performance reporting lagging behind by 25%. At least 80% of Idaho's beneficiary population will be served by a recognized PCMH (75% above level-1 recognition) by that time, and will be receiving patient-centered care coordinated across their medical neighborhoods.

Note. The Timeline for Statewide Scale-Up shows 50%, 75% and 100% milestones for each Model Test activity. Unless indicated otherwise, the milestone shows the current status at the beginning of the milestone box. For more detail and metrics, see the individual quarterly target tables for the related activity.

Timeline for Statewide Scale-Up

Model Test (MT) Activity	Pre-Implementation Year				Model Test Year 1				Model Test Year 2				Model Test Year 3				Post Model Test Year 4			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
80% of Idaho's Beneficiaries have a Recognized PCMH			106,875 (8%)			427,500 (33%)			641,250 (50%)				**961,875 (75%)**				**1,282,500 (100%)**			
Set Up Regional Collaborative Infrastructure	Prep.		RC's in full service (all 7 regions).			90 (50%) Can Work with RCs			**135 (75%) Can Work with RCs**				**180 PCMHs (900 providers) can receive RC services. All PCMHs receive results local needs assessments**							
Recruit 180 Practices (900 Providers) to Transform to PCMHs	Preparation		60 Practices Designated			90 (50%) Designated			**135 (75%) Designated**				**180 (100%) all Designated; All Regions Represented**							
Promote Use of Electronic Medical Records Systems among 180 PCMHs	Prep.		60 Pre-Existing			90 (50%) EMRs			**135 (75%) EMRs**				**180 (100%) EMRs**							
Connect 180 PCMHs to the Idaho Health Data Exchange	Prep.		60 Pre-Existing			90 (50%)			**135 (75%)**				**180 (100%) IHDE Connections**							
Transform 180 PCPs to Nationally Recognized PCMHs	Preparation				15		60 (33%) by Q4		75 (42%) Nationally Recognized				**135 75% (39% > Level 1)**				**180 (100%) (75% above level 1)**			
Train 52 Community Health EMS (CHEM) Workers to serve on PCMH Care Teams in Rural Areas	Preparation		2/8		3 programs trained in 3 Rural Communities				7 programs (54%) 28 Workers				**10 programs (77%) 40 Workers**				**13 Pgms.; 52 Workers (100%) in 13 Rural Communities**			
Train 525 Community Healthcare Workers (CHWs) to serve on PCMH Care Teams in Rural Areas	Preparation		1/25		7 Trainings, 175 Workers (33%)				11 T., 275 (52%) Workers				**15 Trainings, 375 (71%) Workers by Q4, Y2.**				**525 (100%)CHWs trained to work with PCMHs.**			
Establish Telehealth Infrastructure and Training for Virtual PCMHs	Preparation				6/8%	42 Trained (52%) by end of Y2							**55 Trained (73%) by Q3, Y3**				**75 (100%) Virtual PCMHs**			
Establish Performance Reporting Among PCMHs	Preparation								T. A. Starts				60 (33%) Report in Yr 2				50% (90) Report			**135 (75) Report**	**100%**

RISKS ASSUMPTIONS AND MITIGATION STRATEGIES

Assumptions:

1. IDHW will be able to develop RFPs and award contracts within timelines specified in the Operations Plan.
2. IDHW will be able to hire staff within timelines specified in the Operations Plan.
3. IDHW will be able to identify and designate as PCMHs the first 60 PCMHs within first 6 months.
4. Consultant for data analytics will be able to establish baseline on selected performance measures early in year 1 to allow full test for change.

Associated Risk:

Slower start-up on all items above would result in less time to measure system changes and impacts on outcomes and costs.

Mitigation Strategy:

Continue to plan, develop HIT and payment strategies, RFPs and PCMH requirements prior to notice of grant award, preparing as much as possible before 1/1/2015.

BUDGET

The four year budget request anticipates a 6 month pre-implementation phase during Year 1 for certain activities while other activities may take up to 12 months to get in place. Year 1 figures reflect needed pre-implementation funding, which is detailed in the budget narrative.

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TOTAL BUDGET BY PROJECT YEAR

	Year 1 Pre-Implementa-tion	Year 2	Year 3	Year 4	Total
Total Costs	$8,937,216	$15,277,003	$18,800,034	$17,998,510	$61,012,763
Total Direct Costs	$8,861,701	$15,201,488	$18,724,519	$17,922,995	$60,710,703
Total Indirect Costs	$75,515	$75,515	$75,515	$75,515	$302,060

SUSTAINABILITY PLAN

Idaho's sustainability plan is based on two core principles: first, significant one time investment of grant funds to build and transform the service delivery system and second, continued investment by Idaho's healthcare system of those aspects of system change that prove valuable.

The first principle of investment is reflected in this proposal as grant funds are used to invest in significant system transformations that Idaho's healthcare system cannot currently undertake without additional outside resources. These one-time investments will build the foundation and platform for system change. Specifically Idaho proposes that grant funds invest in system transformation through investments in PCPs to become PCMHs, through additional training to PCMHs in use of EHRs, through investment in building regional supports for PCMHs and the medical neighborhood, through establishing a strong telehealth program for Idaho, and through creating training programs for CHWs and CHEMs. One time investments will also be made by building statewide data collection and analytics systems which produce data analytics for individual providers as well as regional and statewide population analytics. The PCP community will take advantage of this opportunity to transform within the 4 year grant period, with the understanding that payments will be evolving towards PMPM and pay for performance, making it more attractive to take on transformation.

CMS Comment:

1. Page 3 of the FOA states, "As a condition of the award, the state must commit to sustain its model after the design and/or test period." Further, stated on page 36, "States need to show how their models will be sustainable after the testing period is complete."

Considering these requirements, please address the following:

a. Describe the state's plan to sustain the innovation initiative as described in your proposal, such as practice transformation support, beyond the SIM period of performance.

IDAHO'S RESPONSE: As we described in the application/proposal we intend use the experience we gained through the Idaho Medical Home Collaborative in developing practice transformation support. We will use contractors to help kick start the process but will sustain the process through the Regional Collaboratives (RC). It will be the responsibility of the RC – working with the primary care practices and the medical neighborhood– to continue to evolve and improve the transformation process by identifying gaps and providing or arranging supports to fill those gaps.

It is the goal of the Idaho Healthcare Coalition (IHC) to move the current health care delivery system from a fee for service, volume based, health care system toward an accountable health care system. The Idaho legislature has given support and direction to Idaho Medicaid via Idaho Code 56-261 and 56-263 to move toward the system of care proposed in the Idaho model.

The second core assumption for sustainability is that the system changes accomplished through these transformations will result in significant improvements to Idaho's healthcare delivery system, improving delivery and quality of care, health outcomes, and ultimately reducing costs. During the four year grant period, the providers and payers on the IHC will continuously evaluate the impact of transformation activities. The IHC will determine which system changes bring the most value to quality and costs and should be invested in for the four years following the grant period and beyond. This on-going evaluation of transformation activities for sustainability will be an integral activity for the IHC.

IDHW staff hired with grant funds will be hired into limited service positions for the four year life of the grant. The ongoing evaluation activities of the IHC will include study of the need for staffing of on-going activities beyond the grant period. The IHC has already discussed the possibility of creating a private, not for profit organization to continue the core work accomplished through the MTP. Stakeholders will continue to study the advisability of this step through the grant period and will determine the appropriate course of action well prior to the end of the grant period. Ultimately those activities which are identified as valuable to the continued success of Idaho's transformed healthcare system will be invested in by payers and providers.

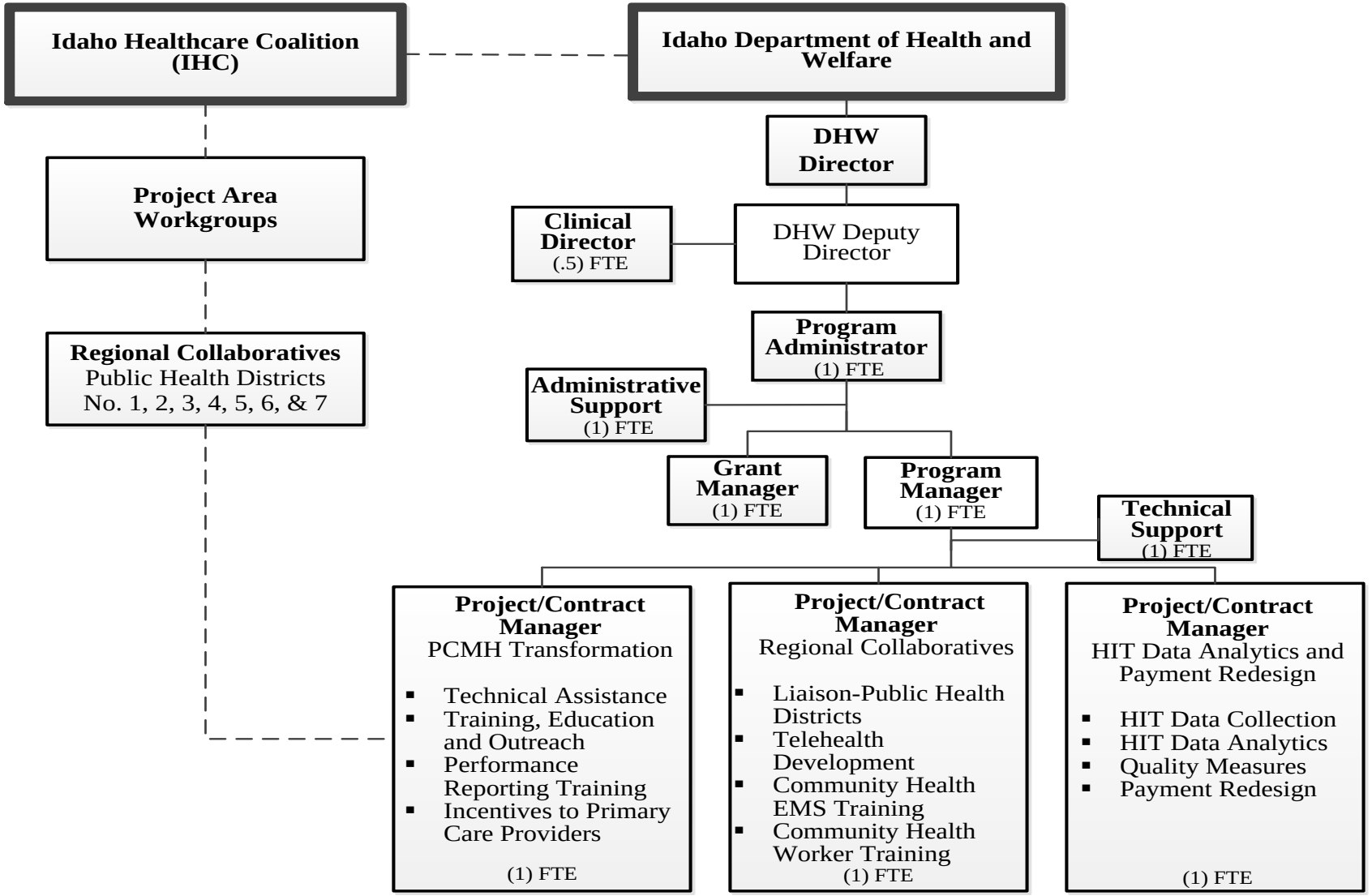
b. CMS Comment: Describe how the staffing level described in the proposal will be sustained after the SIM project period concludes.

IDAHO'S RESPONSE: It is not anticipated that the staffing levels will need to be sustained at the same level when the SIM project period concludes. During the testing period, we expect to use new resources to increase medical home capacity across Idaho's entire healthcare system through initial training and technical assistance. Simultaneously, we will work to establish RCs across the state that will provide any ongoing support and assistance required by primary care practices and the surrounding medical neighborhood. As the project periods concludes, the Idaho Healthcare Coalition, working with the RCs, will continually monitor and review staffing support requirements – both by type and number – to meet the needs of the primary care practices.

c. CMS Comment: In the Operational Plan section of your proposal, you indicate the proposed use of contractors to perform significant activity under this cooperative agreement. Describe the state's plan to integrate the contractors' work following the SIM period of performance.

IDAHO'S RESPONSE: Contractors are being used to help facilitate the development of the model. Once the model is developed (ending the SIM period of performance), some of the contractor tasks will no longer be necessary and other tasks will be assumed by the RCs, IHC and providers

Model Test Proposal Organizational Structure



RESPONSIBILITIES AND TIMELINE

Roles	Pre-Implementation - Year 1	Model Test Period - Years 2-4
Idaho Healthcare Coalition (IHC)	Broad stakeholder advisory group meets monthly per executive order to provide leadership and oversight, in partnership with IDHW, to develop the Model requirements (e.g. PCMH, RCs, Training & Payment).	IHC meets monthly to provide decision-making as needed, to trouble shoot, and to evaluate progress and outcomes of the Model Test, and establish PCMH & population health management as the driver of health improvement.
IDHW	Hires staff & consultants, & convene work teams.	In partnership with the IHC, administers the Model Test grant and oversees all grant activities.
IDHW Project Staff	Facilitates work group teams to develop Model requirements, vendor contracts and the operational plan.	Monitors contracts and Model Test progress and outcomes per assigned areas of the Model, reporting to IDHW, the IHC and CMS.
IHC Work Groups	Assist in development of the Model requirements, vendor contracts and operational plan.	Monitor Implementation of the Plan. Continue to develop the payment model, quality measurement and data analytic plans.
Contractors	Contractors develop services and implementation plans.	Implement services to support transformation of the healthcare system per contract and the operational plan.
Regional Collaboratives		Help PCMHs transform and become integrated; convene local medical neighborhoods, build partnerships and link resources.