



# IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN

NOVEMBER 14, 2013

## Overview

Idaho stands at an important crossroad of designing and developing an integrated, efficient, and effective health care system in our State. The design of Idaho's new system, presented here in Idaho's Statewide Health care Innovation Plan (SHIP), is the result of an unprecedented stakeholder engagement initiative within the State and has the endorsement of providers, consumers of health care services, and the largest public and private payers in the State. The product of this extensive stakeholder engagement process — an innovative, ambitious, forward-thinking plan for the State of Idaho — will be centered on building a robust primary care system statewide through the delivery of services in a patient centered medical home (PCMH) model of patient-centered, team-based, coordinated care. Care will be integrated and coordinated across all health care services in the State yielding cost efficiencies and improved population health. Idaho will achieve its vision of system-wide reform that, with the commitment of commercial payers and Medicaid, will move Idaho from a system that rewards the volume of services (through predominantly fee-for-service (FFS) arrangements), to a system that rewards the value of services (through quality incentives, shared savings, etc.), incentivizing providers to spread best practices of clinical care and achieve improved health outcomes for patients and communities. Key to the success of the model is the development of the Statewide Health care Alliance (Alliance) and its regional collaboratives (RCs) which will support practices at every level throughout and after the transformation to a PCMH. The newly formed Alliance will oversee the development of this performance-driven model. Together, the Alliance and RCs will support the PCMHs in activities to transform and improve the system; including collection of data required to monitor and establish performance targets, providing regional and PCMH-level performance feedback, identifying and spreading evidence-based clinical practice, and providing on-going resources and support to achieve the triple aim of improved health outcomes, improved quality and patient experience of care, and lower costs of care for all Idahoans.

At the crossroads of health care system design, Idaho looked at the trajectory of its current path: what lies ahead was simply more of what had been and where we are now. Today, the system is defined by severe workforce shortages across health care professions, limiting access to services; primary care practices without the resources and support to implement quality initiatives, adopt advanced health information technology (HIT), and coordinate care, resulting in inefficient and often inadequate care; and lastly, a payment system that does not incentivize or reward quality care, resulting in ever rising health care costs but continued poor health outcomes. Knowing that change must occur, and with the goal of developing solutions to overcome such daunting barriers, Idaho engaged stakeholders from every component of the health care system to design a new health delivery model and change the course of health care in Idaho. Under the guidance and direction of a stakeholder steering committee, Idaho's model was developed through information and recommendations gathered from work groups, focus groups, townhall meetings across the State, and discussions with Idaho's six federally recognized American Indian and Alaskan Native tribes. Approximately 60 stakeholder engagements were held around the State. This included the addition of six non-scheduled outreach efforts in the form of townhalls to remote, frontier areas of the State. With nearly 300 unique participants, the State of Idaho was able to gather data on best practices, adaptable and scalable models, community sentiment, and local system needs. These data points will both

validate current system assumptions and justify the innovations detailed in the Statewide Healthcare Innovation Plan (SHIP).

The model developed is supported by the evidence base of research and other state and community experience. While the road ahead is challenging, Idaho knows that through the commitment of providers, payers, and consumers of health care services, the State will be successful in transforming its health care delivery system and improving the health of its population.

This plan represents the continued growth of the PCMH model in Idaho, building upon the Idaho Medical Home Collaborative (IMHC), which began under Executive Order in 2010 and launched PMCH pilots in January 2013. This plan also builds on current innovations and system assets in both urban and rural areas of the State. The end goal of this transformation is to create a system that promotes practice advancement under the PCMH model while respecting the long-standing culture in Idaho of provider and payer autonomy. As such, Idaho's model is a grassroots effort that builds collaboration and momentum for change rather than depending on mandates and legislative action.

Through the Model Design Grant, the State was able to pursue a statewide assessment of strength, barriers, and gaps to inform stakeholder deliberations. The gap analysis revealed important strengths in Idaho's system. Of important note is that over half of Idahoans receive health insurance coverage through commercial health insurers; an additional 15% are enrolled in Medicare, and 15% are enrolled in Idaho's Medicaid program. For the 18% of Idahoans without health insurance coverage, local public health districts and non-profit federally qualified health centers (FQHCs) play a vital role in providing care throughout communities around the State.

The gap analysis also confirmed Idaho's history of collaboration to pursue better care as evidenced by the Idaho Primary Care Association's work to evolve and expand PCMHs, FQHC Advanced Primary Care Practice Demonstration, and the Children's Health Care Improvement Collaboration Pediatric PCMH. Finally, the beginnings of an infrastructure to collect and analyze statewide data through the Idaho Health Data Exchange (IHDE), which facilitates health information exchange (HIE) in Idaho, is a critical asset as the State moves toward a performance-driven payment system.

The model proposed is designed to address many of the serious barriers identified through the system gap analysis. Of great concern is the fact that access to care in Idaho is a significant obstacle to successful health outcomes. One hundred percent of Idaho is a federally-designated shortage area in mental health care and 96.7% in primary care. This, and the rural nature of the State, contributes to the severe unequal distribution of health care resources across the State and many under-served areas. Additionally, electronic health records (EHR) and other advanced HIT is deficient in the State, with many providers experiencing significant barriers to adopting HIT such as connectivity issues and the high cost of HIT tools. As a result, data sharing is not comprehensive or complete. While repositories of statewide data exist for public health purposes (such as the vital statistics registry, the cancer registry, and the registry of reportable diseases), these data collection and analytics efforts only present part of the picture of health in Idaho. Additional barriers to improved system performance reported by stakeholders include the predominant FFS compensation model which rewards volume of service rather than quality improvement.

## Stakeholder Engagement in Model Design

The SHIP model design process included wide representation of stakeholders who together worked to identify current system strengths and weaknesses and generate a pathway to change. The information gathered through the stakeholder model design process has generated a SHIP that truly reflects the sentiment and solutions of Idaho's health care community. The deliberations among this broad group of stakeholders over the course of months are documented on Idaho's SHIP website ([www.idahoshipproject.dhw.idaho.gov](http://www.idahoshipproject.dhw.idaho.gov)).

Stakeholders with targeted expertise were identified to lead the process by participating on the SHIP Steering Committee. The Steering Committee was charged with overseeing the design of the model based on input received from statewide focus groups, recommendations from four stakeholder workgroups (on the topics of clinical quality improvement, network structure, HIT and multi-payer models) and research of successful approaches to health care delivery, payment models, performance measurement, and other issues relevant to the model. It is important to note that consensus was derived concerning the major elements of the model. The Steering Committee's deliberations were aided by "sponsors," individuals who participated in the development of the IMHC model, and others with critical expertise and knowledge. Payers, including Medicaid, Blue Cross of Idaho, Regence Blue Shield of Idaho, and PacificSource, which together cover a preponderance of beneficiaries in Idaho, participated in the Steering Committee as either a member or sponsor and were critical to the construction of this model.

The Idaho SHIP Steering Committee was comprised of representation from the following organizations:

The Governor's office.	Idaho Department of Health and Welfare
Idaho State Senate.	Idaho Hospital Association.
Idaho House of Representatives.	Idaho Medical Association.
Idaho Medical Home Collaborative.	Idaho Primary Care Association.
St. Luke's Health System.	Family Medicine Residency of Idaho.
Saint Alphonsus Health System.	Idaho Academy of Family Physicians.
Idaho Chapter of the American Academy on Pediatrics.	Independent physicians.
Idaho Commission on Aging.	

### *Work Groups*

Stakeholder work groups were at the core of the SHIP model design process. Representation on the work groups included payers, providers, professional associations, advocacy groups, legislative members, State staff, and consumers. The four work groups, on the topics of clinical quality improvement, network structure, HIT, and multi-payer models, were engaged over a period of months and met regularly. The work groups created focus group questions to solicit public input on concepts and collect information to further develop the gap analysis. The work groups also identified current system assets and deficiencies through a structured system gap analysis, which exposed the need early in the model design process, for a system-wide solution and an expansion of current PCMH efforts in the State. With this vision in mind, the work groups developed recommendations in their respective areas of expertise for Steering Committee review. The purpose of each work group is described below:

- *Multi-payer reimbursement strategies work group:* Propose payment model(s) for the new health care delivery system that promotes value (positive health outcomes) versus volume.

- *Network structure and medical home integration work group*: Propose a community care network model to support medical home integration with other aspects of the health care system to improve health outcomes and access through care management and care coordination across an integrated system.
- *Clinical quality improvement work group*: Propose standard, evidence-based guidelines for clinic practice and disease management strategies to address patient population needs, including high-risk and high-cost patient populations statewide.
- *Data sharing, interconnectivity, analytics, and reporting work group (also known as the HIT workgroup)*: Propose a strategy for developing a statewide HIT system that permits the analysis of clinical quality and utilization data throughout the health care system.

#### *Focus Groups and Townhall Meetings*

To ensure the broadest stakeholder input possible, focus groups and townhall meetings were held throughout Idaho. Focus group sessions were held to receive input from primary care providers (physicians, nurse practitioners, and physician assistants), consumers (patients), other service providers (behavioral health, long term services), and other entities critical to the design of transformation in Idaho. In addition, two separate focus groups — one for employers (both large and small, including self-insured employers) and one for hospitals — were held in each focus group location.

During the focus group outreach effort, several stakeholders noted that participants in some rural and frontier counties would need to travel at great length to participate. In response, the State added six townhall engagements in the more rural areas of the State — this also included a townhall engagement on the Fort Hall Reservation.

#### *Tribal Consultation*

Idaho is home to six federally-recognized tribes<sup>1</sup>: Coeur d'Alene Tribe, Kootenai Tribe of Idaho, Nez Perce Tribe, Shoshone-Bannock Tribes, the Northwestern Band of the Shoshone Nation, and the Shoshone-Paiute Tribe. All tribes were invited to participate in the work groups. In addition, IDHW held an informational session for tribes to ensure their understanding of the SHIP purpose and design process, and invited tribal leadership to request tribal consultation for further discussion and input. As a result, tribal consultation was held with the Nez Perce Tribe and a townhall meeting occurred with tribal members on the Fort Hall Reservation. Through these meetings, valuable input was provided regarding system deficiencies and health needs of tribal members.

Each aspect of the stakeholder engagement process brought forth invaluable knowledge, perspective, and insights that informed the model design. Idaho's SHIP is the result of the experience, wisdom, and collective work of Idahoans who care about the health of the State, believe in the vision of improved health, and are committed to bringing about the changes needed to have an effective, efficient, and quality health care system. Indeed, what sets Idaho's model apart from other states is the will and commitment of stakeholders across the entire health care system to implement the model.

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<sup>1</sup> Federal Register, Vol. 77, No.155. August 10,2012.

## **The New Health Care Delivery System**

Idaho's PCMH model will achieve a two-pronged transformation. At the patient level, the model will improve individual's health by delivering all primary care services through a PCMH. Patient-centered care through the medical home will begin with a broad, comprehensive patient assessment that takes into account the individual's behavioral health and socioeconomic needs. The plan of care will reflect cultural knowledge and sensitivity, respect the individual's rights and responsibilities in shared decision-making, and be built upon evidenced-based clinical practice. Recognizing the power of individuals to improve their health, the model will promote patient engagement, education, and self-management. The patient's team of health care professionals will be held accountable for coordinating care across the larger medical neighborhood of specialists, hospitals, behavioral health, and long-term care services and supports. EHR and other HIT tools will be used to support care coordination through efficient, effective and timely communications, and the exchange of patient health data to inform clinical decisions.

The stakeholders who participated in designing Idaho's new model recognized the critical importance of integrating behavioral health at the primary care level. As detailed in the 2011 Idaho State Planning Council on Mental Health Report, Idaho is experiencing an increasing suicide rate, increased utilization of law enforcement, increased psychiatric hospitalizations, and increased utilization of community emergency psychiatric services in our State. The Planning Council's Report also notes reduced life expectancy in persons with a mental illness. The Planning Council suggested adapting the Substance Abuse and Mental Health Services Administration's 10x10 wellness campaign in Idaho to reduce deaths and improve life expectancy among individuals with behavioral health conditions by 10 years, in 10 years. To assist Idaho in accomplishing this ambitious goal, the PCMH model will include a strong behavioral health component that will better equip the primary care community to prevent and treat co-morbid physical and behavioral health conditions. Integration of behavioral health in the new PCMH model will require PCMHs to focus on four essential strategies: (1) conducting a comprehensive needs assessment, (2) documenting individual needs planning, (3) developing communication tools and monitoring programs, and (4) facilitating access to needed services. The PCMHs will be supported in this work by the Alliance, which will establish a behavioral health (BH) committee to identify screening and assessment tools for PCMH use, and provide training and resources to the PCMHs to advance the integration of physical and behavioral health care in the model.

At the system level, the model changes the foundation of health care delivery in the State by establishing PCMHs as the vehicle for delivery of primary care services and integrating PCMHs into the larger health care delivery system. The model will impact, to varying degrees, all health care providers; for example, primary care providers, specialists, and allied practitioners across all disciplines; hospitals and other acute care facilities, nursing homes, FQHCs, and rural health clinics. By aligning payments, performance targets, data collection and other practice policies, Idaho will transform from a disease-focused system of care to a patient-centered, coordinated system that provides all Idahoans access to quality care that will improve health outcomes and lower health care costs in the State.

Transformation will be achieved at the patient and the system levels through support and assistance provided by the Alliance and RCs. A newly formed Alliance will support and oversee the transformation of practices to the PCMH model and the evolution of statewide population health management. Additionally, the Alliance will collaborate with other State and federal

efforts to improve the delivery system, and participate in national forums to both share and learn from the efforts of other states.

Recognizing the limited resources of most primary care practices in Idaho, the Alliance will establish RCs at the local level to serve, along with the Alliance itself, as a supportive network to provide technical assistance and resources across all levels of the model, in areas including, but not limited to: data collection and performance reporting, quality improvement initiatives, evidenced-based practices, utilization of advance HIT tools, integration of physical and behavioral health, comprehensive health assessments, and delivery of coordinated care. The RCs will leverage regional resources and expertise and will work with local providers and non-health organizations, to conduct regional health needs assessments and, with support from the Alliance, implement regional quality improvement and wellness initiatives.

Idaho's model maximizes the use of the existing health care workforce by adopting a team-based model of care that allows each practitioner to practice at the top of their licensure. Using this approach, PCMHs will be led by physicians, nurse practitioners or physician assistants under the supervision of a physician. Some Idaho communities are so severely under resourced, they are unable to provide team-based care within the primary care setting. In these underserved areas, two practitioner types — community health workers (CHWs) and community health emergency medical services (EMS) personnel — will be developed and advanced as key components of PCMH team-based care. Idaho's unique PCMHs will be "virtual PCMHs," as the team working together to provide coordinated primary care will be staffed across multiple agencies in the community or region. Section 4 describes Idaho's strategies to both maximize the existing workforce and expand the health care practitioners throughout the State.

The transformation of Idaho's health system will be supported by a payment methodology that incentivizes quality instead of quantity of care. The Alliance will work to facilitate alignment of payment methodologies among participating payers that reward quality care and improved health outcomes.

## Summary of the New Model

Oversees the development of this performance driven population management system



Alliance

Support practices in transformation to a PCMH



RCs

Provides primary care services and coordinates care across the larger medical neighborhood of specialists, hospitals, behavioral health and long-term care services and supports

PCMH and Care Team



Improved health by receiving all primary care services through a patient-centered approach

Patient



The delivery of care through the PCMH model will maximize the use of Idaho's limited health care workforce by sharing resources across PCMHs in the medical neighborhood and RCs, and encouraging teamwork and coordination among health care providers to provide patients better access to care and a greater role in making care decisions. Key attributes of this model will result in a high-performance health care delivery system that ensures:

- Health care is patient centered and the approach to health is comprehensive, taking into account all the factors — social, economic, psychological, etc. — that impact a person's health.
- Patient health care information is available to all providers at the point of care, enabling providers to make informed health decisions for their patients.
- Patient care is coordinated among multiple providers and transitions across care settings are actively managed.
- Providers in the patient's health care team both within and across care settings are accountable to each other.
- Patients have easy access to appropriate care and information, even after working hours.
- Patients are satisfied with their experience of care.
- Providers and payers are continuously innovating and learning in order to improve patient experience and the quality and value of health care delivery.
- Provider incentives move from volume to value, and payment approaches are coordinated across payers.

Beginning in the model implementation phase and throughout the three year testing phase (and five year demonstration period), the model will be developed statewide. There will be no regional phase-in. Instead, all regions will begin implementation activities immediately.

### **New Payment Model**

Idaho's current payment methods are heavily reliant on FFS arrangements that reward quantity of care. As a result, the current payment system rewards providers that generate a high volume of services for the purpose of attaining financial viability over providers that establish patterns of clinical services for the purpose of attaining good health outcomes for their patients. History in Idaho has shown that the unfortunate consequence of this arrangement is that, too often, services are duplicated and care is uncoordinated.

Idaho will transition to incentivizing value as opposed to volume by aligning payment mechanisms across payers. The new payment model will be phased-in as depicted in the graphic below. The components of the new payment model are:

- Transformation, start-up payments, and accreditation payments provided to the PCMH through the Alliance.
- Per member per month (PMPMs) for care coordination.
- Total cost of care shared savings arrangements.
- Quality incentives provided through the payers participating in the model.

A description of each component of the new payment model is found in Section 2 of the SHIP.

### **Performance Measurement and Population Health Management**

Today, no standardized data collection or performance reporting across payers or populations exists in Idaho. While performance measurement data is collected by IDHW (including the Division of Public Health, the Division of Behavioral Health and the Division of Medicaid), commercial payers, Medicare, and the local public health districts, measures are reported in various forms and in silos that make it difficult or impossible to measure population health changes across Idaho. As such, Idaho does not currently have a mechanism to conduct statewide measurement of the health of Idahoans or evaluate the performance of its health care delivery system.

The IMHC PCMH pilot opened new opportunities to assess the performance of Idaho's health care delivery system. Through the pilot, public and private payers are, for the first time in Idaho, jointly requiring providers to report on performance measures. Clinical quality data are reported for two to three clinical quality measures, as well as, two practice transformation measures. Each payer specifies additional reporting requirements.

To address the lack of standard performance measures across public and private payers or programs, Idaho will develop a performance measure catalog (Catalog). Initial performance measures to be included in the Catalog were targeted because they represent the areas with the most need for health improvement across all Idahoans.

The Alliance will task its quality committee to identify from the performance measure catalog those measures that will be mandatory for reporting in Year two, and a process for inclusion of additional measures that develop over time in response to performance evaluation and community need.

***Idaho's Initial Performance Measure Catalog***

<b>PM Name (and Source)</b>	<b>PM Description</b>	<b>Rationale</b>
Screening for clinical depression	Percentage of patients aged 12 years and older screened for clinical depression using a standardized tool and follow up plan documented.	In Idaho, 22.5% of persons aged 18 or older had a mental illness and 5.8% had a serious mental illness in 2008–2009 while 7.5% of persons aged 18 or older had a major depressive episode (MDE). During the period 2005–2009, 9% of persons aged 12-17 had a past MDE. Suicide is the second leading cause of death for Idahoans aged 15–34 and for males aged 10–14. *Aligns with Healthy People 2020.
Measure pair: (a.) tobacco use assessment  (b.) Tobacco cessation intervention state innovative models	Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period.  Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.	In Idaho, 16.9% of the adult population were smokers in 2010 (>187,000 individuals). Idaho ranked 15 in the country in prevalence of adult smokers and its smoking-attributable mortality rates ranked eight among the states.

<b>PM Name (and Source)</b>	<b>PM Description</b>	<b>Rationale</b>
Asthma emergency department (ED) visits	Percentage of patients with asthma who have greater than or equal to one visit to the ED for asthma during the measurement period.	While asthma prevalence (those with current asthma) was 8.8% in 2010 and has not changed significantly during the 10-year tracking period, reduction of emergency treatment for uncontrolled asthma is a reflection of high quality patient care and patient engagement.
Acute care hospitalization (risk-adjusted)	Percentage of patients who had to be admitted to the hospital.	While Idaho has one of the country's lowest hospital admission rates (81/1000, 2011), this measure is still held as one of the standards for evaluation of utilization and appropriate use of hospital services as part of an integrated network.
Readmission rate within 30 days	Percentage of patients who were readmitted to the hospital within 30 days of discharge from the hospital.	Data currently unavailable. Metric will be used to establish baseline.
Emergency care without hospitalization (risk-adjusted)	Percentage of patients who had to use a hospital ED.	While Idaho has one of the country's lowest hospital ED utilization rates (327/1000, 2011), this measure is still held as one of the standards for evaluation of utilization and appropriate use of emergency services, as well as, a reflection of quality and patient engagement in primary care related to avoidable treatment.
Elective delivery	Rate of babies electively delivered before full-term.	Data currently unavailable. Metric will be used to establish baseline.
Low birth weight rate (PQI 9)	This measure is used to assess the number of low birth weight infants per 100 births.	While Idaho's percentage of low birth weight babies is low compared to the national average, the opportunity to improve prenatal care across settings is an indicator of system quality and the need is reflected in the negative score trend of maternal and child health measures in the Agency for Health Care Research and Quality Report. 1,355 babies had low birth weights in 2011, compared to 1,160 in 1997.
Adherence to antipsychotics for individuals with schizophrenia, health effectiveness data and information set	The percentage 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.	Idaho has a 100% shortage of mental health providers statewide. Without these critical providers, there is little or no support for patient engagement and medication adherence. Improved adherence states may be a reflection of an expanded workforce and improved access to care.

<b>PM Name (and Source)</b>	<b>PM Description</b>	<b>Rationale</b>
Weight assessment and counseling for children and adolescents (SIM)	Percentage 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.	In 2011, 13.4% of children were overweight as defined by being above the 85 <sup>th</sup> percentile, but below the 95 <sup>th</sup> percentile for BMI by age and sex, while 9.2% were obese, i.e., at or above the 95 <sup>th</sup> percentile for BMI by age and sex.
Comprehensive diabetes care (SIM)	The percentage of patients 18-75 with a diagnosis of diabetes, who have 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 or reducing future complications associated with poorly managed diabetes.	Adult diabetes prevalence in 2010 was 8.0%. Overall, this represented one in 12 people in the State.
Access to care	Attestation measure to ensure that members have adequate and timely access to primary care physicians, BH, and dentistry (measure adjusted to reflect shortages in Idaho).	Idaho has a critical access shortage of primary care providers, BH providers, and dentists across the State which impedes access and timely access to the appropriate level of care.
Childhood immunization status	Percentage 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.	While there have been significant improvements in immunization rates, Idaho ranks 43 in the nation with an immunization rate of 87.33% in 2012. * Aligns with Healthy People 2020.
Adult BMI Assessment	The percentage of members 18 to 74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.	Adults — 62.9% of adults in Idaho were overweight, and 26.9% of adults in Idaho were obese in 2010. Children — In 2011, 13.4% were overweight as defined by being above the 85 <sup>th</sup> percentile but below the 95 <sup>th</sup> percentile for BMI by age and sex, while 9.2% were obese, that is, at or above the 95 <sup>th</sup> percentile for BMI by age and sex.

<b>PM Name (and Source)</b>	<b>PM Description</b>	<b>Rationale</b>
Non-malignant opioid use	Percent 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) – target is 100%.	From 2010–2011, Idaho had the fourth highest non-medical use of prescription pain relievers in the country for persons aged 12 or older at 5.73%.

The timeline for developing a baseline and establishing performance reporting to achieve population health management is outlined below.

- The Alliance will establish a baseline for each of these measures in Year 1 of model testing:
  - Due to the lack of uniform reporting that exists today, the Alliance will develop a baseline from the pockets of information that is currently available across payers and populations. An external organization with expertise in performance data collection, analysis, reporting will assist the Alliance in gathering and analyzing the data to establish a baseline by the end of Year one.
- In Year two, the Alliance will select four core performance measures from the initial performance measure catalog to be reported by all PCMHs in Year 2:
  - The statewide performance measures for Year two will include the three SIM measures: tobacco cessation intervention, weight assessment and counseling for children and adolescents, and comprehensive diabetes care.
- In consultation with the Alliance, RCs will identify additional performance measures from the performance measure catalog to be collected from PCMHs in their respective regions in Year three:
  - The additional measures collected in Year three may vary from region to region depending on performance and regional health needs and will be informed by community health assessments and regional specific clinical data.

During the first year of implementation and model testing, the Alliance will analyze the current system capabilities and constraints regarding statewide data collection and reporting. The Alliance will engage stakeholders in the discussion and analysis to ensure that a statewide solution remains viable and acceptable to the different communities in Idaho. By the end of Year One, decisions regarding statewide data collection and protocols for PCMHs to report on performance measures will have been developed.

The development of a performance measure catalog and reporting of statewide performance measures across multiple payers and populations is a major first step for Idaho as we move toward population health management.

### **Cost Savings**

Idaho’s SHIP is designed to lower the overall cost of care for Idahoans. By transitioning to a PCMH model of care, Idaho has the opportunity to eliminate expenses through proactive care

and care coordination. Five key categories of expenses were identified as having a high potential to yield cost savings, but other categories of health care expenditures are anticipated to also yield cost-savings. The initial five cost targets are: increase generic drug use to 85% of overall drug spend, reduce hospital readmission by 10%, reduce overall hospitalizations by 5%, reduce non-emergent ED usage by 10%, and lower premature births by 20% through prenatal care.

The table below details the estimated cost savings associated with reaching each of these goals, as well as additional cost savings estimates for other categories of service.

Savings Assumptions by COS									
Categories of Services	PMPM								
	Medicaid/CHIP				Private/Other		Medicare		
	Adult	Child	Duals	Disabled/Elderly (Without Duals)	Individual	Family	Dual Eligible	Fee for Service/Non-Duals (Parts A and B)	Medicare Advantage Part C
Inpatient Hospital	-4.14%	-4.14%	-4.14%	-4.14%	-4.14%	-4.14%	-3.02%	-3.02%	-3.02%
Outpatient Hospital (total)	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%	-2.01%
Emergency Dept (subtotal)	-1.13%	-1.13%	-1.13%	-1.13%	-0.90%	-0.90%	-1.13%	-1.13%	-1.13%
Professional Specialty Care	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%
Diagnostic Imaging/X-Ray	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%
DME	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%
Professional Other (e.g., PT, OT)	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%
Prescription Drugs (Outpatient)	-0.75%	-0.75%	-0.75%	-0.75%	-2.50%	-2.50%	0.00%	0.00%	0.00%

As shown in the table, savings were also calculated by payer type. Medicaid is projected to reduce costs by \$8 million, commercial insurance by \$22 million, and Medicare by \$41 million over three years. Inpatient Hospital expenses are expected to save \$73 million in total, outpatient and ED visits should be reduced by \$20 million, pharmacy by \$9 million, and another \$7 million saved by reductions in specialists, therapists, and diagnostics. Those savings are offset by the supplemental costs in increased PMPMs to PCMHs for primary care and care coordination efforts later detailed in the SHIP.

The implementation of Idaho’s proposed PCMH model is expected to save \$70 million in three years after factoring in an increase in payment to primary care physicians for care coordination and adherence to the PCMH model. The projected cost savings for public payers (Medicare and Medicaid) is \$48 million.

### Next Steps

What follows is the SHIP, intending to address all of the terms and conditions that accompany the Model Design Award. In addition, it includes the product of the work groups and Steering Committee as supplemented and matured by the various subject matter experts. Each major element of the model has been fully vetted and approved by the Steering Committee by a majority vote (and in most cases a unanimous decision).

Idaho’s Department of Health and Welfare will submit a model testing proposal in pursuit of financial support for the implementation and testing of the model. However, Idaho does not intend to wait on grant funding before proceeding further in planning and model development. The SHIP Steering Committee is continuing in its role of overseeing development of the model. In preparation for the implementation and testing phases, the Steering Committee will establish

interim sub-committees to address critical start-up issues that will lay the groundwork for implementation.

The Steering Committee will continue to define implementation details and move component pieces of the SHIP forward until the Alliance is fully formed and able to assume its responsibility. It is understood among the stakeholders that the SHIP and the Model Testing Proposal will become the blueprints for system transformation with or without a Model Testing Award.

### **Ongoing Community Awareness of and Engagement in SHIP Implementation**

The backbone of Idaho's health care transformation is the strength of its local communities. Community engagement was a critical component that led to the success of the SHIP model design process through the input received from community members who participated in the focus groups and work groups. The work groups considered ways to continue to engage communities in the SHIP implementation phase and to promote awareness of the SHIP activities both in Idaho and around the country as lessons learned begin to emerge. Idaho will continue to use its SHIP website ([www.idahoshipproject.dhw.idaho.gov](http://www.idahoshipproject.dhw.idaho.gov)) to post news and updates regarding the development of the SHIP model. The website will serve as a forum for researchers and other interested parties, as well as the general public, to learn more about implementation activities and later regarding results in achieving access, quality, and cost goals. The State will also facilitate townhall engagements to gauge public sentiment regarding model implementation and continue to ensure alignment with patient and system needs in Idaho. Through participation in CMMI-hosted conferences and other national forums, Idaho will also have the opportunity to share our experiences with our federal partners as well as states that join us in health transformation.