iv Operational Plan

ORGANIZATIONAL CAPACITY

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

Key personnel in this proposal include:

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

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

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

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

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

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

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

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

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

- PCMH requirements and standards, including Virtual PCMHs, the incentive structure and PCMH Mentoring Program.
- Community Health Worker (CHW) and Community EMS (CHEMS) standards and certification requirements.
- Regional Collaborative roles and responsibilities, standards and expectations.
- Requirements for contracts listed below.
- PCMH Payment Structure – enrollment and attribution processes. The payers will set parameters for their patient population risk stratification methodology, and build their PMPM amounts. Payers will consider and/or develop a value-based payment methodology for primary care and Behavioral Health integration, and whether payments may expand to shared savings for more complex clients as PCMHs reach higher levels of accreditation.

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

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

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

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

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

5. **With Project Implementation Contractor:** The project implementation plan & Financial Analysis model will be refined.
6. **With the PCMH Technical Assistance, Training and Coaching Contractor:** The PCMH transformation support plan will be developed.

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

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

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

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

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

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

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

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

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

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

- IDHW, IHC and the work teams will begin to monitor and evaluate the implementation of the Model Test elements according to the approved operational plan.

- IDHW staff will be responsible for monitoring the contracts associated with their assigned teams and disbursement of grant funds, and regular reporting to CMS.

- Contractors will implement their plans under IDHW oversight.

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

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

Goal 1: Accelerate establishment of the PCMH model of care throughout the State by building 180 PCMH primary care practices (a practice is defined as a clinic site) that have reached at least level-1 PCMH recognition or accreditation within their first year of participation in the Model Test.

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

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

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

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

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

a) Increase Health Information Technology Adoption and Use. Over the three-year Model Test period, Idaho Health Data Exchange (Contractor # 2 above) will engage 180 PCMH-designated clinic sites statewide to both adopt and use EHR technology and to connect to the IHDE. Up to 120 designated practices will be connected during the Model Test. The initial 60 practices will have been connected in 2015.

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

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

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

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

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

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

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

continuing education conferences will be held for CHW trained staff, in conjunction with the CHEMS continuing education conference.

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

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

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

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

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

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

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

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

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

RISKS ASSUMPTIONS AND MITIGATION STRATEGIES

Assumptions:

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

Associated Risk:

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

Mitigation Strategy:

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

BUDGET

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

TOTAL BUDGET BY PROJECT YEAR

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

SUSTAINABILITY PLAN

Idaho's sustainability plan is based on two core principles: (1) significant one time investment of grant funds to build and transform the service delivery system and (2) continued investment by Idaho's payers and providers of those aspects of system change that catalyze and sustain market changes.

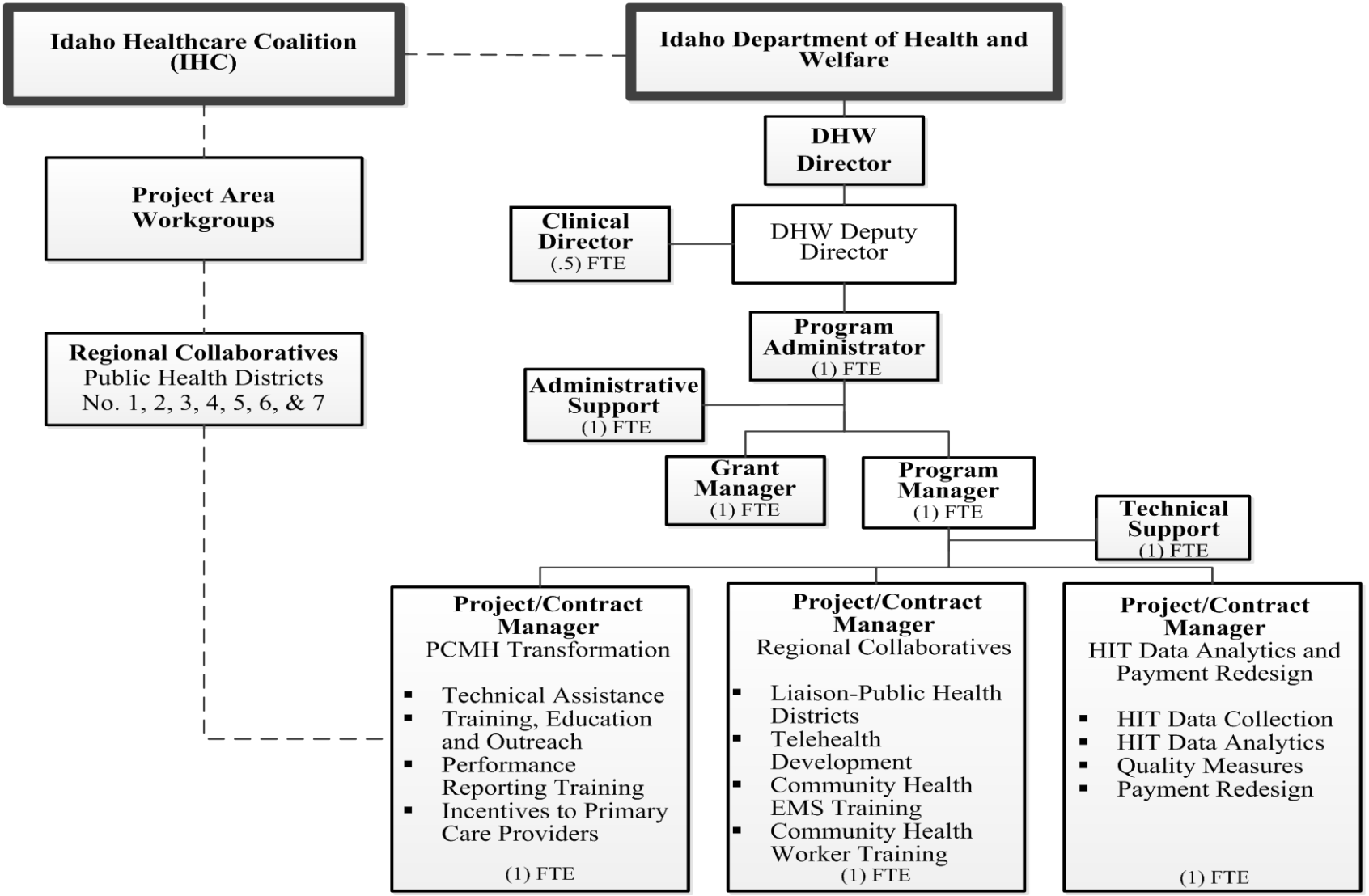
The first principle of investment is reflected in this proposal as grant funds are invested in significant transformations that Idaho's healthcare system cannot undertake without additional outside resources. These one-time investments will build the foundation for system change. Examples of investments in this Model Test include grant funds for PCPs to transform to PCMHs, building the medical neighborhood, and establishing a strong Telehealth program.

The second core principle for sustainability is that these changes will significantly improve Idaho's quality of care and health outcomes, ultimately reducing costs. During the four year grant period, providers and payers on the IHC and the RCs will continuously evaluate the impact of transformation activities on the healthcare system. The IHC will determine which system changes bring the most value to quality and costs and should be invested in long term.

Similar transformation activities in other states have demonstrated sustainability in specific program areas proposed in Idaho's Model Test. For example, Model Test funds invested to expand the use of Telehealth in rural communities will improve patient access to behavioral health and specialty services. Telehealth program development will occur at the RC level to assure regional coordination of services. This coordinated, regional approach will be sustained by establishing a fee-based program which allows rural PCMHs and hospitals to purchase behavioral health and specialty services based on the number consultations needed per year. This approach is modeled after the successful South Carolina program that reduced the cost of tele-psychiatry services by $1,400 per consult and reduced patient wait time from four days to 10 hours. Idaho anticipates that other proposed program initiatives will result in similar savings across the healthcare delivery system.

The IHC has already discussed the possibility of creating a private, not for profit organization to continue the core work accomplished through the MTP. These discussions have included sustainability concepts like payer and provider fees to participate in various on-going initiatives at the end of the 4 year Model Test. Stakeholders will continue to evaluate the value of system components and determine strategies for long-term system maintenance well prior to the end of the grant period.

Model Test Proposal Organizational Structure



RESPONSIBILITIES AND TIMELINE

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