Idaho Model Test Project Narrative

(9/8/14 revisions in blue)

(11/12/14 revisions bolded and in green throughout this document. In response to the 11/6 request from CMMI Idaho has revised this project narrative to reflect reductions to the budget narrative and included discussion in each area regarding the anticipated impact on the MTP based on reduced resources.)

Summary of Idaho 11/12/14 revisions to address reductions to proposed budget:

Idaho's Healthcare Coalition (IHC) members met twice during the one week revision period to develop and refine a number of strategies to reduce Idaho's proposed MTP budget by 33%, from $60,870,782, to $39,683,811 as requested by CMMI. Despite the size of the requested reduction the IHC commits to maintaining all aspects of the proposed model and goals in making these reductions. The strategy for determining reductions was to review each budget line item closely and determine what reductions could be made while maintaining the integrity of the model and the anticipated success of the proposed activities.

Key reduction strategies, discussed in detail in the body of the project narrative below and in the revised budget narrative, include: reducing the number of primary care practices to be transformed from 60 per year to 55 per year for a three year total of 165 practices transformed; reducing the amount of financial incentives awarded to participating practices; reducing technical assistance contracts to assist practices in transformation; reducing the project management/financial analysis contract; reducing proposed equipment to be purchased to support telehealth in rural and frontier communities; reducing proposed IDHW staff from 8.5 FTE to 8 FTE, reducing the overhead allocated to the Regional Collaboratives and reducing the proposed state evaluation to reflect the reduced total budget request.

Idaho's strategy to reach 80% of the population includes the 74% of the population who will be participating in the PCMH model by the end of the model test period, as well as the broader state-wide population that will be impacted through the Regional Collaboratives (RCs), operated by Idaho's 7 public health districts. The 7 RCs, as public health districts, are in a unique position to integrate public health and primary care by mounting population health campaigns focused on specific health issues (diabetes control, childhood immunizations, etc.) as well as campaigns focused on population-wide personal health issues like healthy diet, and exercise. In addition, the Community Health EMS workers (CHEMS) who will be trained to work with individuals in rural and frontier areas of Idaho can reach a larger population by engaging in public health initiatives, such as Ada County's effort to administer the flu vaccine at county government buildings.

Idaho also recognizes that Medicare must come to the table to participate in this model test in order to impact the health and healthcare of the 15% of Idaho's population that has Medicare coverage and to reach the goal of shifting 80% of healthcare payments from volume to value. Idaho requests CMMI's assistance in facilitating Medicare's involvement in this process.

Overview: Idaho envisions a statewide healthcare system transformation that changes the standard of practice for health care for the state, delivering integrated, efficient and effective primary care services through the patient-centered medical home (PCMH), which is integrated within the local Medical Neighborhood, and supported and incentivized by value-based multi-payer payment methods. Through this transformation, Idaho will improve the quality and experience of care for all Idahoans, improve health outcomes and control costs.

The PCMH team provides high quality, integrated and coordinated care for all Idahoans in a cost-effective way. The broader healthcare system is organized at the regional level as a robust Medical Neighborhood, integrating a spectrum of ancillary healthcare providers with primary care. All providers are linked electronically so clear and timely communication occurs, with the central premise that high-quality care occurs as close to home as possible. Public and private payers are aligned to support these practices through a blended payment methodology that values outcomes over volume. The system is patient-centered and partners with engaged patients in shared decision-making. Health promotion and wellness are central tenets of Idaho's healthcare redesign. All of these principles, activated at the community level, create the sustainable healthcare system Idaho needs.

Idaho embarks on this ambitious transformation in response to stakeholders' demands for improved access to care, lower costs, and better health. Currently almost 18% of Idaho's 1.6M residents are uninsured. Those who do have healthcare coverage may have difficulty accessing

services, as 96.7% of Idaho is a federally-designated shortage area for primary care and the entire State is a federally-designated shortage area for behavioral health. This Model Test will convert Idaho's deficits to assets by implementing changes like; addressing the state's workforce shortage through the PCMH model, creating a virtual PCMH to bring high quality healthcare to extremely rural communities and recruiting public health districts to serve as Regional Collaboratives, integrating public health and physical health at the local level.

1) Plan for Improving Population Health: The Public Health Division within the Idaho Department of Health and Welfare (IDHW) will work with Idaho's 7 regional public health districts to develop and implement a state-wide plan for improving population health. Division management has been meeting since June of 2014 to design the Idaho Health Assessment (IHA) which will inform the Idaho Health Improvement Plan (IHIP), Idaho's plan for improving population health. The IHIP will integrate population health with the healthcare delivery system. Between November 2013 and April 2014, the Division of Public Health developed a set of Leading Health Indicators for Idaho. The indicators provide a framework for describing the health of all Idahoans and provide direction for the IHIP. The workgroup has an aggressive timeline, targeting completion of the assessment in December 2014, and completion of the IHIP in May 2015. The foundation of the IHIP will be a thorough statewide health assessment with the following timeline:

June 2014	Plan the assessment by identifying goals and criteria to rank issues, determine timelines, and adopt a framework for the process and the document.
June - August 2014	Gather assessment data including health indicators, demographic elements, environmental factors, social determinants and assets. Primary, secondary,

	quantitative and qualitative data will be included. Internal reviews will include Community Health Assessments from Public Health Districts and hospitals as well as summary measures and reportable disease data. External sources will include stakeholders and citizens through meetings, surveys and/or interviews.
October 2014	Analyze the data and summarize identified trends and emerging concerns. Ask what does it mean? What are the implications for health? Identify priorities.
November 2014	Publish the Idaho Health Assessment Draft, making it available for review internally as well as to stakeholders and citizens.

Following analysis and input from stakeholders, the IHIP will be written to meet the detailed requirements described in the CMS FOA -1G1-14-001. The IHIP will address the core measures of tobacco use and the incidence of obesity and diabetes. Additional measures may be selected based on Idaho needs identified in the IHA. The IHIP planning process will work in concert with the public health districts to develop strategies to address Idaho policies and systems, to support and reinforce healthy behaviors, and to improve the integration of population health and primary care. The IHIP will be completed early May 2015, and will be integrated with the Idaho State Healthcare Innovation Plan (SHIP) to effectively measure the impact of Idaho's healthcare system transformation on the health of Idaho's population.

2. Health Care Delivery System Transformation Plan: Idaho will test a statewide model to transform the healthcare delivery system. In doing so, Idaho will demonstrate that the State's

entire healthcare system can be transformed through effective care coordination between PCMHs and integrated Medical Neighborhoods of specialists, hospitals, behavioral health professionals, long term care providers, and other ancillary care services. Idaho's proposed Model Test will **impact the health and healthcare of all** Idahoans, **through a variety of strategies that are described in the program goals below. Ultimately, Idaho will** achieve the Triple Aim of improved health, improved healthcare, and lower costs for Idahoans by reaching the following delivery system goals:

Goal 1: Build 165 PCMH primary care practices with 825 primary care providers serving 1.2M Idahoans (74% of state population). Idaho will test the effective integration of PCMHs into the larger healthcare delivery system by establishing PCMHs as the vehicle for delivery of preventive and primary care services and the foundation of the State's healthcare system. Idaho's new PCMH model builds on the activities of the Idaho Medical Home Collaborative (IMHC), but expands from the current 27 PCMH pilot sites to statewide primary care provider engagement. The Model Test will also expand the PCMH model to all patients, not just those with chronic conditions. The PCMH model has been proven to produce better outcomes, improved access and reduced costs. A key component of Idaho's model is testing whether access to services can be improved in a rural state with a shortage of healthcare professionals. The IHC will join forces with the Idaho Health Professions Education Council, Idaho Area Health Education Center, and the Idaho Telehealth Council to support workforce expansion efforts and develop innovative strategies to maximize the capacity of the State's limited healthcare workforce. Some barriers caused by the State's workforce shortages will be addressed through the use of multi-disciplinary teams in the PCMH. Each PCMH team member will practice at the top of their license and achieve efficiencies by delivering care at the

appropriate level. Physicians will be able to focus their time on clinical care requiring physician-level intervention while other staff, such as nurses and community health workers (CHWs), provides care within the appropriate scope of their practice.

Goal 2: Improve care coordination through adoption and use of EHRs and HIE connections among the 165 Model Test PCMHs, and across the Medical Neighborhood. This goal also reflects the reduction of proposed PCMHs to be transformed over the four year test from 180 to 165. The proposed budget for the HIE connections with PCMHs has been reduced accordingly. Idaho's proposal include significant investment in connecting PCMHs to the Idaho Health Data Exchange (IHDE), enhancing care coordination through improved sharing of patient information. This Model Test also includes technical assistance to improve practices' use of EHRs. EHRs in primary care settings are proving to be an essential tool to quality and care coordination.

Goal 3: Establish seven Regional Collaboratives to support the integration of each PCMH with the broader Medical Neighborhood. At the local level, Idaho's seven Public Health Districts (PHDs) will serve as Regional Collaboratives (RCs) which will support practices as they transform to a PCMH and support existing PCMHs as they further expand their capacity and enhance their performance. The RCs will also link the PCMHs to the broader Medical Neighborhood to facilitate coordinated patient care through the entire provider community. This broader care coordination is essential to improving quality of care, reducing errors and duplication of services, and ultimately, to controlling costs. **A third key activity of the RCs will be to promote public health campaigns that improve the health of the broader regional population. These activities will include specific targeted populations such as diabetics or children needing immunizations as well as broad population health activities promoting**

healthy lifestyle activities. This link with public health promotion through the seven public health districts will significantly spread the impact of the Idaho model test to the entire Idaho population of 1.6M people.

Goal 4: Improve rural patient access to PCMH by developing 50 virtual PCMHs. This goal includes training over 250 CHWs and CHEMS, and integrating telehealth services into these 50 very rural or frontier practices. In this revised proposal Idaho is reducing the proposed number of CHWs and CHEMs to be trained from 500 to 250, and reducing the number of virtual PCMHs from 75 to 50 to reflect the reduced budget guidelines CMMI has advised. Working in concert with Idaho's seven Regional Collaboratives, rural PCMHs will impact significant portions of Idaho's rural population.

The virtual PCMH model is a unique approach to developing PCMHs in rural, medically underserved communities that will test the impact of telehealth technology and CHWs/community health emergency medical services (CHEMS) personnel in extending the PCMH team-based care model in very rural communities. The virtual PCMH model will also allow for integration of behavioral health services in remote communities via telehealth services.

Proposed CHW and CHEMS training programs will include staff training and on-site technical assistance to assure successful integration of these staff into the PCMH team. The CHEMS staffing model is based upon current, successful Idaho programs that demonstrate a reduction in unnecessary emergency department visits, improved medication reconciliation, and increased vaccination rates through the deployment of CHEMS personnel in community health settings. Idaho's proposed CHW program is a blended learning program consisting of in-person trainings, offered at regional locations statewide, and on-line sessions. Through this model, Idaho will evaluate the effectiveness of CHW and CHEMS personnel in rural communities with very

limited resources. Grant funds will be used to train CHWS and CHEMS, to provide on-site assistance to support virtual PCMH team development, to assure implementation of relevant metrics to evaluate program effectiveness, and to establish telehealth technology to supplement training and technical assistance needs.

Goal 5: Build a statewide data analytics system. Idaho's revised proposal reduces the budget for a statewide data analytics system and reduces the analytics components to be built through this model test. However, Idaho continues to intend to build a dynamic analytics system that will provide individual, regional and state level data for improved patient care and population health analytics. Grant funds will support data collection training at the PCMH level, and development of a state-wide data analytics system to track, analyze and report feedback to individual providers on selected performance and outcome measures to improve their practice. The data analytics system will also report to the RCs on regional population management metrics which will be used to identify and address regional population management issues. At the state level data analysis will inform policy development and program monitoring for the entire healthcare system transformation. Use of data has proven critical at the practice level to improve individual patient care. It is also essential at the regional and state levels to guide broader population health policy decisions.

Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value. This goal remains intact and the reduced Model Test budget will not impact this critical activity. Idaho's 3 largest commercial insurers in the State will participate in the model: Blue Cross of Idaho, Regence BlueShield, and PacificSource. Together, these three payers account for approximately 92% of the individual market, 95% of the small group market, and 97% of the large group market. Idaho's 25,000 state employees are

covered through Blue Cross of Idaho which is committed to the proposed model and actively participating in Idaho's Model Test. Medicaid, the public payer in the model, provides healthcare coverage for approximately 15% of the State's population. **Medicare insures 15% of Idaho's population and accounted for 20% of healthcare spending in Idaho in 2009. However representation from Medicare has been notably missing from Idaho's stakeholder discussions. If Idaho is rewarded a Model Test we request that Medicare join Idaho's efforts to align reimbursement methodology towards payment for value. This will be essential for Idaho's efforts to move toward the goal that over 80% of payments to providers in Idaho are in fee for service alternatives that link payment to value.** Through collaboration rather than mandates, payment across payers will be aligned, supporting primary care practices (through a PMPM) to offset the added costs of maintaining PCMH functionality. Payment will also be aligned with attainment of performance and quality goals.

Goal 7) Reduce healthcare costs: This goal remains intact and the reduced Model Test budget will not impact this critical activity. Financial analysis indicates that Idaho's healthcare system costs will be reduced by $89M over 3 years through new public and private payment methodologies that incentivize providers to focus on appropriateness of services, improved quality of care and outcomes rather than volume of service. Idaho projects a ROI for all populations of 197% for five years.

3) Payment and Service Delivery Model: Idaho will test a statewide, multi-payer service delivery system and payment model that can be replicated in other states. The delivery system will have a foundation of PCMHs that provide primary care services with a focus on patient

accountability and population management. Patient care will be coordinated with specialists, hospitals and other community services through the broader Medical Neighborhood.

Idaho's Model Test both drives and supports the transformation to the new delivery system by utilizing grant funding to support start-up costs for PCMH transformation, and to incentivize higher levels of PCMH recognition. Payer-provided PMPMs and shared savings payments will cover the practice costs associated with ongoing care coordination and patient management, as well as the costs of collecting quality and performance measures.

Critical components of the new delivery system and payment model include:

The Patient-Centered Medical Home (PCMH) is the cornerstone of Idaho's new model. Idaho will build on in-state experience and that of other states to deliver primary care through a PCMH for all individuals regardless of health status. The PCMH team-based care model will include a comprehensive care plan based on assessment of patient needs, a screening for behavioral health needs, engagement of patients in wellness and self-management activities, and provision of evidence-based clinical care. Health information technology (HIT) will enhance patient care through shared patient information via the Idaho Health Data Exchange (IHDE), through coordination of care across delivery settings, through communication with patients across multiple formats, and by utilization of EHR, patient portals, and other HIT tools to provide effective and efficient patient care. PCMHs participating in Idaho's model test will seek recognition/accreditation by a national body such as NCQA. Idaho's provider community brings a strong foundation in PCMH development through the 2009-2012 Qualis Safety Net Medical Home Initiative which engaged community health centers and other safety net providers, through the current Idaho Medical Home Collaborative Pilot, and through the current Children's Health Improvement Coalition (CHIC) which develops PCMHs for children with special needs.

NUMBER OF PROVIDERS PARTICIPATING IN MODEL TEST: Idaho 9/8/14 Response: Medicaid currently has 364 primary care providers servicing 53 locations throughout the state who participate as Medicaid Health Homes. There are 279 primary care providers servicing 33 locations throughout the state participating in the Idaho Medical Home Collaborative. The majority, if not all, of these practices will be the initial model participants. There are numerous additional targeted medical home efforts underway that involve additional providers across the state. These efforts include initiatives by the Idaho Primary Care Association, Regence Blue Shield, the Children's Healthcare Improvement Collaboration, and the Title V Maternal and Child Health Program.

11/12/14 Response: Our revised goal is to add 55 practices (275 primary care providers) per year during the demonstration. We anticipate that at the conclusion of the SIM project we will have an additional 825 primary care providers in 165 practices across the state participating in the model.

WORKFORCE: Idaho 9/8/14 Response: Idaho has a number of collaborative initiatives underway to increase the number of primary care providers in the state. These efforts are supported by the governor's office, legislature, universities, residency programs, and include coordinated, active engagement by stakeholder organizations statewide. Strategies include:

- Expansion of family medicine residency programs: the successful expansion of existing family medicine residency programs and the establishment of a new program. Idaho increased the number of family medicine residency program graduates by 71% over the last 4 years by expanding the size of existing programs and adding a new family medicine residency program this year.
- New internal medicine residency programs: Idaho previously had zero internal medicine residency programs and, within the past three years, two new residencies were established. These two programs produce 14 internal medicine graduates per year. Within the past three years, Idaho also established a psychiatry residency which trains three residents per year in years 3 and 4 of their residency.
- Increase in state-supported medical school seats at the University of Washington and University of Utah: Idaho's governor, legislature, and board of education support access to medical school education for residents by providing state funding for medical school seats. Over the past four years, ten new state-supported medical school seats have been added with plans to continue to grow these programs annually.
- Primary care physician workforce summit on September 17, 2014: the purpose of the summit is to identify gaps in current and future workforce needs, develop strategies to improve recruitment and retention, and create an action plan to increase Idaho's primary care physician workforce. The event is sponsored by sponsored by the Division of Public Health, Idaho Academy of Family Physicians, and Idaho Primary Care Association, and participants include leadership from residency programs, University of Washington and University of

Utah medical schools, Idaho Department of Health and Welfare, State Board of Education, and various stakeholder organizations with workforce expertise.

- Idaho Health Professions Education Council: this governor-appointed workgroup includes leadership from state universities, residency programs, and the Idaho Department of Labor, and makes recommendations for funding appropriations and healthcare program growth. The council's recommendations are based in the context of evidence-based evolving workforce needs in Idaho, use of technology, curricular and field changes of key providers, within the overall strategy for care delivery by healthcare teams. The strategies are designed to address efficient and effective use of health professionals, with input from educational institutions, to plan for Idaho's future workforce needs.
- Rural Training Tracks: Idaho has two well-recognized and successful Rural Training Track (RTT) residency programs to train physicians for rural practice. A high proportion of RTT graduates provide healthcare in designated shortage areas for underserved populations and at least half of graduates remain in rural areas after graduation.
- Expansion of Physician Assistant and Nurse Practitioner training programs: these university-based programs continue to grow to help meet the increasing primary care needs of Idaho residents. This workforce is particularly critical in rural and underserved communities to staff Rural Health Clinics and Federally Qualified Health Centers.

IDAHO MEDICAL EDUCATION RESOURCES: Idaho 9/8/14 Response:

Idaho's medical education programs are uniquely suited to the state's expansive geography and frontier areas. The residents in these programs are being trained in the patient-centered medical home model. This model includes integrated team-based training and allows providers to practice at the top of their licensure level. Care is coordinated to improve outcomes, improve satisfaction, and reduce cost to achieve the Triple Aim. Idaho's model test proposal supports the expansion of this delivery model of the future in a rural and frontier state. It inspires the graduates of our training programs to stay and be a part of that future.

Additionally, Idaho's medical education programs provide physician residents with opportunities to experience their curriculum within practices throughout the state and translate value-based tenets into the reality of diverse practice settings. This bi-directional education helps to shape curriculum, assists in updating clinical practices, and supports graduates in the practical application of value-based care.

In addition we are going to leverage both Telehealth and community health workers to help amplify our primary care efforts and to help provide enhanced patient centered medical home neighborhoods throughout our state that will provide the highest level of care as close to home as possible for our citizens.

STATE METRICS TO MEASURE PCMH TRANSFORMATION: Idaho 9/8/14 Response:
In the IMHC PCMH pilot currently underway, Idaho uses a variety of standardized assessments

and semi-structured interviewing approaches to determine practices' progress towards medical home transformation. These include the PCMH Assessment (PCMH-A), quarterly progress report narratives provided by each practice, on-site practice visits conducted by practice coaches, and resulting clinical quality outcome data, and progress towards PCMH recognition through NCQA. The state will be looking first at progress towards NCQA recognition during the course of the 4 year test. As PCPs become more engaged in the PCMH model, the state and participating payers will be evaluating quality and cost measure outcomes to assess transformation at a deeper level.

INTEGRATION OF PLAN FOR IMPROVING POPULATION HEALTH WITH THE PROPOSED SERVICE DELIVERY MODEL: Idaho 9/8/14 Response:

The Plan for Improving Population Health, also known as the Idaho Health Improvement Plan (IHIP) will be based on the Idaho Health Assessment being conducted by the Division of Public Health in the summer and fall of 2014. This assessment, based on Idaho's leading health indicators, the local public health community health assessments, hospital community health assessments, stakeholder involvement and review of other demographic data, will identify areas of the state for which population health improvement measures must be addressed. These measures and actions, delineated in the IHIP, will address the social determinants of health as they relate to health care and health care delivery. These measures will be cross-tabulated with the service delivery model to ensure that the model is effectively addressing the measures and needs identified in the IHIP, to the extent relevant and possible. There may be regional nuances identified in the IHIP that will direct how the service delivery model is undertaken in that particular region. The Regional Collaboratives will be directed to ensure the medical neighborhood and Regional Collaborative partners are aware of the regional needs and work with the communities, local PCMHs and other partners to address the needs. This work will support the success of the PCMHs and evaluation measures of regional delivery of services will be created to help determine if the model is making a difference in population health improvement. The Regional Collaboratives will report to the Idaho Healthcare Coalition, overseeing the implementation of the service delivery modal, on the performance measures delineated in the IHIP.

To address the social determinants of health, work must be done to address policy, systems and environmental change to increase access to healthy choices and access to health care. Local and state policy must be addressed to provide equitable opportunities and eliminate barriers for people despite income, geography, etc. Well-designed policy, systems and environmental changes can prevent people from falling into poor health where primary, secondary and tertiary interventions are needed, thus reducing healthcare spending and improving health outcomes. These activities and interventions are typically addressed by non-healthcare sector partners, i.e., worksites, schools, community organizations, public health, etc. These are the partners comprising the medical neighborhood and surrounding communities. The work they do and the policies they create impact what is being done in the medical neighborhoods that support the success of the local PCMHs and the Regional Collaboratives. Currently in Idaho, there are multiple state agencies that work together on a regular basis to address issues affecting Idahoans. For example, the Division of Public

Health routinely works with the local public health districts, universities, the Department of Education, Board of Education, Department of Agriculture, Department of Environmental Quality, Department of Corrections, Idaho State Police, Idaho Commission on Hispanic Affairs, and many other state agencies. Additionally, there are many state entities with which the Division routinely works: the Idaho Medical Association, Idaho Hospital Association, American Heart and American Stroke Association, American Cancer Society, American Lung Association, Idaho Chapter of the American Academy of Pediatrics, just to name a few. Each division within the Idaho Department of Health and Welfare has their own slate of state agencies and external entities with which they routinely partner to do their work and address social determinants of health and policy change aimed at better health outcomes for Idahoans. The Director of the Department of Health and Welfare participates regularly in cabinet level meetings with other state agency officials to discuss priorities affecting the population of the state. Compared to clinical interventions, changing the environmental context to make individuals' default decisions healthy have the largest impact on a person's health.

Comment [SEDC61]: Denise, I am thinking that the latter part of this section could be modified to address the last question in this document. I don't know all of the partners for Ross and behavioral health, but maybe put in those partners and some for Medicaid.

The Regional Collaboratives (RCs) will serve as the public health/physical health integrator in local communities. Idaho's seven regional public health districts (PHDs) will contract with IDHW to serve as the RCs. The RC will assist local PCMHs by establishing formal referral and communication protocols within the broader medical neighborhood to facilitate coordinated care, support local innovation and expand evidence-based practices. The RCs will establish advisory boards composed of local stakeholders who will work closely with the IHC, advising on regional issues and providing feedback on regional Model Test progress. **The RCs will remain intact in Idaho's revised budget proposal, with only a reduction in percentage of overhead costs allowed. The RCs will continue to play a key role in PCMH transformation support, medical neighborhood development, and public health/primary care integration, reaching a broad spectrum of Idaho's population.**

The Idaho Healthcare Coalition (IHC)*,* established by Governor Otter through executive order, and composed of key stakeholders from around the state, will guide the statewide implementation of the model. Initially the IHC will focus on continued expansion of Idaho's PCMH capacity and oversee provision of resources and assistance necessary to support practice

transformation while facilitating migration to new payment methodologies. The IHC will determine criteria to designate PCPs as a PCMH participating in the Model Test. Following PCMH designation, participating PCPs will receive training and technical assistance (T/TA) as they work to meet the national PCMH recognition requirements. The IHC and RC will collaboratively explore critical policy issues and related models for program implementation such as community-based end of life care discussions and plans that will help individuals be better prepared for patient-centered end of life choices and options.

The IHC will also study how a state with no previous experience in collecting and analyzing statewide data develops baseline performance measures and establishes reporting requirements across multi-payers (public and private) to evaluate, monitor, and improve population health.

The IHC has discussed the proposed budget reductions in detail and continues to be committed to guide Idaho's model test. IHC discussions regarding how to manage the reductions have focused on presenting a realistic model that will be successful. The IHC will also seek additional funds to augment CMMI funding, if the MTP award is received.

Idaho's Transformed Payment Model will align payment mechanisms across payers and test transformation from a fee-for-service system to one that incentivizes value, rather than volume. The new payment model components will include Per Member Per Month (PMPMs) payments to support care coordination and other PCMH functions, total cost of care shared savings arrangements, and quality incentives.

Details of the payment model components to be tested are described below.

PCMH Practice Transformation Incentives: Several incentives are proposed to assist 55 PCPs/year in the demanding process of transforming to a PCMH. Idaho is proposing to reduce the incentives for participating providers significantly. In discussing the decision to

reduce incentives Idaho primary care providers have indicated that although the one-time incentives are helpful for practice transformation to PCMH, the real incentive will be payment reform that reimburses them for outcomes rather than volume of service. One-time incentives to encourage practice transformation to a PCMH will be financed through Model Test grant funding. Practice transformation costs include development of patient registries, HIT system changes, adjusting clinic flow and staffing patterns, and time spent out of clinic training and coaching team members. Following a readiness assessment by the PCMH transformation consultant that identifies specific practice gaps and development of a specific practice transformation plan, an incentive of $10,000 will be awarded to participating PCPs.

PCMH National Recognition Incentives: To encourage practices to achieve higher levels of PCMH recognition, the IHC will provide PCMHs with incentive payments of $3,000 for reaching NCQA levels one and two, and $4,000 for reaching NCQA level 3. These incentive payments will help reimburse practices for the costs associated with meeting recognition requirements.

Virtual PCMH Program Participation Incentives: Up to 50 of participating Model Test practices will also be identified as participants in the Virtual PCMH model, which will test provision of PCMH services in very rural communities. Practices participating in the virtual PCMH program may receive an additional $2,500 incentive payment upon meeting certain criteria in year 2 or later.

Per Member Per Month (PMPM) Payments: Three of Idaho's four largest payers have agreed to provide a PMPM to practices reaching certain national recognition levels to support ongoing PCMH activities (e.g. care coordination, health promotion and patient management).

The IHC Payment Reform workgroup which includes all 4 payers participating in the Model Test has been working on payment models including PMPM payments since Summer 2013. They will meet regularly prior to receipt of the Model Test award and continue to refine parameters for the payers' patient population risk and stratification methodology upon which the payers will build their PMPM amounts. Payers will work together through the IHC Payment Reform Workgroup to determine appropriate payment methodologies but will negotiate specific PMPM amounts and other new payment methodologies with PCMHs through their regular contract negotiation processes. This approach allows Idaho payers and providers to avoid anti-trust issues that could arise from shared discussion of specific payment amounts. PMPMs are anticipated to escalate based on variables like patient complexity and demonstrated integration of behavioral health. PCMHs will be expected to complete evidence-based training in chronic care models and behavioral health integration in order to qualify for these higher PMPMs.

Total Cost of Care Shared Savings Arrangements: As the cost of care begins to decrease through reduced emergency department visits, reduced hospitalizations, and increased appropriate use of generic drugs, etc., payers will begin to incorporate total cost of care shared savings arrangements with their PCMHs.

Quality Incentive Payments: As part of the SHIP planning process in 2013 Idaho stakeholders, including payers, have already agreed to a standard set of quality measures for PCMH providers. To test the impact of incentivizing PCMHs to report on these quality measures and improve outcomes, the payers will gradually incorporate quality incentives in their contractual arrangements with PCMHs. This will begin as "pay for reporting" and will evolve into "pay for performance".

Idaho 9/8/14 Response:

Under the Idaho Medical Home Collaborative pilot, Medicaid and the commercial health plans worked closely to establish both attribution and payment methodologies that were consistent across payers. From that consistent methodology, payers developed their own specific elements and strategies.

Attribution

Medicaid has a longstanding primary care case management program where each Medicaid participant is enrolled with a primary care provider that coordinates his/her Medicaid services. To determine which participants are eligible for an enhanced per-member-per-month (PMPM) payment, Medicaid evaluates claims data and diagnosis codes from the previous 18-month period to identify a preliminary list of eligible participants. Providers are also asked to evaluate their patient panels to create a similar list of eligible participants. Medicaid then works closely with the provider to reconcile the list and arrive at a final determination of participants who are attributed to each provider.

Other payers – None currently attribute all participants to a primary care provider. Therefore, for medical home attribution, each payer looks at historical claims data and patient diagnoses to establish a list of eligible participants. They then evaluate provider billing patterns to determine which provider has billed for the majority of evaluation and management office visits over the previous 12-18 month period. Providers then work with each of these identified participants to engage and enroll them in the patient-centered medical home.

Reimbursement

Under the medical home pilot, all payers agreed to allow continued fee-for-service billing and to add a PMPM payment for patients who are determined to have multiple chronic conditions and/or to be at high risk for negative health outcomes. Each payer individually developed a specific PMPM amount based on medical home coordination requirements, array of staff that would need to be involved in this coordination, and practice transformation costs such as achieving national PCMH recognition.

Payer Commitment to Shared Savings

Although Idaho is almost completely fee for service in both the commercial and public sectors – there are some small shared saving programs in the commercial sector. There has been a commitment by all payers to move from the current Fee for Service reimbursement system to reimbursement models that move toward paying for value/quality. The reimbursement subcommittee used the CMS reimbursement model chart and agreed that our objective is to continue to move reimbursement from the left side of the chart (Fee for Service) to the right side of the chart (Accountable System of Care including shared savings).

There is payer consensus to move from the volume based Fee for Service reimbursement model to more comprehensive payment models that reward providers for quality and outcomes – this includes continuing the evolution of payment models beyond PCMH to shared savings and capitated models.

Our two State hospitals would coordinate care with the PCMHs as appropriate.

An integral part of our model is to develop the medical neighborhood which will include access and information for long-term services and supports. Work currently underway to support primary care providers efforts in coordinating care for their patients with long-term service and support needs includes the community resource centers administered by the Idaho Commission on Aging, a variety of information and patient engagement opportunities available through Public Health, the pediatric medical

Comment [DS2]: Maybe get some additional details from Elke or Mary?

home portal (www.medicalhomeportal.org), and development of increased access to telehealth services and community paramedicine.

Three commercial payers are participating in our payer model, representing the vast majority of commercial covered lives in Idaho.

The percentage of non-Medicare revenue in Idaho that will be in our payment model is 58.4% of our expenses and revenue would be non-Medicare and 41.6% would be Medicare.

4. Leveraging Regulatory Authority: Since 2007, several key pieces of legislation and executive orders by Idaho's Governor Butch Otter have encouraged progress towards a healthcare system that provides high quality patient-centered care and evolves away from fee-for-service reimbursement towards payment for value. HB 260 is a key policy lever passed by Idaho's legislature in 2011. This legislation directs IDHW to develop a plan for Medicaid managed care. Since 2011 Idaho Medicaid has evolved its dental, behavioral health and transportation programs to managed care, with the intention to continue to evolve additional Medicaid services to managed care over the next few years.

Specifically noted in HB260 was direction to improve coordination of patient care through patient centered medical homes (PCMH). The work of the Idaho Medical Home Collaborative (IMHC), created by Governor Otter through Executive Order 2010-10, parallels this legislative direction. The IMHC was tasked with making recommendations to the Governor regarding policies and activities necessary to transform Idaho's healthcare delivery system to the PCMH model. The IMHC is now in year two of a PCMH Multi-Payer Pilot with 27 primary care clinics around the state working towards PCMH transformation. Clinics participating in the pilot now receive a PMPM from multiple payers for providing coordinated care to patients with chronic conditions. The same payers participating in the IMHC Pilot are now committed to participate in the Model Test. Quality data is being collected and an evaluation of the pilot is underway. Findings from these activities will inform Idaho's continued work on PCMH model through the Model Test.

Idaho stakeholders propose to build on these legislative and policy levers by catalyzing and sustaining market changes. The Idaho Model Test aims to align payment around PCMH to make it economically advantageous for PCPs to transform to PCMH. Through the leadership of the IHC, Idaho is creating and aligning private and public sector market forces and creating a collaborative infrastructure to incentivize the market to move towards paying for value.

In 2013 important legislation was passed in Idaho, establishing a state-based insurance exchange. Idaho's exchange, Your Health Idaho (YHI), began enrolling Idahoans in October 2013 and has proven to be one of the most successful state exchanges in the country, enrolling 77,000 individuals (5% of the population) by the end of the 2014 enrollment period. The success of YHI is improving access to care for previously uninsured Idahoans, and will improve population health outcomes for the state.

During Idaho's 2014 legislative session three key policy levers that support the Model Test were put in place. First, Governor Otter issued Executive Order 2014-02, establishing the Idaho Healthcare Coalition (IHC). The existing membership of the original SHIP Steering Committee (see Stakeholder Engagement section) was appointed to the IHC, charged with 'leading Idaho in the development of an integrated, coordinated healthcare system that focuses on improved population health, improved individual health outcomes and cost efficiencies.' This high level direction by the governor to transform Idaho's healthcare system significantly increases the visibility and importance of the work of the IHC.

Idaho's 2014 legislature also passed two concurrent resolutions that promote key aspects of Idaho's healthcare system transformation. First, HCR046 recognizes the importance of telehealth in a rural state like Idaho, directing IDHW to convene a Telehealth Council. The charge to the Council is to "develop a comprehensive set of standards, policies, rules and

procedures for the use of telehealth and telemedicine in Idaho." The Telehealth Council will "provide recommendations to the 2015 Idaho Legislature regarding telehealth legislation and standards." The newly formed Telehealth Council will also advise the IHC on issues related to telehealth and development of related resources. A second concurrent resolution (HCR 049) directs IDHW to convene a workgroup to study collection of hospital discharge data and to study creation of a comprehensive system of healthcare data, including inpatient, outpatient and other care services. This workgroup will advise the IHC on issues related to development of statewide data analytics capacity.

Idaho is presently one of the states that has not elected to expand Medicaid coverage for low income adults. However, in April of 2014 Governor Otter directed the IDHW to reconvene the Medicaid Redesign Workgroup with the charge to bring updated proposals to him in the Fall of 2014. This signals an opportunity for Idaho to re-examine arguments for expanding Medicaid and presents the possibility that Idaho's legislature may consider the issue during the 2015 session.

As collaboration in implementation of the Model Test continues across payers, providers, communities and individuals, Idaho stakeholders may identify legislative, executive and/or regulatory authorities that would benefit and advance transformation of Idaho's healthcare delivery system. At this time, however, no such authorities are recommended as Idaho is confident that the model can be implemented through the commitment of healthcare system stakeholders and be advanced by incentives to transform Idaho's healthcare system to a patient-centered, population health management approach.

RECENT/DEVELOPING POLICY INITIATIVES-- Idaho 9/8/14 Response:
The outstanding policy initiative related to healthcare in Idaho is the question of expanding Medicaid. Idaho estimates that 77,000 Idahoans are below 100% of poverty and have no access to health care coverage. An estimated total of 104,000 Idahoans are

below 138% of poverty and would qualify for Medicaid under expansion. There is tremendous advocacy support for expanding Medicaid in Idaho and it will be a hotly debated topic during the mid-term elections this fall. The Idaho legislature will be strongly pushed to consider expansion during the 2015 session beginning in January. Linking Medicaid expansion to the State Healthcare Innovation Plan (SHIP) will be essential to the potential success of an expansion initiative. State policy makers are leery of expanding 'traditional Medicaid' which is widely viewed as an entitlement program that does not hold recipients accountable and does not provide sufficient efficiencies. However, policy makers do strongly support the principles of the Idaho SHIP which envisions a total transformation of Idaho's healthcare system. When Medicaid expansion is described as an initiative that would provide access to coordinated, efficient, cost effective healthcare for the uninsured population the case for support is viewed as much stronger in this state.

The Governor's Workgroup on Medicaid Redesign met twice during the summer of 2014 to study developments in Medicaid redesign since their last series of meetings in 2012. The workgroup thoroughly reviewed evolving Medicaid expansion models being adopted in other states, studied updates on Idaho's uninsured population, studied of the impact of the state-based insurance exchange, and reviewed updated cost information. On August 14, 2014 the Governor's Workgroup voted to recommend to Governor Otter that Idaho expand Medicaid to individuals under 138% using a private managed care option operating through a state Medicaid RFP. A final report from the workgroup to the governor will be submitted in October 2014. The workgroup emphasized that expansion of Medicaid must be predicated on the overall redesign of Idaho's healthcare system, based on the State Healthcare Innovation Plan.

MEDICAID EXPANSION AND IDAHO'S GOAL TO REACH 80% OF POPULATION-Idaho 9/8/14 Response:
Idaho presently has 78,000 uninsured adults under 100% of FPL who are not eligible for Your Health Idaho, Idaho's state-based insurance exchange and are not covered by Medicaid, due to the state not yet expanding. This represents 5% of the state population. While it is not optimal to have this population ineligible for healthcare coverage, Idaho should be able to reach the goal of 80% of the population being covered by a PCMH even if Idaho were not to expand Medicaid coverage. Idaho's 13 community health centers currently serve 153,000 individuals, providing primary care, behavioral health services and dental services. 49% of the CHCs' patients are uninsured, representing 75,250 individuals. The CHCs cannot turn away uninsured and are reimbursed on a sliding fee scale. Idaho's CHCs were early adopters of the PCMH model (participants in the Commonwealth Fund's Safety Net Medical Home Initiative from 2009-2012) and are committed to providing care within the PCMH model to all their patients

IDAHO STATE BASED EXCHANGE AND INCLUSION OF PCMH MODEL-Idaho Response: In 2013 important legislation was passed in Idaho, establishing a state-based insurance exchange. Idaho's exchange, Your Health Idaho (YHI), began enrolling Idahoans in October 2013 and has proven to be one of the most successful state exchanges in the country,

enrolling 77,000 individuals (5% of the population) by the end of the 2014 enrollment period. The success of YHI is improving access to care for previously uninsured Idahoans, and will improve population health outcomes for the state.

Idaho's three largest commercial insurers in the State, Blue Cross of Idaho, Regence BlueShield, and PacificSource offer insurance plans through YHI. Blue Cross of Idaho implemented its first patient centered medical home in 2009 and is many years into payment reform initiatives and long term efforts to transition away from fee-for-service payments. Regence BlueShield and PacificSource are active participants in the Idaho Medical Home Collaborative as well as the Idaho Healthcare Coalition and have committed their full support in addressing access, cost, and quality of care via the PCMH model. While there are no specific plans to require health plans participating in the exchange to implement a PCMH model, the collaboration and commitment of Idaho's insurers support the goal to implement a robust network of efficient and clinically effective PCMH's in Idaho.

5. Health Information Technology (HIT)

Current state of HIT Adoption and Utilization in Idaho**:** The Idaho Medicaid Electronic Health Records (EHR) Incentives Program began accepting registrations to Adopt, Implement or Upgrade (AIU) to a certified EHR on July 2, 2012, and for Stage 1 Meaningful Use (MU) in July of 2013. As of June, 2014, 642 of potentially eligible providers (4%) reached AIU, and 262 reached Stage 1 MU. Also 23 eligible hospitals reached AIU (44%), and 10 reached Stage 1 MU. Medicaid expected to reach these levels by the end of the program rather than within the first two years, so participation has been excellent. Also, Medicare has paid 2,146 eligible professionals (14%) and 3 eligible hospitals (CMS Business Intelligence Portal).

As a 501(c) (6) nonprofit corporation, Idaho Health Data Exchange (IHDE) was established to govern the development and implementation of a Health Information Exchange in Idaho. Created as a result of the efforts of the Idaho Health Quality Planning Commission, IHDE is governed by a Board of Directors that includes representation from the public and private healthcare sectors. Initial funding was appropriated by Idaho's Legislature; ongoing funding comes from IHDE participants. IHDE also received a grant from ONC to develop and advance the IHDE. IHDE offers connected providers the use of clinical results and e-prescribing, as well as clinical messaging, or clinical results delivery, and a clinical data repository (which consists of laboratory, radiology, and hospital transcription information) through a clinical portal. Through the portal, providers are able to view patient summaries for their patients. Current connections to the IHDE include 15 hospitals, six laboratories, three payers, and 2,465 provider-group users (providers, mid-levels and staff), amounting to 436 practices. Adoption has grown from 10 hospitals and 1,200 users one year ago.

Idaho's HIT Plan: Planned, statewide, interoperable HIT will integrate PCMHs into the greater healthcare system, empowering them to transform care by improving their care coordination with individual patients and across the Medical Neighborhood. It will also enable the systematic and statewide measurement of population health targets, and the payers' ability to reward outcomes through new payment mechanisms.

The HIT Plan calls for the development and/or expansion of EHR and IHDE technology to support: 1) statewide data collection and performance analysis needed to improve quality and establish value-based payments; 2) shared data to facilitate coordinated care, and; 3) patient portals to increase patient –provider communication and patient self-management. Telehealth technology will also be developed to expand access to healthcare and extend the healthcare work force in underserved areas, and to integrate behavioral health with PCMHs. Finally, the HIT plan will coordinate with Idaho's new Time Sensitive Emergency (TSE) system to leverage improved care coordination for people who experience trauma, stroke or heart attack.

Governance: IDHW, with the advice of the IHC, will support and oversee the statewide implementation of the HIT plan. Increasing EHR adoption and use will be critical to enabling the exchange of clinical and other information between primary care providers and other providers. IDHW will build upon the Medicaid EHR adoption incentive program and IHDE platform to accelerate EHR adoption and Meaningful Use among PCMHs. Provider participation rates will be increased through technical outreach, financial support through incentives, and PCMH payment requirements. Model Test incentives will not supplant those paid through the Medicaid EHR Adoption Incentive Program.

Idaho's revised proposal decreases the amount of the proposed contract to IHDE, taking into account the decrease in number of practices to be transformed from 180 to 165.

However, IHC members continue to identify connectivity between the PCMH and the broader IHDE as critical for improved patient care and development of the medical neighborhood. IDHW will contract the services of IHDE to expand the current IHDE infrastructure and support the integration of remote provider groups who are not yet connected or who have marginal capacity to connect. Additional financial incentives will be offered to PCMHs participating in the Model Test to pay the vendor and IHDE connection fees, as well as the first year IHDE annual fee.

Idaho 9/8/14 Response: Idaho's HIT plan will further the promotion of adoption and meaningful use of electronic health data with the healthcare professionals in Idaho. Specifically, the MTP targets financial support for providers across the state to use and connect their EMRs (via bi-directional connections) to the HIE, thus expanding the availability and interoperability of health information for Idaho's healthcare system. This is essential to the success of the Idaho SHIP.

Tactically, efforts in the first year will be focused on onboarding PCMH pilot clinics that are not already connected to the IHDE. Leveraging off their current enrollment with these existing programs enables early success as some tasks such as introduction and HIE connection can be reduced. This plan will also establish a good base of knowledge and processes for subsequent years that will result in successful HIT technology.

Since already-existing adoption has already occurred for a number of Idaho PCPs, the onboarding of these groups can focus on the integration and implementation of new programs and services. This strategy utilizes current funding sources through the IHDE, individual clinic investment and Medicaid-supported meaningful use funds, and therefore does not supplant other funding sources. Idaho's Model Test Proposal provides the foundation for sustainability by establishing the path to enable the systematic statewide measurement of population health targets. This in turn will enhance the payers' ability to reward outcomes through new payment mechanisms providing a source for sustainability.

IDHW will consider how to leverage any technologies that are championed by LINK Idaho, a federally funded internet broadband initiative addressing connectivity issues in Idaho for expansion of IHDE. LINK Idaho is represented on the Telehealth Council and the TSE and IHC/HIT work groups.

The Medicaid Management Information System (MMIS) will be a full and active partner in the Model Test. IDHW will work with the MMIS vendors to develop a plan for enhancements

that can support the future environment. Currently, the Idaho MMIS is fully able to meet a tiered PMPM payment structure. This system configuration was completed in 2011 to meet the needs of the Primary Coordinated Care Management (PCCM) and updated in 2013 to meet the requirements of the health home initiative.

Technical Assistance: A key driver of EHR adoption in Idaho has been the Washington & Idaho Regional Extension Center (WIREC), which received funding from the Office of the National Coordinator (ONC) to help primary care providers adopt and use EHRs. Services included HIT outreach and education, EHR procurement guidance, workflow redesign, implementation support, and assistance on optimizing the use of EHRs, such as data and systems management support. WIREC also provided guidance for achieving MU of EHRs. Although WIREC completed its ONC contract, technical assistance (TA) to PCMHs is proposed to continue through the Model Test. Mirroring WIREC's strategy, the TA efforts will be coordinated through the Idaho Health Data Exchange (IHDE).

Planned, statewide interoperable HIT will integrate PCMHs into the greater healthcare system, empowering them to transform care by improving their care coordination with individual patients and across the Medical Neighborhood. It will also enable the systematic and statewide measurement of population health targets, and the payers' ability to reward outcomes through new payment mechanisms.

Data Analytics: **Idaho's Model Test Proposal identifies development of statewide data analytics capacity as critical to the success of healthcare system transformation. Although the data analytics budget has been reduced, the IHC also prioritizes this as essential. Data analytics has been scaled back to reflect the reduced funding available, but will remain an essential function going forward.**

As a critical first step in developing a reporting structure for individual practice feedback as well as regional and state-level population health management functions, IDHW will contract with a data analytics consultant to build a structure to collect, analyze and report on selected clinical and cost data at the individual practice level, regional level, and state level. This will include collecting statewide data on defined quality and cost measures from multiple sources including payer (e.g., claims and payment information), clinical (e.g., from EHRs and other clinical sources), and patient data (e.g., patient portal data). This represents a significant innovation for Idaho which does not presently have any type of shared healthcare data systems. Idaho payers and large providers have agreed to share data on those specific quality and cost indicators that have been identified in the MTP. As the model matures and ongoing value of the product is evaluated, the IDHW and IHC will determine the most appropriate ongoing HIT infrastructures to provide aggregation and analytic support to facilitate Idaho's population health management functions.

Privacy and security of HIT are a significant concern for patients, payers and providers. Policies and procedures that govern privacy and a secure technical solution will be developed by the data analytics consultant in partnership with the IHDE to ensure data is protected, and at the same time accessible to those that require it. As the system matures, Idaho may consider regulatory changes to further support data privacy and security, especially as the State considers inclusion of data related to behavioral health and substance use.

6. Stakeholder Engagement

Stakeholder engagement in the Idaho Model Test Proposal remains extremely high. IHC members have met twice on very short notice to study proposed reductions to the

MTP budget and have given valuable input to the process. IHC members are optimistic that Idaho can succeed in the proposed model test, even at the reduced funding level.

In 2013, faced with a fragmented and costly delivery system, the Idaho Department of Health and Welfare (IDHW), at the direction of Governor Otter, convened stakeholders from every aspect of the healthcare system and every area of the state to work together to develop a State Healthcare Innovation Plan (SHIP), to transform the delivery system and the health of Idahoans. Total participation in the planning process included approximately 100 members participating in the SHIP Steering Committee, or one of the four work groups (nearly 30% of planning initiative participants were physicians). Approximately 300 unique individuals also participated in focus groups, tribal meetings and town hall meetings held across the state. Stakeholders represented the entire healthcare delivery spectrum; payers, providers, patients, and representatives from public health, long-term services and support, behavioral health, tribal organizations, local health agencies, schools, consumer advocacy organizations, and community-based organizations.

In February 2014 the SHIP Steering Committee and Sponsors Group evolved to become the Idaho Healthcare Coalition (IHC). The IHC was established through Executive Order by Governor Otter and charged with leading Idaho's healthcare system transformation, under the direction of IDHW. The 25 member IHC is chaired by a highly-respected practicing primary care physician who has led the group since the summer of 2013. IHC membership includes physicians, private and public payers, legislators, and representatives from the Idaho Hospital Association, the Idaho Medical Association, the Idaho Academy of Family Physicians, and the Idaho Primary Care Association as well as key state officials. The CEOs of Idaho's two largest healthcare systems are active members, along with the Governor's Office and the director of

IDHW. It is important to note that these stakeholders have continued to meet monthly since Idaho's SHIP was submitted to CMMI in December 2013. These monthly IHC meetings have been very well attended, with agenda items focused on continued refinement of the Idaho model. The group's membership has stayed intact since June 2013 and demonstrated remarkable consensus regarding the design and implementation plans for Idaho's Model Test. In partnership with IDHW, this strong stakeholder group will guide and oversee implementation of the Model Test. IDHW has committed to a collaborative relationship between the department and the IHC. This has been critical to stakeholder buy-in and will continue to be essential to the success of this initiative.

In order to bring more stakeholders into the process and leverage additional resources, other healthcare initiatives currently active in the state have been asked to advise the IHC in their areas of expertise. For example, the Idaho Medical Home Collaborative (IMHC), which promotes the medical home model across the state, has agreed to advise the IHC on the PMCH transformation process. The IHC will also receive topic-specific guidance from the Idaho Telehealth Council, the Health Quality Planning Commission, the Idaho Health Professions Education Council and Idaho's tribal communities.

At the local level, Idaho's seven Public Health Districts (PHDs) will serve as Regional Collaboratives (RCs) providing support, technical assistance and resources to practices as they transform to a PCMH, and to existing PCMHs as they further expand their capacity and enhance their performance. The RCs will facilitate development of the medical neighborhood to strengthen patient care coordination and convene a local stakeholder advisory board. The RC stakeholder advisory boards will have direct input to the IHC so regional and local concerns are raised at the state level. In the role of RC, Idaho's PHDs will lead integration of public health

and population management into the model, and will bring an intimate familiarity with local healthcare resources to developing the medical neighborhood. **The involvement of the public health districts in the role of regional collaboratives will also spread the impact of the model test, as a greater proportion of Idaho's population will be reached by public health campaigns for disease specific efforts as well as general population campaigns.**

By transforming the primary care delivery and payment system, Idaho will impact all healthcare provider entities within the State, from hospital systems, outpatient clinics, community health centers, Veteran's Affairs (VA), and tribal health centers to small rural physician practices and long term care providers. Behavioral health and specialty providers will benefit from early detection of patients' needs through screenings conducted by the PCMH and through care coordination with specialty care.

IHC members have reviewed and approved this Model Test application and will continue to be actively engaged in the Model Test phase. The major private and public payers in Idaho are members of the IHC and will be engaged through the alignment of payments to support PCMHs and incentivize quality of care. With PCMH transformation incentives and changes in payment methodologies, the primary care provider community will be incentivized to build their PCMH capacity and move along the continuum of PCMH recognition. Specialists and hospitals will engage through improved coordination of care and collaboration with the PCMHs as part of the Medical Neighborhood.

Other key stakeholders will also contribute to the development and implementation of the model through participation on the IHC and participation on the RC regional advisory boards. Communities will participate in community needs assessments and will work with the RCs to align specific performance metrics for the PCMHs in their region with identified areas of need.

Most importantly, active engagement of stakeholders throughout the model testing period at the state, regional and local levels will ensure rapid feedback on the model and quick identification of barriers. Stakeholders will provide continuous guidance and direction on modifications needed to enable the successful achievement Idaho's transformation goals of improved health, improved healthcare, and lower costs for all Idahoans.

7. Quality Measure Alignment

Idaho's plan to implement the quality measure alignment process as described in this proposal will not be impacted by necessary reductions in the proposed budget. The revised budget still includes funding for PCMH training in quality data collection and reporting, as well as funding for data reporting and analytics at the local, regional and state levels.

An essential component of the Model Test is the State's ability to implement uniform performance measurement and reporting requirements across multi-payers to evaluate, monitor and improve population health, thus laying the groundwork for continuous improvement. To this end, Idaho recently reached a new level of collaboration by bringing together a broad representative group of healthcare and payer stakeholders to identify a common set of healthcare performance measures. As part of the State Healthcare Innovation Planning (SHIP) process, the stakeholders reached consensus on an initial catalog of performance measures that represent the areas with the most significant opportunities for improvement in health for all Idahoans. These will serve as the starting point for a coordinated quality reporting system. Idaho's payers agree that an alignment of measurement requirements in the healthcare transformation process will better support population health management and make these efforts workable for practices who

must work with multiple payers. Listed below, the initial catalogue of measures for the Model Test includes both preventive and chronic healthcare and outcome metrics.

Catalog of Initial Performance Measures:

- Screening for clinical depression.
- Asthma ED visits.
- Acute care hospitalization (risk-adjusted).
- Readmission rate within 30 days.
- Childhood immunization status.
- Elective delivery.
- Low birth weight rate (PQI 9).
- Comprehensive diabetes care (SIM)
- Access to care.
- Adult BMI Assessment.
- Non-malignant opioid use.
- Measure pair: (a.) Tobacco use assessment; (b.) Tobacco cessation intervention (State Innovation Models (SIM) measure).
- Avoidable emergency care without hospitalization (risk-adjusted).
- Adherence to antipsychotics for individuals with schizophrenia (HEDIS).
- Weight assessment and counseling for children and adolescents (SIM measure).

Measure Alignment across Payers

Currently underway, the multi-payer Idaho Medical Home Collaborative (IMHC) Pilot presented new opportunities for the evaluation of health measures across populations and payers. For the first time in Idaho, public and private payers are jointly requiring providers participating in the pilot to report on a core set of quality performance measures. Clinical quality and outcome data are voluntarily reported using national measures (e.g., HEDIS, AMA, PCPI & IPRO) for Diabetes Hemoglobin A1c Testing, and Poor Control; Blood Pressure and Hypertension Measurement and Controlling High Blood Pressure; Screening for Clinical Depression and

Antidepressant Medication Management; Asthma Assessment, Asthma Pharmacologic Therapy, and Management Plan for People with Asthma, among others.

The Model Test seeks to replicate the cross-payer reporting methods that have shown success in the IMHC pilot, as well as draw on the valuable lessons learned from this experience. The pilot was the venue for educating stakeholders about different payer approaches to PCMH, learning that can be transferred to the Idaho Healthcare Coalition (IHC). Stakeholders also concluded that PCMH focused on case managing just chronically ill people, without attending to relatively healthy people, is not a good long-term investment.

IDHW and the IHC, inclusive of the payers, will continually monitor, evaluate and increase performance targets to advance the health of Idahoans in line with the healthcare needs of the population. The initial statewide quality plan is described below. It will continue to evolve using baseline data for the catalogue measures as a springboard.

Initial Clinical Quality Measurement Plan

During the pre-implementation year, IDHW will contract with a quality review organization to establish a baseline for measures in the Catalog. The contractor, along with the program evaluation contractor, will help identify baseline measures from the Catalog. Baseline data will be collected directly from providers and other entities with relevant data on the selected performance measures. IDHW and the IHC have agreed upon three primary measures for Model Test reporting; 1) tobacco cessation intervention, 2) weight assessment and counseling for children and adolescents, and 3) comprehensive diabetes care. Another measure may be required.

IDHW and the IHC will review the baseline data to establish performance targets for reporting in Year 2 of the Model Test. Reported measures will be reviewed at the State and regional levels by IDHW, the IHC and the Regional Collaboratives (RCs). The RCs will provide

feedback to each PCMH in their regions. Quality initiatives will be identified and implemented to improve individual and regional PCMH performance. RCs, in consultation with IDHW and the IHC may identify additional performance measures to be reported in Year 3 for their respective regions. Regional-specific performance measures will be identified after consideration of both initial performance results and regional health needs as determined by community health assessments and other clinical and service data.

In Year 3, PCMHs will report on the statewide performance measures and potential regional-specific measures. IDHW and IHC's quality committee will evaluate data from multiple sources, e.g., PCMHs, hospitals, behavioral health assessments, community health needs assessments, and national trends to identify additional performance measures to be added to the Catalog. The IHC will review performance results and select statewide performance reporting requirements from the expanded Catalog.

8. Monitoring and Evaluation Plan

Idaho has reduced the funding proposed for the monitoring and evaluation plan, in alignment with the reduced amount of the overall project budget. The new proposed evaluation budget is 8% of the proposed budget.

Idaho plans to monitor and evaluate the success of the Model Test to strengthen population health, transform the healthcare system, and reduce per capita health care spending. The State's program evaluator will be selected in the pre-implementation phase so that the evaluation plan can be finalized and baseline data collection implemented according to plan. Idaho will coordinate with CMMI as needed on the Model Test evaluation. A multi-payer performance measurement and reporting system will also be established through a data collection and analytics contractor to lay the groundwork for healthcare performance measurement and

reporting. The evaluation and performance measurement efforts will be coordinated to reduce the data collection impact on providers. Also, building on the financial analysis efforts already undertaken, a contractor will coordinate with participating payers to aggregate statewide data for cost savings analysis.

IDHW and IHC will oversee the collection and use of data for these purposes. An initial uniform set of measures has been developed for monitoring and assessing the development and performance of the new model, in comparison to milestones for healthcare transformation, population health and cost savings. Data collection on these measures will begin in Year 1 to establish statewide baselines. 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, and health system monitoring functions. The measures, listed below, all assess their respective whole populations, including quality measures that target Idaho's specific health needs (Idaho's initial catalogue of Performance Measures), PCMH transformation measures that target the entire primary care population including policy levers such as accreditation requirements (Model Process and Patient Experience of Care Measures), and cost savings measures for the participating payers' populations (Cost Savings Measures).

Idaho 9/8/14 Response:

The state has data available through the Medicaid Management Information System that can be provided to Federal Evaluator/CMS for beneficiaries affected by the Idaho MTP.

The three commercial insurers that have agreed to participate in the model have also agreed to make available needed information and data for monitoring and evaluation of the model. So as long as the information/data requests are reasonable and useful commercial payers will participate.

Idaho is able to provide Medicare identifiers to the federal evaluator/CMS for beneficiaries affected through the current system.

The state intends to fully cooperate with the federal contractor conducting the evaluation by producing any non-PII or non-PHI data from any public payer and will secure the necessary permissions to release

any non-PII or non-PHI data from private payers for the purpose of the evaluation and to coordinate data collection activities in an expeditious manner.

Performance Measures for Population Health

Screening for clinical depression: Percent (%) of patients aged 12 years and older screened for clinical depression using a standardized tool and follow up plan documented.

Measure pair: (a.) Tobacco use assessment: (b.) Tobacco cessation intervention (SIM):

1) % of patients who were queried about tobacco use one or more times during the two-year measurement period; 2)% of patients identified as tobacco users who received cessation intervention during the two-year measurement period.

Asthma ED visits: % of patients with asthma who have greater than or equal to one visit to the ED for asthma during the measurement period.

Acute care hospitalization (risk-adjusted): % of patients who had to be admitted to the hospital.

Readmission rate within 30 days: % of patients who were readmitted to the hospital within 30 days of discharge from the hospital.

Avoidable emergency care without hospitalization (risk-adjusted): % of patients who had avoidable use of a hospital ED.

Elective delivery: Rate of babies electively delivered before full-term.

Low birth weight rate (PQI 9): # of low birth weight infants per 100 births.

Adherence to antipsychotics for individuals with schizophrenia (HEDIS): The % of individuals 18–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Weight assessment and counseling for children and adolescents (SIM): % of children, two through 17 years of age, whose weight is classified based on Body Mass Index (BMI), who receive counseling for nutrition and physical activity.

Comprehensive diabetes care (SIM): % of patients 18-75 with a diagnosis of diabetes, with optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure <140/90 mm Hg, tobacco non-use, and daily aspirin usage for patients with diagnosis of IVD) with the intent of preventing/reducing future complications of poorly managed diabetes.

Access to care: % of members who report adequate and timely access to PCPs, behavioral health, and dentistry (measure adjusted to reflect shortages in Idaho).

Childhood immunization status: % of children two years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine, and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Adult BMI Assessment: The % of members 18 to 74 years of age who had an outpatient visit & who's BMI was documented during the measurement year or the year prior.

Non-malignant opioid use: % of patients chronically prescribed an opioid medication for non-cancer pain (defined as three consecutive months of prescriptions) that have a controlled substance agreement in force (updated annually).

Model Transformation and Patient Experience of Care Measures

Establish PCMHs statewide: % of practices that achieve PCMH designation and recognition or accreditation tier requirements in required amount of time.

Patient enrollment in PCMHs: % of Idahoans who enroll in PCMHs.

Establish regional support for practice transformation through the establishment of RCs:

% of PCPs desiring to transform to a PCMH that can receive assistance through an RC.

Establish PCMH care coordination: % of PCMHs who have established protocols for referrals and follow up communications with providers in their medical neighborhood.

Establish Virtual PCMHS: % of rural communities establishing a virtual PCMH following assessment of need.

Training of lay community health workers: Number of new community emergency medicine personnel and community health workers trained.

Establish payment incentives: % of payers who adopt total cost of care shared savings reimbursement models.

PCMH integration of certified EHRs: % of PCMH participants with active EHR.

Regional Health Needs Assessments: % of PCMHs who receive results of community health needs assessments to guide development of quality initiatives within their practice.

Care Experience Measures:

Patient Engagement: % of enrolled PCMH patients reporting they are an active participant in their healthcare.

Stakeholder Engagement: Number of stakeholder forums occurring to inform, refine and improve delivery system model.

Idaho's Cost Measures to Monitor Cost Savings Targets

Appropriate Generic Drug Use: % of all generic fill rates.

Re-hospitalizations: % of all hospitalizations.

Acute Care Hospitalizations: % all acute hospitalizations.

Non-Emergent ED use: % of all ED visits.

Early Deliveries (in weeks 37–39 of gestation): % of total NICU admissions.

9. Alignment with State and Federal Innovation

Idaho's model of healthcare delivery and payment reform leverages existing state and national healthcare initiatives, elevating their impact on the population. Idaho will not use federal funds for duplicative activities or to supplant current federal or state funding. Current state and federal healthcare innovation initiatives in Idaho that will be coordinated with the Model Test include:

1. **Idaho Medical Home Collaborative** will advise IHC on PCMH model and spread.
2. **Idaho Telehealth Task Force/Council** will advise IHC on telehealth standards/training.
3. **Idaho Oral Health Strategic Plan** will guide participation of oral health providers in medical neighborhoods.
4. **Idaho Workforce Professions Education Council** will advise IHC on healthcare workforce education and development.
5. **Idaho Money Follows the Person Initiative** builds stronger community resources for disabled population and can improve patient linkages through medical neighborhood.
6. **Children's Health Improvement Coalition** (Federal grant to develop PCMH for kids) IHC will coordinate PCMH development with CHIC model for special needs children.
7. **National Public Health Campaigns** through State Health Division align with Healthy People 2020, the Million Hearts Campaign, the National Prevention Strategy, and the National Quality Strategy.
8. **Local Nonprofit Hospitals** will partner with RCs and IHC to conduct community needs assessments and identify regional differences in population health outcomes.
9. **Idaho Health Quality Planning Commission** will advise IHC regarding quality initiatives and measures at state level.