

## Idaho Model Test Project Narrative

**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

achieve the Triple Aim of improved health, improved healthcare, and lower costs for Idahoans by reaching the following delivery system goals:

**Goal 1: Build 180 PCMH primary care practices with 900 primary care providers serving 1.3M Idahoans (80% 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 180 Model Test PCMHs, and across the Medical Neighborhood.**

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 7 Regional Collaboratives to support the integration of each PCMH with the broader Medical Neighborhood.** At the local level, Idaho's 7 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.

**Goal 4: Improve rural patient access to PCMH by developing 75 virtual PCMHs.** This goal includes training over 550 CHWs and CHEMS, and integrating telehealth services into these 75 very rural or frontier practices. 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.** 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.** 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. Representation from Medicare has been notably missing from Idaho's stakeholder discussions. If Idaho is rewarded a Model Test we will request that Medicare join Idaho's efforts to align reimbursement methodology towards payment for 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:** 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.

***The Regional Collaboratives (RCs)*** will serve as the public health/physical health integrator in local communities. Idaho's 7 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 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.

*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 60 PCPs/year in the demanding process of transforming to a PCMH. 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. An initial incentive of \$10,000 will be provided to PCPs that are designated by the IHC as participants in the Model Test. Following a readiness assessment by the PCMH transformation consultant that identifies specific practice gaps and development of a specific practice transformation plan a second incentive of \$20,000 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 \$10,000 upon reaching each of three tiered levels of national recognition. These incentive payments will help reimburse practices for the costs associated with meeting recognition requirements.

Virtual PCMH Program Participation Incentives: Up to 75 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 \$5,000 incentive payment upon meeting certain criteria in year 2 or later.

Per Member Per Month (PMPM) Payments: Payers will 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".

**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.

## **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.

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.

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:** 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**

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 7 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.

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

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.
- Non-malignant opioid use.
- Measure pair: (a.) Tobacco use assessment; (b.) Tobacco cessation intervention (State Innovation Models (SIM) measure).
- Elective delivery.
- Low birth weight rate (PQI 9).
- Comprehensive diabetes care (SIM)
- Access to care.
- Adult BMI Assessment.

- 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 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 IDHW 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).

### **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.