Statewide Healthcare Innovation Plan

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN

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Introduction

Idaho stands at an important crossroad of designing and developing an integrated, efficient, and effective healthcare system in our State. The design of Idaho's new system, presented here in Idaho's Statewide Healthcare Innovation Plan (SHIP), is the result of an unprecedented stakeholder engagement initiative within the State, and has the endorsement of providers, consumers of healthcare 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 healthcare 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.). Payment methods will incentivize 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 Idaho Healthcare Coalition (IHC) and it's Regional Collaboratives (RCs) which will support practices at every level throughout and after the transformation to a PCMH. The newly formed IHC will oversee the development of this performance-driven model. Together, the IHC and RCs will support the PCMHs in activities to transform and improve the system, including collecting 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 healthcare system design, Idaho looked at the trajectory of its current path: what lay ahead was simply more of what had been and where we are now. Today, the system is defined by severe workforce shortages across healthcare professions, limiting access to services; primary care practices without the resources and supports 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 healthcare 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 healthcare system to design a new health delivery model and change the course of healthcare 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, 44 focus groups, townhall meetings across the State, and discussions with Idaho's six federally-recognized American Indian and Alaskan Native tribes. The model developed is supported by the evidence base of research and other state and community experience. And while the road ahead is challenging, Idaho knows that through the commitment of providers, payers, and consumers of healthcare services, the State will be successful in transforming its healthcare 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 strengths, 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. See Appendix B for a map of Idaho's seven local public health districts.

The gap analysis also confirmed Idaho's history of collaboration to pursue better care, as evidenced by the Idaho Primary Care Associations' work to evolve and expand PCMHs, the FQHC Advanced Primary Care Practice Demonstration, and the Children's Healthcare 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 healthcare, and 96.7% of Idaho is a federally-designated shortage area in primary care. This, and the rural nature of the State, contributes to the severe unequal distribution of healthcare resources across the State and many under-served areas. Additionally, the use of 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 fee for service (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 healthcare 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).

Stakeholder Engagement

- 11-member Steering Committee charged with overseeing model design.
- 13 Steering Committee sponsors with critical expertise and knowledge.
- 4 work groups (Clinical Quality Improvement, Network Structure, Health Improvement Technology and Multi-Payer Models) with 100+ members.
- 44 statewide focus group engagements.
- Townhall meetings.
- Meetings with tribal leaders.

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, Health Information Technology, and Multi-Payer Models) and research of successful approaches to healthcare 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 Medical Home Collaborative
Idaho State Senate	Idaho House of Representatives
Saint Alphonsus Health System	St. Luke's Health System
Idaho Academy of Family Physicians	Idaho Chapter of the American Academy of Pediatrics
Idaho Commission on Aging	Idaho Department of Health and Welfare (IDHW)
Idaho Hospital Association	Idaho Medical Association
Idaho Primary Care Association	Family Medicine Residency of Idaho
Independent physicians	Idaho Department of Insurance

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 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 Models Work Group:* Propose payment model(s) for the new healthcare delivery system that promotes value (positive health outcomes) versus volume.

- *Network Structure Work Group:* Propose a community care network model to support medical home integration with other aspects of the healthcare 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 Work Group)*: Propose a strategy for developing a statewide HIT system that permits the analysis of clinical quality and utilization data throughout the healthcare 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. In total, 44 focus group engagements were held across the State.

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[1]: 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 healthcare system. Indeed, what sets Idaho's model apart

[1] Federal Register, Vol. 77, No.155. August 10, 2012.

from other states is the will and commitment of stakeholders across the entire healthcare system to implement the model.

The New Healthcare Delivery System

Idaho's PCMH model will achieve a two-pronged transformation. At the patient level, the model will improve individuals' health by delivering primary care services through a patient-centered medical home. 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 individuals' 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 healthcare professionals will be held accountable for coordinating care across the larger medical neighborhood that includes specialists, hospitals, behavioral health, and other services. EHRs and other HIT tools will be used to support care coordination through efficient, effective and timely communication, 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. 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 (SAMHSA) 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 IHC, which will establish a behavioral health 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 healthcare delivery in the State by establishing PCMHs as the vehicle for delivery of primary care services and integrating PCMHs into the larger healthcare delivery system. The model will impact, to varying degrees, all healthcare providers, e.g., primary care providers, specialists, 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 Idahoans access to quality care that will improve health outcomes and lower healthcare costs in the State.

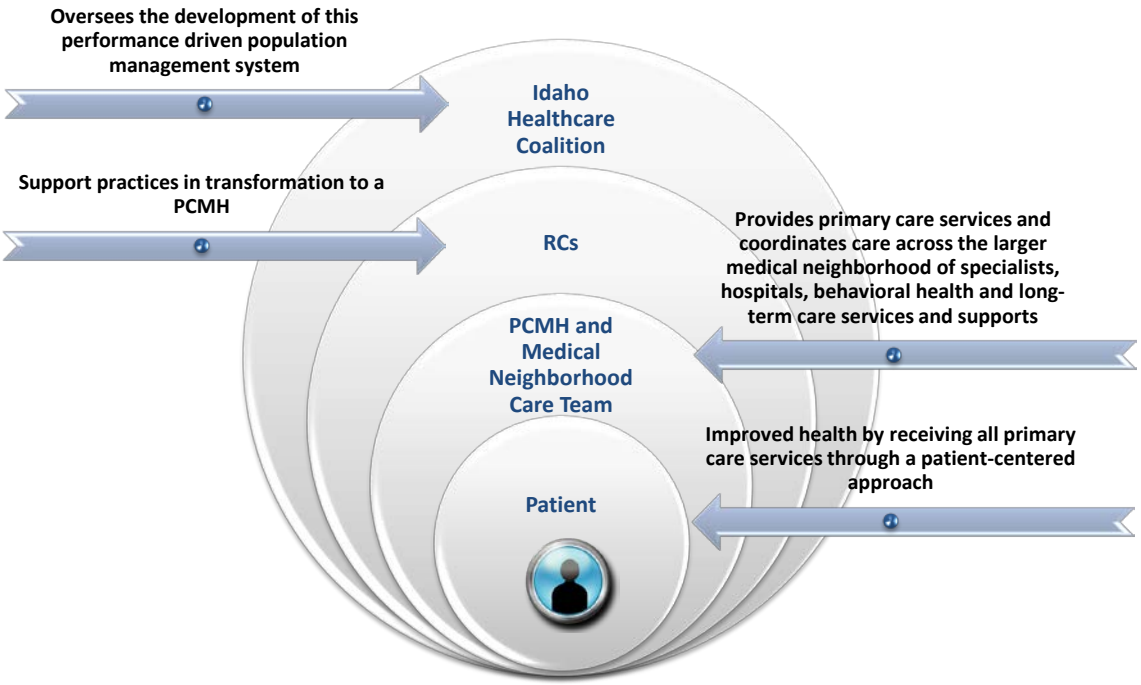
Transformation will be achieved at the patient and the system levels through oversight and supports provided by the Idaho Health Coalition (IHC) and Regional Collaboratives (RCs). A newly formed Idaho Healthcare Coalition (IHC) will support and oversee the transformation of practices to the PCMH model and the evolution of statewide population health management. Additionally, the IHC

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 IHC will establish RCs at the local level to serve, along with the IHC 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 advanced 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 IHC, implement regional quality improvement and wellness initiatives.

Idaho's model maximizes the use of the existing healthcare 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 that 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 healthcare practitioners throughout the State.

Summary of the New Model



The delivery of care through the PCMH model will maximize the use of Idaho's limited healthcare workforce by sharing resources across PCMHs in the medical neighborhood and RCs, and encouraging teamwork and coordination among healthcare 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 healthcare 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 with their patients.
- Patient care is coordinated among multiple providers and transitions across care settings are actively managed.
- Providers in the patient's healthcare 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 healthcare 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.

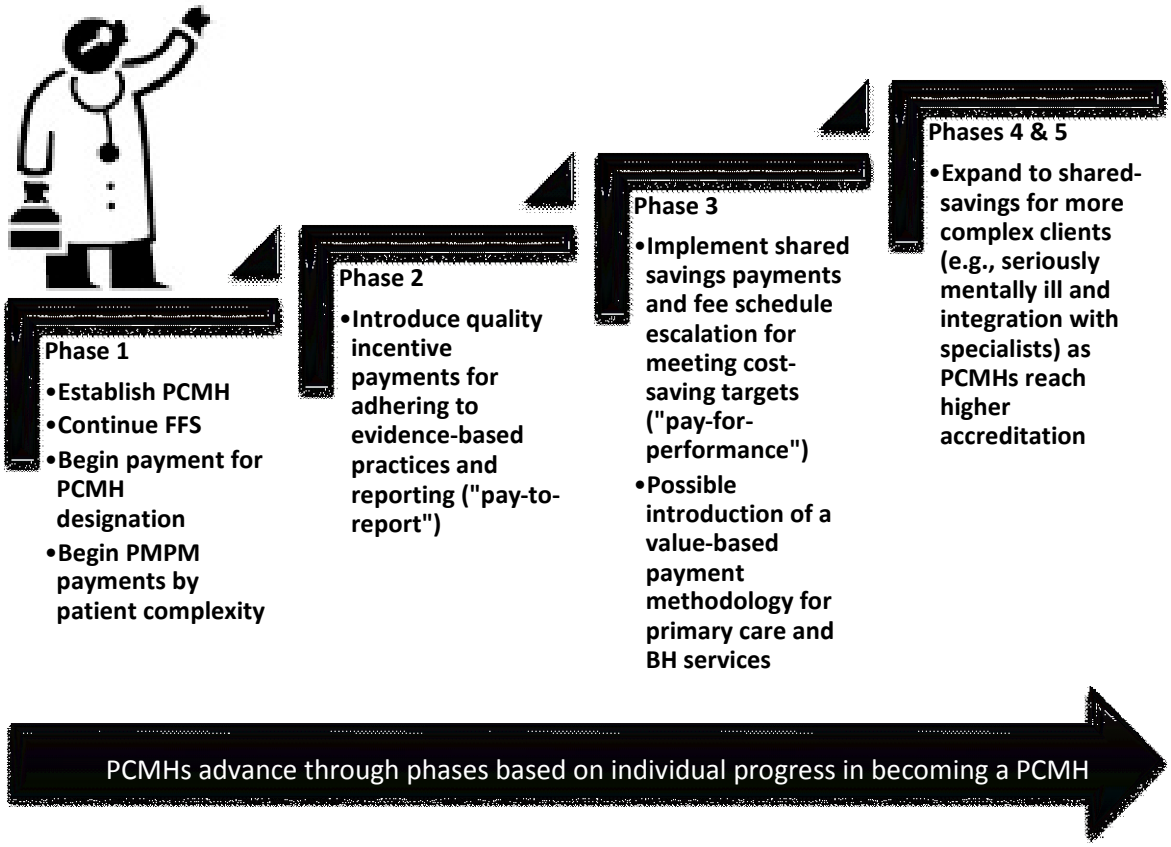
The transformation of Idaho's health system will be supported by a payment methodology that incentivizes quality instead of quantity of care. The IHC will work to facilitate alignment of payment methodologies among participating payers that reward quality care and improved health outcomes.

New Payment Model

Idaho's current payment methods are heavily reliant on fee for service (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 IHC,
Per member per month (PMPMs) for care coordination,
Total cost of care shared savings arrangements, and
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 healthcare delivery system.

The IMHC PCMH pilot opened new opportunities to assess the performance of Idaho's healthcare 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 an Initial 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 IHC will task its quality committee to identify from the Performance Measure Catalog those measures that will be mandatory for reporting in Year 2 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

Measure Name (and Source)	Measure Description	Rationale for the Measure
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 SMI 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. This measure aligns with Healthy People 2020.
Measure pair: (a.) Tobacco use assessment. (b.) Tobacco cessation intervention (SIM)	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 ranks fifteenth in the country in prevalence of adult smokers and its smoking-attributable mortality rate is ranked eighth in the country.
Asthma 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) in Idaho was 8.8% in 2010, 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 in 2011), this measure is held as one of the standards for evaluation of utilization and appropriate use of hospital services as part of an integrated network.

Measure Name (and Source)	Measure Description	Rationale for the Measure
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.
Avoidable emergency care without hospitalization (risk-adjusted).	Percentage of patients who had avoidable use of 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. 1,355 babies in Idaho had low birth weights in 2011, compared to 1,160 in 1997.
Adherence to antipsychotics for individuals with schizophrenia (HEDIS).	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 may be a reflection of improved access to care and patient engagement.
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 85th percentile, but below the 95th percentile for BMI by age and sex, while 9.2% were obese, i.e., at or above the 95th percentile for BMI by age and sex.

Measure Name (and Source)	Measure Description	Rationale for the Measure
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 Idaho had diabetes.
Access to care.	Members report adequate and timely access to PCPs, BEHAVIORAL HEALTH, and dentistry (measure adjusted to reflect shortages in Idaho).	Idaho has a critical access shortage of primary care providers, behavioral health providers, and dentists across the State which impedes 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 43rd in the nation with an immunization rate of 87.33% in 2012. This measure aligns with Healthy People 2020.
Adult BMI Assessment.	The percentage of members 18 to 74 years of age who had an outpatient visit and who's BMI was documented during the measurement year or the year prior to the measurement year.	In 2010, 62.9% of adults in Idaho were overweight, and 26.9% of adults in Idaho were obese.

Measure Name (and Source)	Measure Description	Rationale for the Measure
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).	From 2010–2011, Idaho had the fourth highest non-medical use of prescription pain relievers in the country among 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 IHC 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 IHC will develop a baseline from the pockets of information that are currently available across payers and populations. An external organization with expertise in performance data collection, analysis, and reporting will assist the IHC in gathering and analyzing the data to establish a baseline by the end of Year 1.

- In Year 2, the IHC 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 2 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 IHC, RCs will identify additional performance measures from the Performance Measure Catalog to be collected from PCMHs in their respective regions in Year 3.
  - The additional measures collected in Year 3 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 IHC will analyze the current system capabilities and constraints regarding statewide data collection and reporting. By the end of Year 1, decisions regarding construction of the statewide database and protocols for PCMHs to report on performance measures will have been developed. The IHC will engage stakeholders in this discussion to ensure that a statewide solution is viable and acceptable to the different communities in Idaho.

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 healthcare expenditures are anticipated to also yield cost-savings. The initial five cost targets are: increase appropriate generic drug use to 85% of overall drug spend, reduce hospital readmissions by at least 5%, reduce overall hospitalizations by at least 1%, reduce non-emergent emergency department (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

	PMPM								
	Medicaid/CHIP				Private/Other		Medicare		
Categories of Services	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 (The savings calculations for Medicare assumes that provider efforts will naturally affect all types of patients, not just those outside of Medicare. Therefore behavior and utilization will improve across the board, and providers will treat patients/members similarly whether or not they are on Medicare). 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.

Savings Estimation Methodology: To determine cost savings from the model, a comparison model of care was built using fee-for-service data supplied by IDHW, from CMS, and from Mercer's proprietary commercial claims database. Mercer also used payers' public filings to the extent that they were available. Those costs were trended forward using actuarially sound methods to determine expected expenses without implementing the SHIP, establishing a baseline for comparison. Using savings assumptions based on data obtained from initiatives in other states and other public sources, five areas were determined to have high potential savings for Idaho. The savings assumptions called for reductions in ED usage, hospitalizations, re-hospitalizations, NICU, and an increase in the generic fill rate for pharmaceuticals. In addition, expenses related to diagnostic imaging and durable medical equipment were also introduced. The baseline data was

then projected taking into account those savings assumptions, offset by increased costs to primary care physicians. The resulting data was then compared to the baseline data to determine three and five year costs savings.

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 through 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 IHC is fully formed and able to assume its responsibility.

Ongoing Community Awareness of and Engagement in SHIP Implementation

The backbone of Idaho's healthcare 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) to post news and updates regarding the development of the SHIP model. The website will serve as a resource 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 experiences with federal partners as well as states that join them in health transformation.

2

Idaho's Healthcare System Transformation

Vision

Idaho will deliver integrated, efficient and effective primary care services, supported and incentivized by value-based payment methods, through the patient-centered medical home model and, in doing so, improve the quality and experience of care for Idahoans while improving health outcomes and effectively controlling healthcare costs.

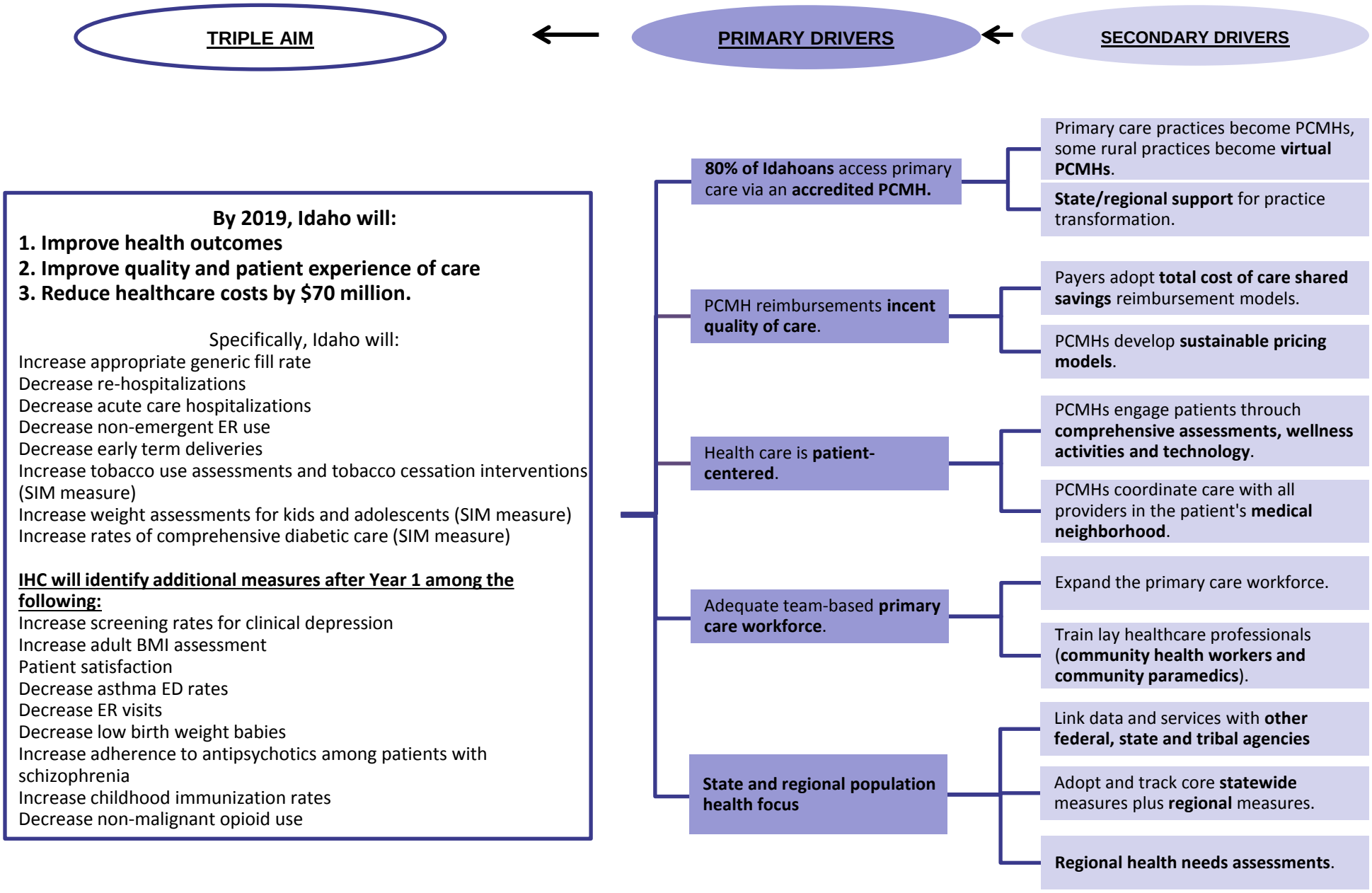
The following is Idaho's vision for health system transformation, as approved by the Steering Committee:

Idaho stands at an important crossroads of designing and developing an integrated, efficient, and effective healthcare system. This system will be a regional-facing model built for each Idaho community (including rural and frontier areas) on a robust primary care based system with an empowered PCMH. The PCMH is led by a primary care provider (in conjunction with other healthcare team members), and empowers a broad-based healthcare team to integrate and coordinate care for the patient in a cost-effective and high-quality way. This system will be a robust "medical neighborhood" integrating additional community support consisting of secondary care providers and consultants, community home health agencies, hospitals, and other ancillary healthcare provided in those communities. All of this will be integrated electronically with EHRs and other HIT tools, such as telehealth, so that clear and timely communication can occur, all with the central premise that high-quality, evidence-based care occurs as close to home as possible. Payment systems will be aligned to support these practices to be a blended and bundled system that is responsible and accountable to a value-driven system that enhances patient's health as affordably as possible. This system will be patient-centered and will partner with engaged and accountable patients in shared decision making. Health promotion and wellness will be central tenets of Idaho's healthcare redesign. All of these principles will be combined at the community level to help create the sustainable healthcare system that Idaho needs.

Our goal for health system transformation is to achieve the Triple Aim in Idaho. Specifically, our goals are to:

- Improve the quality and patient experience of care for each Idahoan.
  - Individuals can get the care and services they need, as close to home as possible, and care will be coordinated regionally with access to statewide resources when needed.
  - 80% of Idahoans will have access to a recognized PCMH by 2019.
  - Physical health and behavioral health are integrated and coordinated, and prioritize prevention and wellness strategies that keep individuals healthy rather than only caring for them when they are sick.
  - Care is evidence-based, and evaluation of care is transparent to stakeholders, and supported by performance measure analysis and reporting.
- Improve the health of Idahoans (see the Initial Performance Measure Catalog for specific health improvement measures).
- Improve affordability as measured by reductions in the total cost of care.
  - Costs are reduced through new payment systems and standards that emphasize outcomes and value rather than volume, and make care more affordable for everyone.

Idaho's Driver Diagram



Current Healthcare Delivery System Models in Idaho

Idaho's current healthcare delivery systems reflect the vastly rural nature of the State. A little over 1.5 million Idahoans live in its 44 counties, 35 of which are rural counties (those with no cities over 20,000 residents) accounting for approximately 88% of the State's land area. See Appendix C for a map of Idaho's population distribution. Residents of these counties generally receive their care through small physician practices or solo practices. The State's 12 non-profit FQHCs and 1 FQHC "look alike," located in 37 counties, expand the choice of care for Idahoans in rural and medically underserved areas and function as a critical care provider for the uninsured. As in many rural states, Idaho's public health system also plays a critical role as a service provider. Direct services offered by the 7 local public health districts range from community and home health nursing to dental hygiene and nutrition.

Idaho has five large population centers: Boise (population 205,000), Nampa (81,000), Meridian (75,000), Idaho Falls (56,000), and Pocatello (54,000) and seven additional cities with population sizes ranging from 20,000 to 50,000. Idahoans living in these cities have a greater choice in care than their rural neighbors. Choice in care ranges from large private healthcare systems, such as St. Luke's and Saint Alphonsus health systems, to smaller physician practices. Large private healthcare systems, which group together networks of hospital facilities and outpatient clinics, are becoming increasingly prevalent in Idaho.

The Idaho health care delivery system is challenged by a shortage of primary care providers and large rural areas that limit accessibility. These obstacles, which have impeded the development of an integrated health care delivery system, have also been a source of innovation. The independent primary care providers in solo and group practices by necessity have used limited resources to deliver evidenced based care and begin the transition to patient centered medical homes. For example, Dr. Keith Davis is the sole physician in Lincoln County, Idaho — an area about the size of Rhode Island with a population of more than 5,000. It is hard to find a health care program in the community that has not been impacted by Dr. Davis. In addition to running the Shoshone Family Medical Center, Dr. Davis is the medical director of a local hospice, the county coroner, an ER physician at St. Luke's Jerome Medical Center, and the emergency medical services director for Lincoln and nearby Jerome counties. To help meet the needs of the community, Dr. Davis has brought additional patient-centered medical services into Lincoln County. He hired two licensed clinical social workers to provide behavioral health services to county residents. He has also expanded his practice to offer patients an American Diabetes Association-recognized diabetes education program. Dr. Davis's office uses electronic medical records, maintains an active internet site where patients can access their health information, and employs a nurse practitioner to expand access to care. Dr. Davis was recently named the American Academy of Family Physicians' Family Physician of the Year.

Current Provider Models

- Large public provider systems, such as the Veteran's Affairs (VA) system.
- Large private healthcare systems, such as the St. Luke's and Saint Alphonsus systems.
- Group physician practices.
- Solo physician practices.
- 13 community health centers.
- 44 rural health clinics (RHCs).
- Indian Health Services and tribal health programs.

Contributing significantly to the health of Idahoans is Idaho's commercial payers, as over half of Idahoans

are covered through commercial plans. The top three commercial payers are Blue Cross of Idaho, Regence BlueShield of Idaho (Regence), and PacificSource Health Plan Group (PacificSource). In 2011, these three payers accounted for approximately 92% of the individual market, 95% of the small group market, and 97% of the large group market. Both Medicaid and Medicare play a major role in the current Idaho health market, with Medicare beneficiaries representing about 15% of the State's population and another almost 15% enrolled in Idaho Medicaid/Children's Health Insurance Program (CHIP).

Further description of the current healthcare delivery system can be found in Appendix D.

Today, the patient's experience of care, which plays such a critical role in patient wellness in terms of prevention, diagnosis, and treatment adherence, is not always positive in Idaho, particularly in rural areas. Based on stakeholder engagement and focus groups throughout the SHIP model design process, consumers have articulated several recurring themes about today's patient experience. Stakeholders reported lack of provider choices, especially in the areas of behavioral health providers and diagnostic technologies, as well as limited provider use of HIT tools, such as patient portals, that facilitate patient access to health information. Stakeholders also reported primary care providers being rushed or overloaded and not spending enough time with their patients, challenges in accessing specialty care including out-of-state travel in many situations, and limited primary care after-hours access.

In many situations, responsibility has fallen on the patient to coordinate their own care. Often, the integration of specialist and ancillary care depends on the patient's own ability to effectively understand and navigate the health care system to find providers, obtain referrals for services, and share information among providers in their care team. However the patient cannot always be the best advocate, and often patients receive the wrong care at the wrong place at the wrong time, which can lead to unnecessary services and cost, or, worse, overall decline in health status.

Current Public Behavioral Health Model

Idaho is actively working to build a more integrated behavioral health system that coordinates mental health and substance abuse services and integrates these services to a greater degree into physical health care models. While significant strides have been made, integration of behavioral health into the physical health arena is extremely limited in Idaho and is an area for continued collaboration and focus.

Behavioral health services are available for Idaho Medicaid participants through a Section 1915(b) waiver that authorizes the Idaho Behavioral Health Plan (IBHP), which was implemented September 1, 2013.

Idaho contracts on a capitated basis with a single, statewide managed care entity, Optum Heath, to administer behavioral health services to eligible Medicaid members. The contractor provides behavioral health services, including outpatient community-based mental health services, substance use disorder treatment, and case management services to children with serious emotional disturbance (SED), adults with serious mental illness (SMI), as well as any adults or children who have symptoms of mental illness. The contractor will begin offering three new services: peer support services, family support services, and community transition support services in approximately February, 2014. The IBHP contract includes financial incentives for the stabilization and reduction of inpatient hospitalization costs.

The Children's Mental Health (CMH) program is a developing partnership of community-based systems of care for children with a SED and their families.[2] While most children in the CMH program are served by private providers reimbursed through Medicaid, the CMH program enhances the private network with crisis intervention, case management, and other supports that increase the capacity for children with SED and their families to live, work, learn, and participate fully in their communities.

Idaho also provides State-funded and State-operated voluntary outpatient mental health services for adults with severe and persistent mental illness (SPMI) through regional mental health centers (RMHCs). RMHCs, which are located in each of the seven health districts, provide mental health services through a system of care that is both community-based and consumer-guided. Adult outpatient services for eligible individuals include: crisis screening and intervention, psychiatric clinical services, case management, individual and group therapy, psychosocial rehabilitation, assertive community treatment, patient assistance program, benefit assistance, co-occurring disorders treatment, pharmacological education, and short-term mental health intervention. Community health centers also offer limited behavioral health services, though a common practice is to refer more complicated cases to the RMHCs.

Inpatient services are offered through community psychiatric hospitals and state psychiatric facilities. There are two state psychiatric facilities in Idaho, one in the northern and one in the southern parts of the State. State Hospital North is a 55-bed adult psychiatric facility, while State Hospital South has 90 adult psychiatric beds, 29 skilled nursing beds, and 16 beds for adolescents. These state facilities, which only accept involuntary admissions, run at capacity most of the time. Unfortunately, many Idahoans in need of behavioral health inpatient services must receive their care through facilities far from home, which isolates them from their support systems and community services that are crucial for recovery.

The Idaho State Planning Council on Mental Health was established in 1990 by Executive Order of the Governor and pursuant to Public Law 102-321. The functions of the Planning Council are to advocate for children and adults with mental health issues; advise the State Mental Health Authority on issues of concern, policies and programs; provide guidance in the development and implementation of the State Mental Health Systems Plan; monitor and evaluate the allocation and adequacy of mental health services within the State, and serve as a vehicle for intra and inter-agency policy and program development.

At the local level, regional mental health boards oversee the activities of the regional public behavioral health system and encourage inter-agency collaboration. The boards are comprised of county commissioners, law enforcement, consumer representatives, advocates or family members, IDHW employees representing the mental health system within the district, a physician or other licensed practitioner of the healing arts, a mental health service provider, a representative of a hospital within the region, and a member of the regional substance abuse advisory committee. A representative from each of the seven regional mental health boards is appointed to the State Planning Council. The role of the regional mental health boards is to advise the State Planning Council on local mental health needs and progress, assist and monitor the formulation of an operating policy for the regional services, interpret the regional mental health services to the citizens and agencies of the region as needed, collaborate with the regional substance abuse advisory committee, and promote improvements in the delivery of mental health services and coordinate/exchange information regarding mental health programs in the region.

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[2] IDHW Facts, Figures, and Trends Report 2012-2013, viewable at http://healthandwelfare.idaho.gov/Portals/0/AboutUs/Publications/FFT2012-2013LR.pdf

Idaho is actively working to improve coordination between mental health and substance abuse services. Currently, substance abuse services are offered through Idaho's 68 substance abuse providers who serve 132 locations throughout the State as well as 35 stand-alone recovery support service providers at 65 locations statewide. Substance abuse treatment services include detoxification, outpatient therapy, and residential treatment. Recovery support services include case management, family life skills, adult safe and sober housing, childcare, transportation, and drug testing. Specialized services are available for pregnant women, women with dependent children, and adolescents. Services are funded through Medicaid, other federal funds, and state funds.

Significant movement has been made in recent years towards using drug, mental health, and veteran's courts to provide substance use treatment to offenders as an alternative to other sentences, including incarceration. In SFY 2012, these courts offered community services and supervision to 2,216 felony, misdemeanor, and juvenile offenders.[3]

The efforts made in recent years to better coordinate and integrate services both within and between physical health and behavioral health delivery systems have played an important role in expanding awareness of the benefits of integrated care and has laid the groundwork for the design and implementation of the SHIP model presented here.

Bridge to Healthcare Delivery System Reform

In recent years, stakeholders in Idaho's healthcare system have made efforts to begin integrating the network concept into the delivery of better coordinated and more efficient and effective care. A key initiative is the Idaho Medical Home Collaborative (IMHC). The IMHC provides a springboard to the statewide, ambitious reform that Idaho will pursue through the SHIP.

Idaho Medical Home Collaborative

In January 2010, Governor Butch Otter established the IMHC to address gaps in the current healthcare delivery system. Recognizing the success of the patient-centered medical home model in delivering integrated, cost-effective care in other states, Governor Otter tasked the IMHC with developing recommendations regarding policies and activities needed to establish PCMHs in Idaho. The pilot launched on January 2, 2013, and 36 provider practices have agreed to achieve at least Level-1 PCMH recognition from the National Committee for Quality Assurance (NCQA) within the two years of the pilot. In order to track improved outcomes, practices that participate in the IMHC are required to build and maintain a patient disease registry and report data on a variety of measures regarding clinical quality, preventive quality, and practice transformation. All three of Idaho's major commercial payers (Blue Cross of Idaho, Regence, and PacificSource) as well as Idaho's Medicaid program participate in the IMHC pilot. The payers support the PCMHs through PMPM payments for patients who have specified chronic conditions (the payment amount and patient eligibility criteria vary by payer and are negotiated directly between the payers and the practices).

The IMHC has been successful not only in recruiting providers to transform their practices to a PCMH model, but importantly in bringing together a wide range of health system stakeholders around system transformation to create stronger, more integrated networks of care. This success provides a critical foundation that will enable stakeholders to continue to evolve the system from a FFS volume-driven model to a value-based, coordinated system of primary care where reimbursement is based on improved health outcomes for all Idahoans.

[3] "Smart Justice: Saving Prison Beds, Tax Dollars, and Lives." Report to Governor C.L. "Butch" Otter and the 1st Regular Session of the 62nd Idaho Legislature from the Idaho Judiciary.

Innovative and Visionary Primary Care Leaders

As noted earlier in describing the work and impact of Dr. Keith Davis, the innovation and success of the IMHC and other healthcare delivery system initiatives could not be achieved without the vision and dedication of Idaho's physicians working to rise above the challenges of rural, medically under-resourced communities. Dr. Scott Dunn, a member of a family practice group in a smaller community in northern Idaho, is another example of this leadership and dedication. As the co-chairman of the IMHC, he has led the collaboration of primary care physicians, private health insurers, healthcare organizations, and Idaho Medicaid to make recommendations to Governor Otter on the development, promotion, and implementation of a PCMH model of care statewide. Dr. Dunn's own practice utilizes electronic medical records, encourages patients to use a secure internet portal for accessing their health information, and as part of the clinic's transformation to a patient centered medical home, uses care plans for high risk patients.

Recognition of gaps in the delivery system and the need for better collaboration and integration has long existed among Idaho's healthcare practitioners. In 1994, the providers of the five north Idaho counties formed the North Idaho Health Network (NIHN).The NIHN is a nonprofit organization that collects member fees and manages risk-based shared-savings programs. Currently, more than 200 physicians located in five north Idaho counties participate in the network, which contracts with the largest commercial payers in Idaho. The NIHN is run by a Board of Directors, including community employer representatives, and has an executive director and medical director. A medical management team oversees clinical initiatives. The NIHN exemplifies the effective leadership of Idaho's healthcare community that has long existed within Idaho. Dr. Mike Dixon, NIHN Executive Director, shared his experience and lessons learned through the NIHN as he chaired the Network work group and provided leadership in the formation of the network model.

Another example of leadership that bridges the gap from the current system to more integrated and innovative care is the Primary Health Medical Group (PHMG), a predominantly primary care independent medical group in southwest Idaho that has over 250,000 patient visits a year. PHMG established "combination clinics" providing both family practice and urgent care at the same sites. Through this model, services are provided to over 8,000 Medicaid patients annually, enabling increased access to appropriate care and reducing emergency room visits. Unlike the traditional model, the urgent care and appointment providers work synergistically to address patient's episodic and chronic care needs. The efficiency of sharing resources and offering both services at one location ensures lower costs for the patient. With support of a grant from PacificSource, PHMG is providing "virtual" coordinated care for 2,000 adult diabetics and has data demonstrating improved compliance and better laboratory results. Primary Health Pediatric Clinic, currently attesting for level III NCQA patient centered medical home designation, is managing 400 asthmatic children with care plans, regular follow up, and coordinated care.

Impetus for Statewide Health Innovation

While efforts have been made to realign healthcare delivery systems in Idaho towards achieving the Triple Aim of quality care, improved health outcomes, and lowered costs, these initiatives are still smaller in scale. The majority of Idahoans still receive care through system models that are fragmented and misaligned to reward volume and the treatment of disease as opposed to rewarding value and the promotion of wellness. The gap analysis performed by the work groups revealed the need for solutions that engage patients to seek healthy behaviors, incentivize providers to partner with patients, help providers share healthcare data among all providers in the patient's care team, and hold all participants in the system accountable for improving patient outcomes and experience of care. The gap analysis identified the need to take bold steps towards aligning current systems — regardless of payer source or practice size — to deliver on a commitment to statewide health system transformation that will impact all Idahoans.

Stakeholder Model Design Deliberations on Future Healthcare Delivery System

Input from Tribal Health

Consideration of tribal communities' health needs and coordination with tribal health service providers was a discussion among stakeholders, in workgroups, and between IDHW and tribal leaders and representatives. Six tribes reside in Idaho: 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. In the model design phase of the SHIP, IDHW Director Richard Armstrong and Deputy Director Denise Chuckovich hosted an informational session for all tribes on the purpose of the SHIP and the process for its development. Following the informational session, each tribe received a letter from Director Armstrong inviting them to request a formal tribal consultation. A formal consultation was held with the Nez Perce tribe and a tribal townhall was held with Shoshone-Bannock tribal members and service providers on the Ft. Hall Indian Reservation. Tribes were also encouraged to participate in workgroups. Discussions with tribal community members and service providers, such as Indian Health Service (IHS) providers, focused on identifying tribal health needs and how the model could coordinate with and improve services provided to tribal members. Tribal representatives reported great difficulty in accessing adequate specialty services for their patients, in particular behavior health. Coordination of care with providers outside the tribal community can also be challenging, making it difficult for the primary care provider in the tribal health center or IHS to establish continuity in care for individuals with chronic or complex medical conditions. It was noted that it is important to include IHS and tribal health centers in improved communications across the medical neighborhoods in order to benefit tribal health members. Also, discussed was the need for telehealth expansion in order to increase access to specialty services, particularly behavioral health, for tribal members.

Input from Work Groups, Focus Groups and Townhall Meetings

The information gathered at the 44 focus group meetings and multiple townhall engagements, as well as the diligent work by four stakeholder work groups, all under the direction and leadership of the Steering Committee and its sponsors, has generated a model for healthcare delivery that truly reflects the sentiment and solutions of Idaho. Some examples of the discussions and recommendations of stakeholders that led to the development of the delivery system design are noted below. The full deliberations among this broad group of stakeholders over the course of months are documented on Idaho's SHIP website (www.idahoshipproject.dhw.idaho.gov).

The importance of a patient-centered model was a topic of significant discussion in Network work group meetings and focus groups held throughout the State. Stakeholders uniformly agreed that Idaho needs a model that is responsive to the individual's complete health needs and engages the individual to fully participate in healthcare and wellness activities. Patient engagement at the practice level was identified by stakeholders as being vital to improving health status and increasing compliance with care plans. They stressed that physician practices should offer patients the tools and education they need to take care of themselves. The Network work group suggested expanding patient engagement techniques that Idaho physician practices, payers, and employers are already using to varying degrees such as: having a patient portal where patients can access their health information, using motivational interviewing techniques with patients to engage them in creating a realistic and manageable care plan, and providing patients access to wellness programs and chronic disease self-management programs. Some stakeholders, including members of the Network and Multi-Payer work groups, also suggested using financial incentives for patients based on changes in behaviors and outcomes (e.g., premium reductions).

The Network and CQI work groups considered methods for achieving greater coordination between healthcare providers, public health authorities, community services and supports, and patients in the new system. Referring to this larger network as the "medical neighborhood", work group members agreed that promoting integration and collaboration between providers, patients and community-level resources and supports should be one of the model's guiding principles. Work group members also agreed that public health authorities are valuable resources in Idaho because they are aware of community health needs, have working relationships with stakeholders, and are familiar with the community's strengths and weaknesses. To promote collaboration, it was recommended that the IHC and RC work with public health to conduct community assessments, using the tool currently used by public health, the CDC's Community Health Assessment tool. At the RC level, the representatives of the local provider community, community organizations and public health authorities will collaborate in reviewing community health needs assessments, reporting to the IHC on local PCMH and public health activities, and advising the IHC on how to improve collaboration at the State and regional levels.

Integration of physical and behavioral health was also identified by Network work group members and stakeholders as necessary to better identify and respond to patients' needs. Valuing the independence and autonomy of providers, particularly in rural areas of the State, stakeholders did not recommend mandating integration but encouraging better coordination and eventual integration through the use of behavioral health screening tools and increased access to behavioral health specialists at the local level through improved care coordination.

The Clinical Quality Improvement (CQI) work group proposed that the public health infrastructure be utilized as the framework for the regional networks. It was noted that there is a history and inclination of public health entities to work with other public entities, private agencies, and not-for-profit organizations, which supports the goals of the SHIP, enhances the creation of PCMHs and the delivery and coordination of healthcare services. However, after discussion at the Steering Committee level, it was decided that the RCs are best constructed as extensions of the IHC in order to quickly implement the model and promote consistency across the State.

In every stakeholder discussion, the issue of Idaho's healthcare workforce shortage emerged as a significant problem. Across all stakeholder types, it was understood that the healthcare delivery model must be supported by strategies to expand the workforce but yet be a model that can work within the current capacity of the workforce. The Network work group identified the importance of aligning the workforce efforts implemented through the SHIP with work being done by the Idaho Health Professions Education Council, established by Governor Otter through executive order in 2009. The Council has been working to develop healthcare workforce objectives for the State and recommend strategies to address healthcare shortage across a range of professions.[4] The Network work group recommended that many of the Council's recommendations be incorporated into the Idaho SHIP strategies for workforce improvement, including expanding family medicine residency slots in rural track programs, expanding existing loan repayment programs, establishing preceptor programs to increase specialty training for primary care physicians (PCPs) in medically under-served areas, and expanding training programs for mid-level support practitioners.

The Network work group considered several methods for improving Idaho's PCP workforce beyond the Council's recommendations. Incorporated in the SHIP is the Network work group's recommendation that "virtual patient-centered medical homes" be developed in communities without the resources to perform all the functions of a PCMH. The virtual PCMHs, as later described

[4] Idaho Health Professions Education Council, 2013 Annual Report to Governor C. L. "Butch" Otter, submitted August 13, 2013 available at http://gov.idaho.gov/HealthCare/PDF/2013%20IHPEC%20Annual%20Report.pdf

in this document (page 26), would use CHWs and community emergency medicine personnel to perform many key functions of a PCMH in workforce shortage areas.

Of great concern to stakeholders was the lack of behavioral health professionals. The entire State of Idaho is a federally-recognized health professional shortage area for behavioral health providers. Stakeholders recommended expanding telehealth technologies across the board, but particularly for the purpose of increasing access to behavioral health services. Specific telehealth activities are described in Section 5.

Many of the PCMH model components will be new functions for the majority of Idaho's physician practices. All four work groups were concerned about providers' willingness to incorporate many of these functions into their practice due to the associated costs and the fact that physicians are already overworked and under-resourced. Workgroup members considered whether policies mandating some key functions, in particular EHR utilization, patient registries, data collection and performance reporting, should be pursued. However, it was recognized that mandates would be unsuccessful in Idaho and that more important would be the provision of statewide and local supports and resources to assist practices in the transformation process. As such, the IHC and RCs were recommended as key structures for providing critical supports needed to implement and sustain the model.

More information regarding stakeholder deliberations regarding specific components of the existing and future models can be found throughout the SHIP.

Future Healthcare Delivery System Model

Idaho will transform its healthcare delivery system from a disease-focused, volume-driven model to a value-based model that builds a system of primary care upon the foundation of the PCMH model. PCMHs will be integrated with the larger healthcare delivery system through coordinated care between the PCMH and specialist and ancillary providers as well as collaborative quality improvement efforts at the regional level to improve health outcomes. Idaho's model will be patient-centered, delivering care that is individualized, culturally sensitive, and responsive to the patient's needs. Services delivered through the model will include the full range of primary care services for all age groups, across multiple payers, and will include, but not be limited to, prevention and wellness activities, routine healthcare services and evidence-based care of chronic and complex conditions. PCMHs will deliver team-based, coordinated care using advanced HIT to increase efficient and timely communications and appropriate data sharing. Performance targets will be established and monitored across PCMHs, regions and statewide. Payment methodologies will align with the value-driven goals of the model, and include quality and performance incentives and shared savings.

Idaho's vision for a patient-centered, value-driven model of healthcare is rooted in supporting primary care practices in becoming PCMHs. The transformation of primary care practices to the PCMH model will be supported and facilitated by a new statewide entity, the Idaho Healthcare Coalition (IHC). The IHC will be established as an independent non-profit organization with a Board of Directors to whom IHC staff will be accountable. The role of the IHC will be to facilitate and incentivize transformation and provide necessary tools, resources, and performance monitoring to achieve the goals of the model. The IHC will establish support at the local level through regional collaboratives (RCs). Given Idaho's diverse geographic differences, it is expected that the levels and types of assistance required by primary care practices will vary. The RCs will be responsible for helping primary care practices identify gaps in their practice and providing the assistance needed to facilitate the transformation process. RCs will also assist established PCMHs' as they endeavor to enhance their capacity within the model.

The model will be implemented statewide, with all regions beginning implementation activities at the onset of the model testing phase. The model's impact will extend, to varying degrees, to all healthcare providers, e.g., primary care providers, specialists, practitioners across all disciplines, hospitals, FQHCs, rural health clinics, etc.

The delivery of care through the team-based PCMH model will maximize the use of the State's limited healthcare workforce. Through the use of multi-disciplinary teams in the PCMH, the model will compensate, in part, for the shortage of healthcare providers by allowing each team member to practice at the top of their license and achieve efficiencies by delivering care at the appropriate level. In other words, physicians will be able to focus their time on clinical care requiring physician-level assessment and practice while other staff, i.e., nurses, CHWs, medical assistants, etc., provide care within the appropriate framework of their scope of practice. Additionally, the model encourages sharing of resources across PCMHs, which generates efficiencies in the system, and establishes RCs to help PCMHs initiate and support efficient sharing of resources. More information regarding workforce development strategies in Idaho's SHIP can be found in Section 4.

Idaho's model adopts some of the core components and lessons learned from Community Care of North Carolina (CCNC). However, Idaho's model goes beyond the CCNC model to include all patients, not just Medicaid participants or those with chronic conditions or complex health needs. Idaho's model spans multiple payers as the PCMHs will serve patients across Medicaid, Medicare, and commercial insurers. As a result, it is most important that three major commercial payers, Blue Cross of Idaho, Regence Blue Shield of Idaho, and PacificSource, have participated in developing the model and are strong partners in Idaho's SHIP. The cooperation and participation of other payers, such as smaller insurers, self-funded plans, hospitals, and FQHCs is also recognized as vital to the successful adoption of the model throughout the State.

The three levels of the stakeholder designed delivery system model, i.e., PCMHs, the RCs and the IHC, are discussed in detail in the following section. In addition, the role of IDHW in model implementation is also discussed as IDHW is the single State authority of the Medicaid program and potential grant administrator for model testing.

Idaho's Patient-Centered Medical Homes

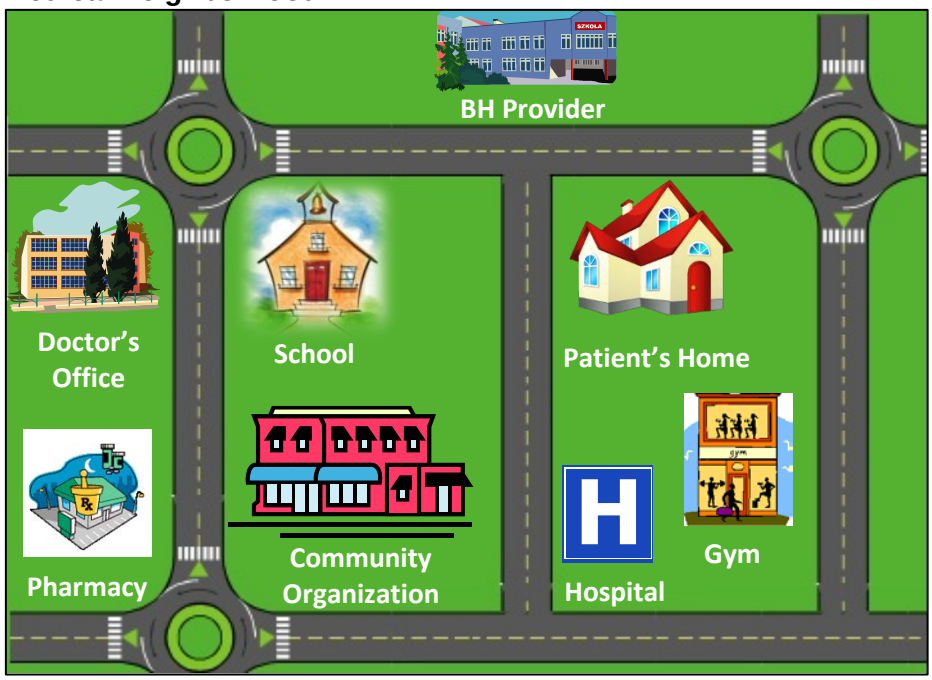
In Idaho's new model, PCMHs will be the vehicle by which primary care services are delivered, establishing patient-centered healthcare as the foundation of the State's delivery system. Equally important is the role PCMHs will play in moving Idaho's healthcare delivery system from its current fragmented, siloed approach to a cohesive healthcare system of coordinated services.

Clinical leadership of the PCMH will be provided by a physician, nurse practitioner, or physician assistant under appropriate supervision by a physician. As noted elsewhere in this SHIP, Idaho is a workforce shortage area. To support the expansion of a coordinated, team-based primary care system within a PCMH, Idaho proposes to pursue several strategies to expand the State's healthcare workforce, as described in Section 4.

Idaho recognizes that one's health is greatly impacted by factors beyond medical services, notably culture, lifestyle, nutrition and socio-economic factors. As such, the model acknowledges the importance of the medical neighborhood, which includes community services and supports, hospitals, specialty services, behavioral health, public health, long term services and supports and other organizations. The model requires that linkages and coordination of services occur across the medical neighborhood in order to establish and maintain shared knowledge of the "complete picture" of the individual's health status and care across all service providers. The PCMH will be

responsible for establishing formal communication protocols with other service providers and organizations within the medical neighborhood, and will be supported in this effort by the RCs. Coordination of care will occur with all existing service delivery systems in the State that are involved in the care of patients enrolled within the PCMH, including the VA system, tribal clinics, IHS, public health clinics, behavioral health centers, school-based services, and long term service and support providers. Clinical care coordination will be performed by a variety of different practitioners, including registered nurses, social workers, licensed advanced practice nurses, etc.

Medical Neighborhood



HIT is a critical component of the model. At the PCMH level, as a requirement of PCMH accreditation, practices will use EHRs and patient portals to centralize health data, share appropriate health information with other care providers to coordinate care and allow efficient, timely communications in urgent situations, and provide patients with tools and information needed to engage in effective self-management. PCMHs will also use clinical decision-support tools to expand evidence-based practices, reduce medical errors, and promote good health. By the end of the five-year project period, Idaho intends to have every PCMH using HIT to support efficient and effective care coordination and communications.

Key Functions of the PCMH

The key functions of the PCMH will be to:

- Implement evidence-based practice guidelines for clinical care and demonstrate performance on identified measures.

- Provide screening for physical and behavioral health needs and refer as appropriate.

- Develop a comprehensive care plan for patients based on a comprehensive assessment. The PCMH will plan and deliver care that is based on a holistic and comprehensive assessment of the person's health needs, and that is respectful of the person's culture, preferences, and shared decision-making responsibilities.

- Coordinate the delivery of care with the patient and his/her specialty providers and organizations in the patient's medical neighborhood to ensure a coordinated and patient-centered delivery plan.

- Identify and collaborate with community resources.

- Implement strategies to enhance patient engagement and active participation in health and wellness.

- Implement quality improvement activities that address local needs, as well as provide information needed for regional and statewide performance measurement reporting.

- Maintain a central registry or database containing all pertinent patient medical home information.

- Effectively use certified EHRs to support the delivery of care.

- Communicate with patients across multiple formats, e.g., email, telephonic consultation, and follow-up.

- Submit performance data to the IHC and/or its data and evaluation subcontractors. The PCMH will work with the RCs and the IHC to examine and use data to drive quality improvement.

- Utilize decision support tools in the provision of care, e.g., clinical guidelines, condition-specific order sets, diagnostic support, computerized alerts of reminders of care, etc.

- Arrange for the provision of 24/7 care for patients enrolled in the PCMH. Care may be provided through the medical neighborhood instead of by the PCMH itself. However, the PCMH must both arrange the 24/7 hour care and ensure that the emergency department is not the only option for after-hours care.

In recognition of the challenges that practices will face in assembling the resources needed to perform as a PCMH, Idaho has included in its model the establishment of a statewide IHC and RCs to support practices in the transformation process and provide ongoing assistance to functioning PCMHs. The support at both the regional and State level is critical to assuring successful transformation throughout Idaho and the delivery of care to 80% of the state's population through this model.

Virtual Patient-Centered Medical Homes

To build a robust primary care system based on the PCMH model in Idaho, the State must look beyond traditional practitioners, e.g., physicians, nurses, etc., as the primary care team, given that many communities lack primary care practices with the resources to provide team-based care with all the functions of a PCMH as listed above. 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.

In developing the concept of a virtual PCMH, Idaho reviewed existing Idaho-based models and researched and reviewed efforts of other states and nations to establish primary care systems in

rural and underserved areas. In Alaska, California, and many areas around the world, CHWs are a key contributor to an effective primary care extension system. Recently, the Annals of Internal Medicine published the results of a study that concluded that adding "care guides to the primary care team can improve care for some patients with chronic disease at low cost."[5] A September 2013 article in the New England Journal of Medicine discussed three models for organizing CHWs in the healthcare system: (1) as extensions of the hospital or clinic system to provide clinical services most generally for individuals with a chronic disease; (2) perform health educational activities and outreach, e.g. nutrition, diabetes, and behavioral health, as part of a community-based nonprofit organization; and (3) work as part of an organization of CHWs integrated with clinical and community organizations to perform various activities, such as increase self-management support in community settings, assist primary care coordination for chronic conditions, etc.[6] Regardless of the model used to develop and integrate CHWs in the healthcare system, Idaho recognizes that CHWs can play a vital role in improving population health across underserved areas.

At least two counties in Idaho (Bonner and Ada counties) have community health EMS/Community paramedic programs. In this model, EMS personnel function outside their usual roles of emergency response and transport to increase access to primary care in medically underserved communities, provide in-home monitoring or follow up, and/or facilitate reductions in inappropriate or overuse of EDs. For example, in Bonner County,[7] community EMS personnel provide preventive medical care in the home when other in-home providers are not present due to cost or availability. Bonner County community EMS personnel also work in conjunction with the patient's physician and other healthcare providers as a team to provide health education and disease management and monitoring of chronic conditions in their home.

Some of the initiatives of the Ada County Community Paramedic Program[8] include the Community Paramedic System Wide Field Referral Program. This program was designed to give Ada County paramedics and area fire department personnel the opportunity to refer patients to a program where the community paramedic may be able to assist with patient care coordination. This care coordination includes home environment and fall risk assessment, medication education, and assisting the patient in finding a PCP. The care coordination also includes information about area resources ranging from mental health programs to dental and nutritional programs. Ada County community paramedics have also partnered with several healthcare providers on pilot programs for in-home patient follow up with specific patient types. This follow up includes physical assessment, disease and medication education and management, home environment assessment, and assisting the patient in actively managing his/her own healthcare. In Ada County's 911 Community Paramedic program, the community paramedic is functioning within the 911 setting as a single person emergency response unit. On low acuity call types, the community paramedic arrives on scene with the responding paramedic unit. Depending on the patient complaint and resulting paramedic assessment, the community paramedic releases the 911 ambulance crew back into service, and the community paramedic stays on scene with the patient and coordinates alternate transport to a more appropriate healthcare facility such as an urgent care clinic. The community paramedic works with the patient's PCP in setting up a care plan in combination with clinic visits.

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[5] Adair, Richard, M.D., et al. "Improving Chronic Disease Care by Adding Laypersons to the Primary Care Team" Annual of Internal Medicine, 159(3): 176-184, August 2013.

[6] Singh, PraBehavioral healthjot, M.D. et al. "Community Health Workers – A Local Solution to a Global Problem" New England Journal of Medicine, 369: 894-896, September 5, 2013.

[7] http://www.bonnerems.com/wp-content/uploads/PDF%20and%20documents/StrategicPlanNarrative2013DRAFT03-07-2013_000.pdf

[8] http://healthandwelfare.idaho.gov/Medical/EmergencyMedicalServicesHome/CommitteesandWorkingGroups/CommunityHealthEMS/tabid/2179/Default.aspx

The IHC will build off the Bonner and Ada county programs, as well as that of other states, to encourage the development of CHWs and community health EMS personnel/community paramedics as part of PCMH team-based care in rural, medically-underserved communities. The IHC will partner with local experts to train CHWs and community health EMS personnel/community paramedics to provide healthcare services in response to identified community needs. CHWs' activities are likely to include providing health education to individuals with chronic conditions, performing protocol-driven early risk detection or providing primary care coordination. Community health EMS personnel/community paramedics may provide home checks following hospital discharge and for individuals at risk for hospitalization, provide mobile immunizations, and/or be trained to assess and divert to appropriate care instead of transporting to the ED. The actual services provided by CHWs and community health EMS in a particular community/region will be determined by local needs as identified through community health assessments and/or by regional/community clinical data.

CHWs and community health EMS personnel/community paramedics will receive training through the IHC using a variety of training methods, including videoconference technology. Training will be conducted by subject matter experts on topics such as preventive medicine, diabetes management, and patient-assessment skills.

Similar to New Mexico's Project ECHO (Extension for Community Healthcare Outcomes), Idaho will use telehealth technology to increase the trained workforce in underserved areas across the range of primary care and associated health professions that will comprise the virtual PCMHs. As described in Section 5, the IHC will work with Idaho's Telehealth Task Force to expand telehealth capacity in the State. Partnerships with community, county, and State organizations with videoconference technology will be facilitated by the RCs to provide access to telehealth training. The IHC will work with the Idaho Area Health Education Center (AHEC) and the RCs to identify healthcare experts to provide training in response to community needs.

RCs will work with communities to determine the need for a virtual PCMH within the region. Community needs assessments and clinical data will be used to determine service gaps in the community and determine the role of the CHWs and community health EMS personnel/community paramedics in the virtual PCMHs.

Further development of the model will be developed by the IHC with stakeholder input.

Integrating Behavioral Health into Patient-Centered Medical Homes

Idaho recognizes the critical importance of integrating behavioral health into the PCMH model in order to increase quality of life and life expectancy for individuals with behavioral health conditions. The 2011 Idaho State Planning Council on Mental Health Report suggested adaptation of SAMHSA's 10x10 wellness campaign in Idaho to reduce deaths and improve life expectancy among individuals with mental health and substance abuse conditions by 10 years, in 10 years. This cannot be accomplished without primary care integration to assist the behavioral health community in prevention and treatment of associated co-morbid chronic behavioral health and medical conditions.

Successful integration of behavioral health into the PCMH model will require practices to implement 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.[9] Idaho's PCMH model will support practices in implementing these strategies through technical assistance around any needed practice transformations, identifying and sharing community resources, aligned payment incentives and strong monitoring by the IHC and its RCs.

The IHC will establish a behavioral health committee during the early days of its formation in order to develop further the strategy for behavioral health integration in the PCMH model. The behavioral health committee will be tasked with identifying evidence-based screening tools appropriate for use in the PCMH setting. The RCs will then work with the PCMHs to incorporate use of these tools in the practice. The behavioral health committee also will examine tested local and national evidence-based practices and select models that are most likely to be effectively adopted by Idaho practitioners. Training on selected models will be offered to PCMH providers.

The behavioral health committee will consider lessons learned from two models that have been effectively integrated with the physical health delivery system in Idaho and have shown promising outcomes. The first is the Integrated Outpatient Care Program (IOCP) model which is currently established in Idaho through Regence BlueShield of Idaho.[10] Regence participated in a pilot program in Puget Sound, and, as a result of the pilot, expanded IOCP to other service areas, has helped shepherd the use of IOCP with sister Blue Cross Blue Shield plans throughout the country, and has advocated for use of the program nationwide. The IOCP is one of the few programs to show improvements in not only cost, but functional scores in those with chronic illness – including mental health.[11]

The second model the IHC's behavioral health committee will consider is the IMPACT model, a collaborative, stepped-care management intervention for depression and anxiety used in a wide range of primary care practices.[12] The IMPACT model is established in Idaho through a grant from the John A. Hartford Foundation to expand IMPACT depression care model into western states and Alaska. The IMPACT model has shown that at 12 months, 50% of clients reported at least a 50% reduction in depressive symptoms, compared with only 19% of those in usual care.[13] A four-year study examined healthcare costs and found that IMPACT resulted in substantial savings compared with usual care. IMPACT participants had lower mean healthcare costs per patient ($29,422) compared with usual care per patient ($32,785), representing a cost savings of $3,363 per patient during the study.

The IMPACT program offers practices onsite and online training on topics such as systematic diagnosis, stepped care, and monitoring for success with validated tools. IMPACT participants also receive evidence-based treatment training on topics such as antidepressant medication adherence, referral to psychotherapy and how to improve the satisfaction of care.

Patient-Centered Medical Home Accreditation

Primary care practices will be accredited as a PCMH through a national accrediting body. The IHC will identify several national accrediting organizations from which PCMHs can choose to pursue

[9] C. Boult, G.Wieland, Comprehensive Primary Care for Older Patients with Multiple Chronic Conditions "Nobody Rushes You Through" JAMA. 2010;304(17):1936-1943
[10] See Regence's website at http://www.regence.com/about/awards.jsp
[11] A. Milstein, Are Higher-Value Care Models Replicable? Health Affairs November/December 2009 http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/
[12] IMPACT is a program of the University of Washington, Department of Psychiatry & Behavioral Sciences http://impact-uw.org/about/research.html
[13] J Unützer Collaborative Care Management of Late-Life Depression in the Primary Care Setting A Randomized Controlled Trial, *JAMA.* 2002;288(22):2836-2845.

accreditation. PCMHs will receive resources and supports to achieve accreditation and incentives to advance in accreditation levels as later described in this Section.

The IHC will establish a minimum set of core operational and staffing requirements that a primary care practice must attain in order to be designated as a PCMH. All primary care practices that desire to become PCMHs and be designated as such must meet the core minimum requirements of a PCMH. Designation as a PCMH may be obtained prior to achieving Level 1 PCMH accreditation, and will allow the receipt of PMPM payments to support care coordination and other functions of a PCMH.

Idaho recognizes that not all primary care practices may be able to achieve higher levels of accreditation because of the extreme resource-limited area in which they practice. For example, Lincoln County has one physician that serves the entire county. Because Idaho believes that the value-driven, coordinated care approach will improve the health of its residents, it chooses to make healthcare delivery system transformation available throughout all its communities. To achieve the larger goal of transformation and improved health outcomes, Idaho recognizes that there are unique differences between communities and that the model must include resources and supports to develop opportunities for all practices to transform. As such, all practices will be provided supports to be designated as a PCMH and delivery quality care, but not all PCMHs will be required to pursue higher levels of accreditation in order to participate in the model.

While advanced accreditation status may not be attainable by all PCMHs, the provision of high quality care through the PCMH is expected and established as a primary goal. Quality improvement initiatives and supports will be integrated into all levels of the model. The capacity to collect and report performance measurement data will be a core requirement to be designated as a PCMH. PCMHs will be required to implement quality initiatives to improve practice performance, manage population health, and improve health outcomes. PCMHs will be offered technical assistance from quality improvement experts, provided through either the IHC or the RC, to help the PCMH attain the highest level of quality care.

Idaho Healthcare Coalition

Idaho will develop an independent non-profit organization with responsibility for supporting and overseeing system implementation and population management statewide, including supporting physician practices in all stages of PCMH development, facilitating the expansion of evidence-based practices, measuring and improving population health, and advancing coordination with medical neighborhoods, including hospitals, specialists, behavioral health, tribal/IHS programs, long term care providers, and social service organizations. The Idaho Healthcare Coalition (IHC) will establish RCs to provide supports at the local level in addition to those provided by the statewide IHC.

The role of the IHC and its RCs is critical to ensure consistency and accountability for performance and providing technical assistance and resources to improve the quality of care and the population's health throughout the State. Due to the current lack of performance reporting across payers and populations in the State, an initial priority for the IHC will be to establish baseline data for statewide population health management. An external organization will assist the IHC in collecting baseline data in Year 1. The IHC will also obtain the services of quality experts to provide training and technical assistance to practices so they can begin data reporting on statewide metrics in Year 2.

The IHC will partner with Idaho's Health Quality Planning Commission (HQPC) in the pursuit of improved health outcomes. The HQPC was established by legislation to "promote improved quality

of care and improved health outcomes through investment in HIT and in patient safety and quality initiatives in the State of Idaho."[14] The Commission, whose membership is appointed by the Governor, will have representation on the IHC's Board of Directors to facilitate the development of strategies to identify and measure the quality of care delivered by the PCMHs. The goals of this partnership will be to advance the development of technology and information sharing that supports the PCMH model, and to partner on quality initiatives that address the health and safety needs of the citizens of Idaho by promoting participation in the PCMH model.

The HQPC is charged with performing the following duties:

1. Monitor the effectiveness of the IHDE.

2. Make recommendations to the legislature and the department on opportunities to improve the capabilities of HIT in the State.

3. Analyze existing clinical quality assurance and patient safety standards and reporting.

4. Identify best practices in clinical quality assurance and patient safety standards and reporting.

5. Recommend a mechanism or mechanisms for the uniform adoption of certain best practices in clinical quality assurance and patient safety standards and reporting including, but not limited to, the creation of regulatory standards.

6. Monitor and report appropriate indicators of quality and patient safety.

7. Recommend a sustainable structure for leadership of ongoing clinical quality and patient safety reporting in Idaho.

8. Recommend a mechanism or mechanisms to promote public understanding of provider achievement of clinical quality and patient safety standards.[15]

The IHC's role and functions will change as the model is established throughout Idaho. Initially the core functions of the IHC will be to support and oversee statewide transformation of the delivery system, which includes facilitating practice transformation to the PCMH model through technical assistance and resources, initiating performance reporting and population health management, and working with payers to achieve payment reform that supports the PCMH model. After the model has been fully implemented and primary care is delivered predominantly through the PCMH model, the IHC will shift its primary focus from facilitating practice transformation to quality and population health management. The IHC will maintain and update the Performance Measure Catalog, adding new measures and adjusting targets to continuously improve the population's health. Using performance reported data and community health needs assessments, the IHC will provide feedback to PCMHs and regions on performance and assist them in identifying and implementing appropriate quality improvement activities. The IHC will continue to serve as a vehicle for spreading best practices through learning collaboratives, trainings and other forums. Lastly, the IHC will work closely with payers so that clinical practice, performance targets and payment methods within the model align with the goals of payers.

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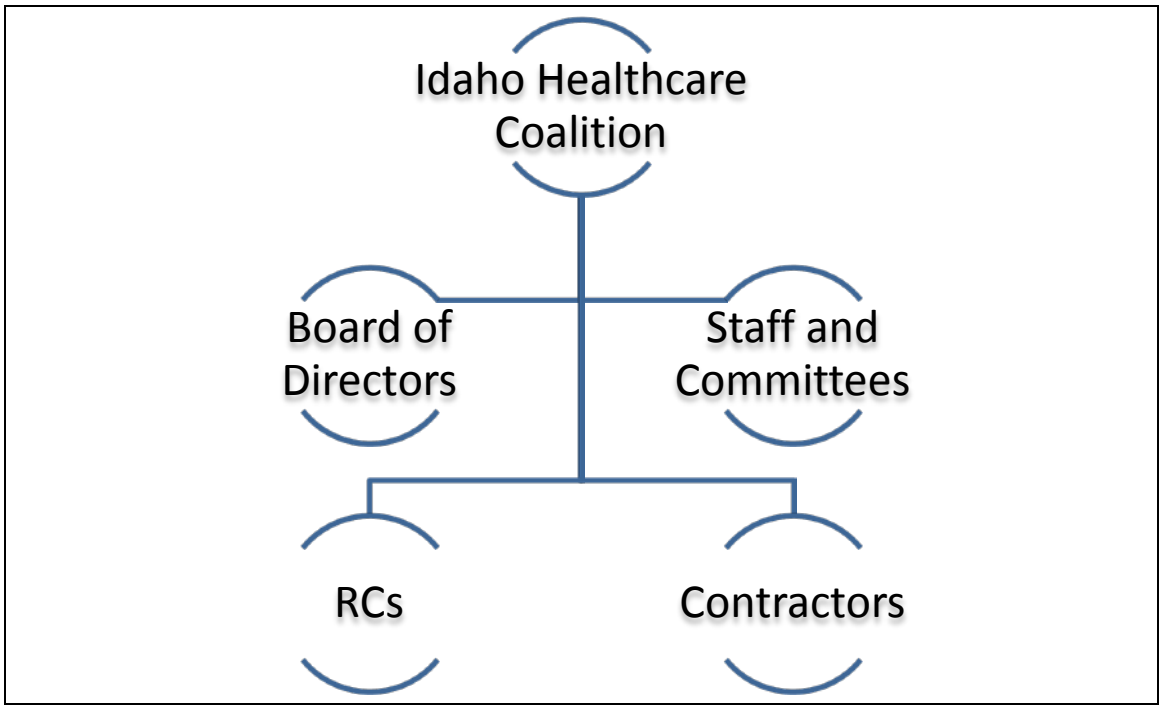
[14] Idaho House Bill 494, 2010 Legislature.

[15] Idaho Code §56-1054



In sum, the functions of the IHC include:

- Provide ongoing support, encouragement and consultation to practices endeavoring to transform to a PCMH, both directly and through the IHC's RCs. Examples of assistance include:
  - Assisting PCMHs in identifying strategies and resources needed to sustain practice changes.
  - Facilitating resources needed across the various levels of the model to achieve transformation goals.
  - Facilitating spread of best practices.
  - Providing education and technical assistance on data collection methods and performance reporting.
  - Providing training and support in the establishment of patient registries and the adoption and utilization of HIT tools, (e.g. EHRs, patient portals).

- Administer and monitor funding to assist PCPs with up-front costs of implementing the PCMH model.

- Develop basic core requirements for designation as a PCMH, assess practices' fulfillment of the requirements and designate practices that meet the core requirements as PCMHs. Practices designated as a PCMH must obtain at least Level 1 PCMH accreditation from a national accrediting body within a timeframe to be established by the IHC.

- Identify national accreditation organizations which will be recognized as accrediting bodies within the model. Provide technical assistance, supports and resources to practices as they work to achieve PCMH accreditation. Provide incentives to PCMHs to advance in accreditation levels.

- Develop statewide baseline data on the measures that comprise Idaho's Performance Measure Catalog (further described in this section) and set statewide performance targets.

- Evaluate performance measures at the state, regional and PCMH level. Provide feedback to PCMHs and RCs on performance trends and facilitate the implementation of quality initiatives to improve performance and health outcomes.

- Partner with State and local public health districts to conduct, review, and analyze the results of the regional community needs assessments (using the CDC Community Health Assessment and Group Evaluation tool) and work with the RCs to implement activities to target improvement in identified areas of need.

- Recruit practitioner and medical neighborhood participation in the model through physician and community educational materials and other educational forums. Work with payers, provider associations, State agencies, community-based organizations and others to facilitate understanding and expansion of the model.

- Convene payers to establish parameters for components of the payment arrangement, including patient population risk stratification and patient attribution.

With the evolution of the IHC's responsibilities over time and the need to operationalize the IHC quickly in order to enter the model testing phase, the IHC must have the flexibility to hire staff quickly and provide resources and supports in response to the needs of practices, medical neighborhoods, and regional networks. Stakeholders recommended that the IHC not be established as a governmental or quasi-governmental entity in order to allow the organization the flexibility and responsiveness that the growing system will demand.

Idaho's commitment to healthcare system reform is evident in the decision of the SHIP Steering Committee to continue its work to further refine the model and prepare for its implementation. The Steering Committee has identified several tasks that need to occur prior to the model testing period, including establishing the IHC and developing an initial IHC staffing plan, to be finalized by the IHC's Board of Directors. Key initial positions are likely to include an executive clinical director, staff with expertise in quality, information management, and finance, and regional collaborative staff. Due to the potential for the IHC's staffing needs to change over time, some key functions of the IHC will be initially fulfilled through contractual arrangements with technical experts in the areas of quality, data management, and clinical care. The IHC's staffing needs may change over time as its role changes in the developing system.

The SHIP Steering Committee will develop criteria and a process for the selection of the IHC Board of Directors and will oversee Board appointments. Under the direction of the Board, the IHC will establish a committee structure to research, evaluate, and make recommendations in targeted areas. Committees will advise in areas of behavioral health integration, quality improvement including performance evaluation and feedback, HIT standards and improvements, clinical care, evidence-based practices, and other key areas of focus related to advancement of the model and population health management.

Regional Collaboratives

The challenges that all primary care practices, but especially small practices, face in becoming a PCMH are well documented. Recent studies have shown that PCP practices transition to PCMH status more easily and more quickly when practice support tools are available close to the practice

level.[16] A wealth of research from the CCNC model and other similar models has also shown the value of building regional networks to support physician practices.

The IHC will establish RCs to provide support services to local practices endeavoring to become PCMHs and to existing PCMHs as they work to enhance their capacity to provide comprehensive, coordinated, high quality care. Lessons learned from the IMHC pilot identified the need for support at the local and regional level in addition to statewide oversight. Participating practices in the IMHC pilot receive technical assistance and guidance from the statewide collaborative but physician practices have no regional forum for navigating their local health system, sharing best practices, and collaborating with other practices that face similar challenges in their area. A key lesson learned from the IMHC is that support for practices is needed at the local level to achieve the greatest impact in an efficient manner.

The mission of the RCs is to help practices transform to the PCMH model and provide high quality care in an efficient and cost-effective manner through the model. The RCs will be a regional extension of the IHC and in this capacity will facilitate, at the local level, the integration of PCMHs in the larger healthcare system. RCs will play a critical role in establishing referral and communication protocols between the PCMH and other providers in the medical neighborhood, e.g., specialty care, hospitals, behavioral health, IHS and tribal programs, elder care services, social service organizations. RCs will also support public health and local organizations' efforts to assess the health needs of the community through the CDC's Community Health Assessment and Group Evaluation tool and provide a forum for sharing assessment results with PCMHs. The RCs will work with PCMHs and others in the community to implement activities in response to the identified health needs and support local innovation.

A key role for the RCs is assisting practices in implementing quality improvement initiatives. The focus of these initiatives will include activities to advance fulfillment of PCMH requirements, expand the use of evidence-based clinical care within the practice, improve performance in targeted areas, and implement activities and services in response to community health needs. Together the IHC and RCs will provide feedback to the PCMH regarding practice performance and identify resources needed to help the practice improve the quality of care and patient experience. Through these supports, Idaho's primary care practices will move beyond an individual, disease-specific focus to functioning as a key driver in population health management.

As noted previously in the SHIP, the capacity of practices to fulfill all the requirements of a PCMH will vary by practice. Practices in under-resourced areas will receive additional supports from the RC, including providing direct resources for critical components of the model such as care coordination, arranging for after-hours care, and behavioral health specialty consultation.

In sum, the key function of the RCs will be to support practices and the PCMH model through a variety of activities, including the following:

- Encourage adoption of the PCMH model through physician and medical neighborhood education. This will be achieved through numerous approaches, including training and toolkits related to clinical, quality improvement, and HIT improvements, evidence-based best practices and Health Insurance Portability and Accountability Act (HIPAA) security efforts.

- Facilitate implementation and accreditation of the PCMH by providing resources and supports, such as trained facilitators, to guide practices through the transformation process.

[16] http://link.springer.com/article/10.1007/s11606-013-2386-4

- Ensure ongoing success of the PCMHs by supporting regional and practice-level data gathering and analytics using systems and reports created at the IHC.

- Partner with local public health experts to conduct the periodic community needs assessment using the CDC's Community Health Assessment and Group Evaluation tool. Use assessment results to identify additional activities, services, and practice improvements that are needed to improve the community's health.

- Advise the IHC on effective quality initiatives for their region and PCMHs based on local knowledge of communities and cultures.

- Provide on-the-ground assistance to the PCMHs, or secure the technical assistance from the IHC on behalf of the region, in order to attain improved quality care and achieve good health outcomes within the region.

- Facilitate coordination and integration of services through strengthening relationships between the PCMHs and the medical neighborhood. Assist the PCMH in establishing formal communication and referral protocols between the practice and medical neighborhood.

- Provide support for under-resourced practices that need help in fulfilling the requirements of a PCMH. Support may be provided through contractual arrangements, staffing, and/or facilitation of shared resources across PCMHs.

Idaho Department of Health and Welfare

To achieve total transformation of Idaho's healthcare system, the model encompasses a multi-payer approach. This requires participation, collaboration, and partnership with many key entities across the State. Most notable are the three major commercial payers: Blue Cross of Idaho, Regence Blue Shield of Idaho, and PacificSource. IDHW is another large payer in Idaho's healthcare system as the single State agency for Medicaid. While the role of each payer, large or small, is valued and deemed important to the success of the model, special note is given to the role of IHDW in the future system for a number of reasons. First, IDHW is uniquely positioned to facilitate the integration of publicly funded behavioral health and long term care services in the model as the administrator of those programs. Through changes to those programs' policies and payment mechanisms to better align programs at the State level, the current siloed systems can become better coordinated to provide more effective and efficient care for the individual. IDHW will embrace the opportunity to develop program policies, establish contract requirements, and implement payment mechanisms across Medicaid primary care, public health, behavioral health, and long term care services and supports (i.e., home- and community-based services (HCBS)) to support the coordination and integration of these services within the PCMH and across the medical neighborhood.

Secondly, through education and outreach to its sister agencies administering elder care, correctional health services, education and juvenile justice programs, IDHW will further advance understanding and support of the PCMH model. IDHW will advocate and support coordination of program requirements, policies, and payment mechanisms across programs whose services are to be integrated at the community level in order to best support improved community health. Through collaboration at the State level, partnerships at the community and regional levels will more easily be formed and supported. More information regarding how existing State and federal health initiatives will be leveraged in the new model can be found in Section 6.

IDHW will also seek grant funds and potentially other sources of revenue to support the implementation of the model.

As noted previously, true transformation of the system cannot be achieved without participation of multiple payers, all of which are important partners in the State's healthcare system. As Idaho moves from implementation of the new system to sustaining the integrated, comprehensive system, IDHW and other major payers will continue to play an important role in supporting PCMHs and improving health outcomes for the State's residents.

Payment Model

Current Payment Methods

Fee for service (FFS) payment is the most common payment method, across the private and public market, in Idaho today. Commercial payers have a significant role in Idaho's healthcare delivery system as over half of Idahoans are covered through commercial plans. Among commercial payers, the dominant plan type is preferred provider organizations (PPOs). The prevalence of health maintenance organizations (HMOs) is small, with only a 5.4% penetration rate in July 2011 as compared to 22.5% nationally.[17]

In 2012, there were 242,889 Medicare beneficiaries in Idaho,[18] representing about 15% of the State's population. Approximately 70% of these Medicare beneficiaries received services on a FFS basis, and 30% (70,562) were enrolled in a MA plan offered by various insurers, including the three major insurers. Many of the Medicare beneficiaries in MA plans (38,861) were in local PPOs, while 24,454 were enrolled in HMOs and 6,815 in private FFS (PFFS) plans.[19] There were only 632 beneficiaries enrolled in a Special Needs Plan for Duals (D-SNP) for persons on both Medicare and Medicaid.[20]

The Idaho Medicaid Program is administered by the Division of Medicaid, which is located in the IDHW. In federal FY 2012, 237,801 average monthly eligibles were enrolled in Idaho Medicaid/CHIP, which represented an estimated 14.8% of the State's population that year.

The Idaho Medicaid State Plan offers four benefit packages: the Standard State Plan, which provides mandatory minimum benefits, and three benefit plans that are aligned with the health needs of specific populations and include an emphasis on prevention and wellness. The Basic Plan is for low-income children and adults with eligible children who have average healthcare needs. The Enhanced Plan is for participants with disabilities or special health needs. The Medicare-Medicaid Coordinated Plan is for participants who are enrolled in both Medicare and Medicaid. Participants in the Medicare-Medicaid Coordinated Plan can voluntarily elect to receive some of their Medicaid coverage through Blue Cross of Idaho, which is an MA Plan.

Most participants in the Medicaid Basic or Enhanced Plan must enroll in Healthy Connections, a mandatory primary care case management (PCCM) program that was implemented in 1992. Under

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[17] [17] The Kaiser Family Foundation State Health Facts, viewable at http://kff.org/other/state-indicator/hmo-penetration-rate/

[18] Henry J. Kaiser Family Foundation, State Health Facts: Total Number of Medicare Beneficiaries. Referenced on August 7, 2013 viewable at http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/

[19] Henry J. Kaiser Family Foundation, State Health Facts: Medicare Advantage: Total Enrollment, by Plan Type. Referenced on August 7, 2013 viewable at http://kff.org/medicare/state-indicator/total-enrollment-by-plan-type/

[20] Henry J. Kaiser Family Foundation, State Health Facts: Medicare Advantage: Special Needs Plan (SNP) Enrollment by SNP Type. Referenced on August 7, 2013 viewable at http://kff.org/medicare/state-indicator/snp-enrollment-by-snp-type/

this program, Medicaid participants must select or be assigned to a PCP. The PCP is responsible for coordinating care and providing referrals for most medically necessary services not provided by the PCP. In addition to reimbursement for services rendered, PCPs enrolled in Healthy Connections are paid a monthly case management fee. The fee is increased by $0.50 PMPM when the PCP's office offers extended hours of service to see patients equal to or greater than 46 hours per week.

Most Medicaid services are paid by IDHW on a FFS basis. However, Idaho Medicaid does provide some services through capitated managed care contracts. The Medicare-Medicaid Coordinated Plan is provided through a capitated contract with Blue Cross of Idaho. Idaho Medicaid contracts on a capitated basis with a transportation broker to administer, coordinate, and manage all non-emergency medical transportation (NEMT) for eligible Idaho Medicaid participants. Dental services for all participants are provided through a capitated contract with Blue Cross of Idaho and its subcontractor DentaQuest. Since September 1, 2013, Idaho Medicaid also contracts on a capitated basis with Optum to administer behavioral health services to eligible Medicaid participants.

Bridge to Payment Model Reform

All three of Idaho's major commercial payers and Medicaid participate in the IMHC. Through this initiative, new payment methods have been piloted. Blue Cross supports medical homes in the IMHC pilot with a tiered PMPM structure. Providers meeting the mandatory participation criteria are eligible for a PMPM for patients with qualified chronic conditions (asthma, diabetes, and/or congestive heart failure) who opt in to the program. Practices meeting additional optional participation criteria are eligible for an enhanced PMPM. Regence supports participating providers with a PMPM to support an embedded registered nurse (RN) care manager for the top 3%–5% of the sickest patients attributed to the practitioner/clinic, supporting participating clinics with a PMPM for members who meet eligibility criteria, including diagnosis of severe and persistent mental illness (SPMI)/ SED, diabetes and asthma, diabetes and a co-morbidity or specified risk factor, or asthma and a co-morbidity or specified risk factor.

The Idaho Medicaid program has implemented health homes pursuant to Section 2703 of the ACA and is part of the IMHC. The Medicaid health homes program is an enhancement of the IMHC for persons with a qualifying chronic health diagnosis. The additional Medicaid requirements include providing 46 hours of clinic access per week for patient care and providing timely clinical advice by telephone during office hours (NCQA Standard 1; Element A; Factor 2), or by secure electronic messages during office hours (NCQA Standard 1; Element A; Factor 3).

Medicare is funding payment method reform initiatives in Idaho to move from reimbursement of volume towards reimbursement of value through ACO and PCMH initiatives. The St. Luke's Clinic Coordinated Care ACO will distribute shared savings from improved outcomes and lowered costs to the providers participating in the joint venture through an arrangement that dictates 25% for strategic infrastructure investments; 25% for care process redesign; and 50% for provider compensation. These payment model innovations are beginning to change the way that Medicare pays for health services in Idaho, laying a foundation for Medicare's role in the new PCMH model.

Gaps in Current Payment Methods

As noted above, Idaho's current payment methods are still heavily reliant on FFS arrangements that reward quantity of care. As a result, stakeholders identified that the volume of services is too often driven by financial incentives rather than the needs of patients. 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. For the patient, staying healthy in this system can be burdensome, as the patient is caught in the role of being his or her own care coordinator. For the provider, the quality of the patient relationship is diminished and the provider is frustrated because they often just do not have the tools to provide the best possible care. The net effect of this payment system is that care is costly and outcomes are often poor.

Stakeholder Deliberations Regarding Payment Model Reform

The Multi-Payer work group, comprised of representatives from Idaho's three major commercial payers, two largest hospital systems, the Idaho Hospital Association, Idaho Medicaid, the local public health districts, employer groups, including self-insured employers, and the Idaho Department of Insurance and physicians, met regularly to discuss the transition from FFS payment (payment based on volume), to payment based on outcomes. The work group began by discussing a spectrum of delivery system/reimbursement model options from FFS to fully integrated models (ACOs, MCOs). Given the geographical complexities of Idaho, and the starting point of Idaho's current care delivery system, the group thought moving directly to fully integrated care and reimbursement models for all of Idaho might be difficult and proposed taking an incremental step of moving Idaho's medical delivery system to PCMH networks. This would not exclude organizations from moving to more advanced integrated care models.

After deciding on a phased approach for the delivery system, payment options were discussed. Options considered were combinations of PMPMs, quality incentives, shared savings, risk-sharing, partial capitation, and full capitation. Consensus around a blend of PMPM payments, quality incentives, and shared savings was immediate, although the work group thought it should be a phased approach. Capitation and risk-sharing were deemed unlikely to succeed or gain enough support in Idaho. This is due in part to Idaho's low average healthcare costs. Physicians were also skeptical of risk-based payments without including some incentive for patient compliance to prescribed treatment.

Innovative concepts around payment for telehealth and non-face-to-face (e.g., phone or email) consults and visits were deemed necessary because of the rural nature of Idaho. All payer representatives deemed payment for these non-traditional visits necessary but agreed that it would take some time to determine appropriate payment levels and update provider contracts.

Regarding PCMH payment, stakeholders that were participants in the IMHC pilot were quick to point out that the PMPMs paid in the IMHC, which was designed for patients with chronic conditions, only covered about half of the costs necessary to maintain the PCMH. In order to make the concept financially feasible, more patients would need to be attributed to the PCMH, including attribution of healthy consumers that rarely use medical services.

Payment approaches for PCMHs from other states were considered, such as the up-front payment used in Southeast Pennsylvania; payment for achieving higher NCQA PCMH recognition status, like in Colorado; and payment based on the complexity of the patient, like Minnesota. The work group agreed to adopt all of these payment approaches as part of Idaho's model. CCNC was also discussed but not deemed an appropriate model since it was Medicaid-only and would not generate the multi-payer, statewide reform that Idaho envisions.

PCMH attribution methodologies discussed included retrospective attribution based on claim and utilization history, patient selection, and prospective PCMH assignment. The work group decided to propose all of these methodologies, except that prospective assignment will include the option for the patient to change the PCMH assigned. Each payer will determine which attribution methodology

(ies) to use as negotiated with its contracted PCMHs. Both Medicaid and the three major commercial payers (including for their MA Plans) agreed to attribute membership. However, the commercial payers may implement attribution using a phased approach (e.g., patients with chronic conditions first).

Future Payment Model

Idaho will transition to incentivizing value as opposed to volume by aligning payment mechanisms across payers. The components of the new payment model are transformation start-up payments and accreditation payments provided to the PCMH through the IHC, PMPMs for care coordination, total cost of care shared savings arrangements, and quality incentives provided through the payers participating in the model. Details of these components are described below.

Transformation Start-Up Payments

Payments to support practice transformation to a PCMH will be distributed by the IHC and financed through Model Testing Proposal grant funding. The funding is intended to support practices endeavoring to meet, at a minimum, Level 1 PCMH accreditation requirements. The IHC will be responsible for determining eligibility criteria for receipt of funding. Funding will only be provided to those practices that identify resources needed based on a readiness review (developed by the IHC) that identifies practice gaps and needs. The start-up payments are intended to be sufficiently high to recruit existing and new practices to become PCMHs by covering most of the costs associated with becoming a PCMH, including establishment of patient registries, system and practice process changes, and time spent training physicians. The amount of the funding will vary depending on the estimate of the costs associated with building a practice's capacity to achieve Level 1 accreditation. Milestones for closing the gap and achieving practice transformation will be established by the IHC for each practice and monitored with the aid of the RCs. Practices that are not achieving adequate progress toward accreditation will not receive the balance of their approved funding. Moreover, if a practice does not meet the minimum level of PCMH accreditation within the specified timeframe, the practice will have to return funding per policies and controls established by the IHC.

Current PCMHs in the State will also be eligible for "start-up" funding, though this funding will be used to help defray their costs of further enhancing their functionality as a PCMH. Examples of established PCMH activities eligible for funding are adoption and training in the use of clinical decision tools, improvements of EHR and HIT functionality, expansion of patient registries, advancement of telehealth within the practice and community, and other tools and activities that support the advancement of the model and improved health outcomes. The IHC will determine eligibility criteria and the process for applying and receiving funds. As with non-PCMH practices, milestones, and conditions for continued funding and/or recoupment of funds will be established and monitored by the IHC.

Accreditation Payments

To encourage practices to achieve higher levels of accreditation, the IHC will also use Model Testing Proposal grant funds to provide PCMHs with tiered accreditation payments. Practices will receive one-time payments upon achieving each level of the accreditation by a nationally recognized accreditation organization, as approved by the IHC. These payments are intended to reimburse practice costs related to building functionality in order to perform as a more advanced PCMH.

Per Member per Month Payments

Payers will provide PCMHs achieving at least State designation as a PMPM to support ongoing PCMH activities (e.g., care coordination, patient management). PCMHs already established will

receive PMPM payments to expand their efforts from their previous focus on chronic disease patients to all patients. Payers will negotiate PMPMs with PCMHs through their regular contract negotiation processes. PMPMs are expected to escalate based on patient complexity. During the Implementation period, the IHC will convene the participating payers to set parameters for the payer's patient population risk stratification methodology upon which the payers will build their PMPM amounts. Payers will require PCMHs to complete evidence-based education and training in chronic care models and behavioral health programs in order to qualify for higher PMPMs based on patient complexity. The IHC will work with payers to establish standards for training requirements.

Total Cost of Care Shared Savings Arrangements

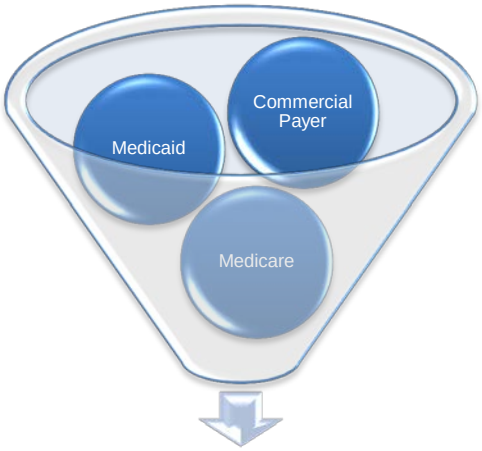
As the cost of care begins to decrease through decreased emergency department visits, decreased use of non-generic drugs, etc., payers will begin to incorporate total cost of care shared savings arrangements in contract negotiations with their PCMHs. The IHC will expect that total cost of care shared savings arrangements follow CMS guidelines. If a significant portion of the payment to the PCMH is tied to the shared savings arrangement, the provider may be required to hold stop loss insurance.

Quality Incentive Payments

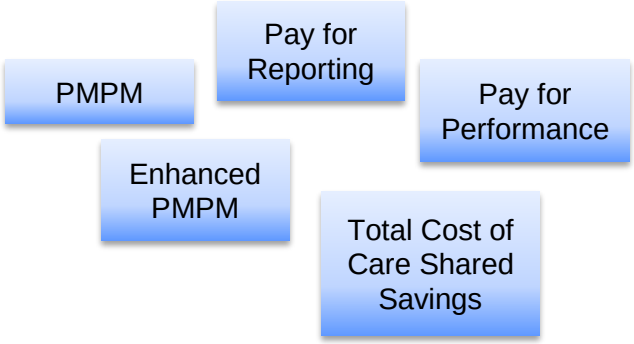
To incentivize PCMHs to report quality data and improve outcomes, the payers will also begin to incorporate quality incentives in their contractual arrangements with PCMHs that achieve at least a Level 1 accreditation. This will begin as a "pay for reporting" payment and will evolve into a "pay for performance" payment. The specifics of the payments will be negotiated between the payers and the PCMHs. As previously mentioned in the SHIP, the IHC and its RCs will provide technical assistance to PCMHs to assist with meeting "pay for reporting" then "pay for performance" requirements.

Summary of the Future Payment Model

Idaho's future PCMH model has higher up-front costs as compared to FFS but is designed to reduce future costs by transforming how care is organized and delivered. Payments to the PCMH as detailed above will be additive as the PCMH grows capacity. As shown in the graphic below, practices desiring to transform to a PCMH will receive transformation start-up payments to facilitate increased capacity to perform the functions of a PCMH. Practices that meet the requirements for State PCMH designation will be eligible to receive PMPMs for PCMH activities through the payers. As the PCMH continues to expand its capacity as a PCMH and meet accreditation requirements, it will become eligible for the accreditation payments and eventually for quality incentives and shared-savings payments. Practices that are already PCMH-accredited or are further along on the path towards PCMH accreditation, such as the practices that are currently participating in the IMHC, will qualify for the PMPMs, quality incentives and shared-savings payments more quickly.



Multi-Payer Model



Performance Measurement and Population Health Management

Current Performance Measures

General

The major entities involved in measuring and evaluating Idaho's current healthcare system are 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. However, no standardized data collection or performance reporting across payers or populations exists today. 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 complete picture of health of Idahoans or evaluate the performance of its healthcare delivery system.

Some of the main sources of healthcare performance data collected and used by IDHW are the Behavioral Risk Factor Surveillance System (BRFSS), the Pregnancy Risk Assessment Tracking System (PRATS), the Vital Records, and community health surveys conducted by Idaho's providers and local public health districts using the CDC's Community Health Assessment and Group Evaluation tool. Other sources of healthcare performance data are reportable disease tracking, the Cancer Data Registry of Idaho, and the Idaho Trauma Registry. Based on information from these data sources and other assessments of public health indicators, IDHW has developed its 2011-2014 strategic plan, which includes the following objectives aimed at improving health:

- Improve healthy behaviors of adults to 75.40% by 2015. This measure is a composite of five healthy behavioral indicators: (1) not a current smoker (2) consumes five or more fruits and

vegetables a day, (3) not a heavy drinker of alcoholic beverages, (4) participates in leisure time physical activities and (5) has not used illicit drugs in the past 12 months.

- Increase the use of evidence-based clinical preventive services to 70.33% by 2015 as measured by the Clinical Preventive Services Composite. The performance measure is a composite of six evidence-based clinical preventive service indicators that impact health. They are the number of: (1) adults screened for cholesterol in the last five years, (2) adults 50 and over who have ever received colorectal cancer screening, (3) women age 40 and over who received a mammogram in the last two years, (4) adults who had a dental visit in the last 12 months, (5) women who received adequate prenatal care and (6) children 19–35 months whose immunizations are up to date.

Currently, IDHW also publishes performance measures on its CHIP population in the State's annual CHIP report. In the 2012 report, the performance measures and current performance levels were:

- Chlamydia screening (34.76%),
- Well-child visits in the first 15 months of life (38.22% for 6+ visits),
- Well-child visits in the third through sixth years of life (51.4%),
- Adolescent well-care visits (30.53%),
- Access to primary care practitioners (91.65% for 12–24 months, 75.79% for 25 months–6 years, 61.9% for 7–11 years, and 61.13% for 12–19 years),
- Appropriate testing for children with pharyngitis (72.3%),
- Emergency department visits (11.5 visits per 1,000 member months), and
- Asthma patients with one or more asthma-related emergency department visit (2.99%).

The State's quality goals for the CHIP population include 95% of children having a medical home (current rate is 93%) and 90% of two-year olds having up to date vaccinations (current rate is 68.9%).

Similar to the IDHW, the local public health districts produce an annual strategic plan and an annual performance measurement report. The performance measures in the 2012 performance measure report[21] include measures from the BRFSS (percent of adults who smoke, percent of adults with diabetes, percent of adults who are overweight and/or obese, and percent of adults with asthma) and Vital Records (teenage pregnancy rate 15–19 years of age).

There is very little public information on the performance of Idaho's commercial payers or providers. While a select few commercial payers in Idaho (Aetna, SelectHealth, and United HealthCare) are NCQA-accredited, none of the three major commercial payers are currently NCQA-accredited. However, BlueCross of Idaho and PacificSource are scheduled to have NCQA accreditation reviews in early 2014 for their exchange products. PacificSource's review will also include its

commercial PPO. Regence is in the process of obtaining Utilization Review Accreditation Commission health plan accreditation.

Current Health Status of Idahoans

The limited State-level information available through State and national sources indicate that the health status of Idahoans is generally considered to be average as compared to other states.[22] However, there are areas of concern. These include childhood immunizations, obesity, diabetes, tobacco use, and mental health disorders.

- In 2010, **62.9%** of adults were overweight and **26.9%** were obese
- In 2010, **one of every 12** adults had diabetes
- Idaho ranked **fifteenth** in the country in prevalence of adult smokers
- In 2008–2009, **22.5%** of Idahoans age 18 or older had a mental illness
- Idaho ranked **fortieth** in the nation on the number of suicides per 100,000 population
- In 2011, **13.4%** of children were overweight, while **9.2%** were obese
- In 2012, Idaho ranked **forty-third** for the percent of children ages 19 to 35 months who received all recommended vaccines

[22] See, e.g., *America's Health Rankings®*— 2012 Edition, which is available at www.americashealthrankings.org and the 2011 National Healthcare Quality Report, available at http://statesnapshots.ahrq.gov/snaps11/

One area in which Idaho ranks poorly compared to other states is childhood immunizations. According to America's Health Rankings 2012,[23] Idaho ranked forty-third for the percent of children ages 19 to 35 months who received all recommended vaccines. Similarly, the 2011 National Healthcare Quality Report (NHQR) ranked Idaho as forty-ninth on this measure.[24]

Another area of concern is the number of Idahoans who are overweight or obese. In 2010, 62.9% of adults in Idaho were overweight (i.e., had a BMI of 25 or greater) and 26.9% were obese (i.e., had a BMI of 30 or higher).[25] Since 2003, there has been a significant increase in the percentage of Idaho adults who are overweight and obese. Men are significantly more likely to be obese than women. College graduates are significantly less likely to be obese than those with lower levels of education. In 2011, 13.4% of Idaho's children were overweight as defined by being above the eighty-fifth percentile but below the ninety-fifth percentile for BMI by age and sex, while 9.2% were obese, i.e., at or above the ninety-fifth percentile for BMI by age and sex.[26]

In 2010, the prevalence of diabetes among adult Idahoans was 8.0%. Overall this represented one in 12 people in the State.[27] Those with incomes below $25,000 were twice as likely to have diabetes as those with incomes of $25,000 or more.

In 2010, 16.9% of adult Idahoans were smokers, which meant that Idaho ranked fifteenth in the country in prevalence of adult smokers, and Idaho's smoking-attributable mortality rates ranked eighth among the states.[28]

As previously mentioned in the SHIP, behavioral health conditions are a significant area of concern in Idaho. In 2008–2009, 22.5% of Idahoans age 18 or older had a mental illness and 5.8% had a severe mental illness.[29] According to the 2011 National Healthcare Quality Report,[30] Idaho ranked fortieth on the measure of suicide deaths per 100,000 population. In 2010, suicide was the second leading cause of death among Idaho residents ages 15 to 34.[31]

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[23] *America's Health Rankings®*— 2012 Edition is available at www.americashealthrankings.org

[24] See the 2011 National Healthcare Quality Report, available at http://statesnapshots.ahrq.gov/snaps11/

[25] *Idaho Behavioral Risk Factors: Results from the 2010 Behavioral Risk Factor Surveillance System*. Boise: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics, 2012. Available at http://healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/BehavioralRiskFactorSurveillanceSystem/tabid/913/Default.aspx

[26] Results of the 2011 Idaho Youth Risk Behavior Study, Published by the Idaho Department of Education, viewable at http://www.sde.idaho.gov/site/csh/docs/YRBS%202011.pdf.

[27] 2010 Report: At A Glance. Published by IDHW, Public Health Division, Bureau of Community, and Environmental Health published 2011 viewable at http://www.healthandwelfare.idaho.gov/Portals/0/Health/ataglance_LR.pdf.

[28] Center for Disease Control-Tobacco Control State Highlights for 2010 published in 2011 viewable at http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2010/pdfs/states/idaho.pdf.

[29] Mental Health, United States, 2010 Report produced by the US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration viewable at http://www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf

[30] See the 2011 National Healthcare Quality Report, available at http://statesnapshots.ahrq.gov/snaps11/

[31] *Idaho Behavioral Risk Factors: Results from the 2010 Behavioral Risk Factor Surveillance System*. Boise: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics, 2012. Available at http://healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/BehavioralRiskFactorSurveillanceSystem/tabid/913/Default.aspx

Additional information regarding current population health statistics and delivery system performance can be found in Appendix F.

Bridge to Performance Measurement Reform

The IMHC pilot has opened new opportunities to assess the performance of Idaho's healthcare delivery system in a more comprehensive manner. Through the pilot, public and private payers are, for the first time in Idaho, jointly requiring providers to report on performance measures. Participating practices report data for two clinical quality measures from the list below unless asthma is chosen, which requires all three asthma-related measures to be reported:

- Diabetes: Hemoglobin A1c Testing (NCQA – NQF # 57).
- Diabetes HbA1c Poor Control (NCQA – NQF # 59).
- Controlling High Blood Pressure (NCQA – NQF # 18).
- Hypertension: Blood Pressure Measurement (AMA – PCPI – NQF # 13).
- Anti-Depressant Medication Management; Effective Acute Phase and Effective Continuation Phase Treatment (NCQA – NQF # 105).
- Screening for Clinical Depression (CMS – NQF # 418).
- Asthma Assessment (AMA – PCPI – NQF # 1).
- Asthma Pharmacologic Therapy (AMA – PCPI – NQF # 47).
- Management Plan for People with Asthma (IPRO – NQF # 25).

In addition to the above measures, IMHC also specifies that participating practices report on two practice transformation measures. Each payer has specified additional reporting requirements. For example, Regence requires its providers to report on three HEDIS measures: low-density lipoprotein (LDL) control for cardiovascular conditions, LDL control for diabetes, and adult body mass index (BMI) value. Performance targets for these measures are set by the payers and will be monitored by the payers and IMHC.

Gaps in Current Health System Performance Measurement

As part of the model design process, an environmental scan of clinical quality and beneficiary experience outcomes was conducted. As noted above, the analysis revealed that there are currently no standard performance measures across public and private payers or programs. Providers collect and report data according to specific payer requirements but there are no uniform reporting requirements that provide statewide assessment and performance targets.
Statewide population health information is available through IDHW's annual reports and the IDHW website but the ability to analyze this data by region or other variables is limited. Additional pockets of information regarding quality and cost of care is available, but is restricted to specific systems, provider groups, or payers, and is often proprietary. Across providers and health systems, there is a lack of a consistent model or approach to defining, collecting, reporting, and utilizing performance measure data. At the provider level, practices often lack the tools and technology necessary to report data needed for system-wide analysis to inform the development of system-wide performance measures.

Future Performance Measures

Performance Measure Catalog: Initial Set of Performance Measures

To address the lack of standard performance measures across public and private payers or populations in Idaho, the CQI work group identified the need for a performance measure catalog, such as the Massachusetts Quality Measure Catalog which is an inventory of the healthcare quality measures currently in use in Massachusetts. Idaho's initial performance measure catalog was developed by the CQI work group and adopted by the Steering Committee. The development of this catalog by stakeholders that represent a cross-section of providers, payers and other health system participants, is an innovative and important step forward for Idaho, and will ensure alignment of quality measurement and improvement activities across the State. The performance measures selected for inclusion in the catalog were targeted because they represent the areas with the most need for health improvement across all Idahoans, and also represent a balance of short-term and long term goals.

Idaho's Initial Performance Measure Catalog

Measure Name (and Source)	Measure Description	Rationale for the Measure
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 SMI 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. This measure aligns with Healthy People 2020.
Measure pair: (a.) Tobacco use assessment.	Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period.	In Idaho, 16.9% of the adult population were smokers in 2010 (>187,000 individuals). Idaho ranks fifteenth in the country in prevalence of adult smokers and its smoking-attributable mortality rate is ranked eighth in the country.
(b.) Tobacco cessation intervention (SIM).	Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.	
Asthma 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) in Idaho was 8.8% in 2010, 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 in 2011), this measure is held as one of the standards for evaluation of utilization and appropriate use of hospital services as part of an integrated network.

Measure Name (and Source)	Measure Description	Rationale for the Measure
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.
Avoidable emergency care without hospitalization (risk-adjusted).	Percentage of patients who had avoidable use of 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. 1,355 babies in Idaho had low birth weights in 2011, compared to 1,160 in 1997.
Adherence to antipsychotics for individuals with schizophrenia (HEDIS).	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 may be a reflection of improved access to care and patient engagement.
Weight assessment and counseling for children and adolescents (SIM).	Percentage of children, two through 17 years of age, whose weight is classified based on BMI, who receive counseling for nutrition and physical activity.	In 2011, 13.4% of children were overweight as defined by being above the 85th percentile, but below the 95th percentile for BMI by age and sex, while 9.2% were obese, i.e., at or above the 95th 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 Idaho had diabetes.

Measure Name (and Source)	Measure Description	Rationale for the Measure
Access to care.	Percentage of members who report they have adequate and timely access to PCPs, behavioral health, and dentistry (measure adjusted to reflect shortages in Idaho).	Idaho has a critical access shortage of primary care providers, behavioral health providers, and dentists across the State which impedes 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 43rd in the nation with an immunization rate of 87.33% in 2012. This measure aligns with Healthy People 2020.
Adult BMI Assessment.	The percentage of members 18 to 74 years of age who had an outpatient visit and who's BMI was documented during the measurement year or the year prior to the measurement year.	In 2010, 62.9% of adults in Idaho were overweight, and 26.9% of adults in Idaho were obese.
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).	From 2010–2011, Idaho had the fourth highest non-medical use of prescription pain relievers in the country among persons aged 12 or older at 5.73%.

The development of an Initial 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. Idaho will continue to advance slowly but with a definite and unyielding commitment to gather the data and information needed to ascertain the health needs of Idahoans and build a system fully responsive to those needs.

Phased Approach to Building Performance Measure Reporting and Analytics

Idaho proposes to phase in the performance measure reporting and related quality activities, including providing feedback to providers, developing community initiatives, and making performance measure results available to the public.

In Year 1 of model testing, the IHC will establish a baseline for each of the performance measures in the catalog. Due to the lack of uniform reporting that exists today, the IHC will develop a baseline from the pockets of information that are currently available across payers and populations. An external organization with expertise in performance data collection, analysis, and reporting will assist the IHC in gathering and analyzing the data to establish a baseline by the end of Year 1.

During Year 1 of model testing, the IHC will also analyze the current system capabilities and constraints regarding statewide data collection and reporting. The IHC will engage stakeholders in discussion and analysis to ensure that a statewide solution to data collection remains viable and acceptable to the different healthcare communities in Idaho. By the end of Year 1, decisions regarding construction of the statewide database and protocols for PCMHs to report on performance measures will be developed.

In Year 2, the IHC will select four core performance measures from the initial Performance Measure Catalog to be reported by all PCMHs in Year 2. The mandatory statewide performance measures for Year 2 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 IHC, RCs will identify additional performance measures from the Performance Measure Catalog to be collected from PCMHs in their respective regions in Year 3. The additional measures collected in Year 3 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.

Additional details regarding the proposed performance measure reporting activities by year are described below.

Primary Focus of Year 1

- The IHC gathers baseline data on each performance measure in the Performance Measure Catalog. Baseline data is gathered by an independent, external quality review organization tasked with obtaining data from the various sources and compiling and analyzing the data to establish baselines.

- The IHC educates providers about the Performance Measure Catalog. Providers will receive a toolkit detailing information on the performance measures including explanations and instructions on data collection. Wherever the technical specifications of the measures allow, the toolkit will include pre-formatted templates for data collection to ensure consistency across reporting PCMHs. The RCs will provide on-the-ground training and technical assistance to practices in preparation for performance reporting in Year 2.

- At the end of Year 1, the IHC and RCs will review the baseline data and select four performance measures to be targeted statewide in Year 2, three of which will be the SIMs performance measures of tobacco cessation intervention, weight assessment and counseling for children and adolescents, and comprehensive diabetes care. A fourth required measure will be selected from the Performance Measure Catalog by the IHC after review of the results of baseline data. Statewide performance targets will be set on the four required performance measures via a process that includes the following activities:
  - Research available national benchmarks and evaluate each region's baseline data relative to the benchmark.

- Compare key health system or community initiative elements that support improvement of the measure in regions that do not meet the benchmark target.
- Adjust initial national benchmark targets where necessary to reflect the need for system or program developments that support performance measure improvements.

- The IHC and RCs develop quality initiatives, along with educational campaigns and community initiatives, to support activities to improve selected performance measures that do not meet benchmarks/targets.

Primary Focus of Year 2

- The activities from Year 1 (education, mentoring, developing community initiatives, etc.) continue.

- PCMHs begin reporting on the four required performance measures electronically or via paper records, depending on their reporting capacity.

- A SHIP website is implemented to provide information and education on the PCMH model.

- At the end of Year 2, the IHC and the RCs review regional performance and provide feedback to each PCMH.

- Quality initiatives are developed and implemented to improve performance.

- The IHC and RCs report the number and percent of practices participating as PCMHs and the accreditation phase. This information will be used to update community needs assessments as a part of the continuous quality improvement process.

- The RCs, in consultation with the IHC, identify additional performance measures beyond the initial set of four measures to be reported in Year 3 for their respective regions. Regional-specific performance measures are determined after consideration of both performance results and regional health needs as determined by community health assessment and other clinical and service data. The IHC sets targets for the regional-specific performance measures.

- The IHC, working with the RCs, identifies new measures to add to the Performance Measure Catalog. The IHC's quality committee will have primary responsibility for researching, maintaining, and updating the quality performance measure catalog with new measures and establishing baselines and targets.

Primary Focus of Year 3

- The activities from Years 1 and 2 (identifying new measures, developing baselines and targets, PCMH reporting, providing performance feedback, and implement quality initiatives) continue.

- PCMHs report on statewide performance measures and regional-specific measures.

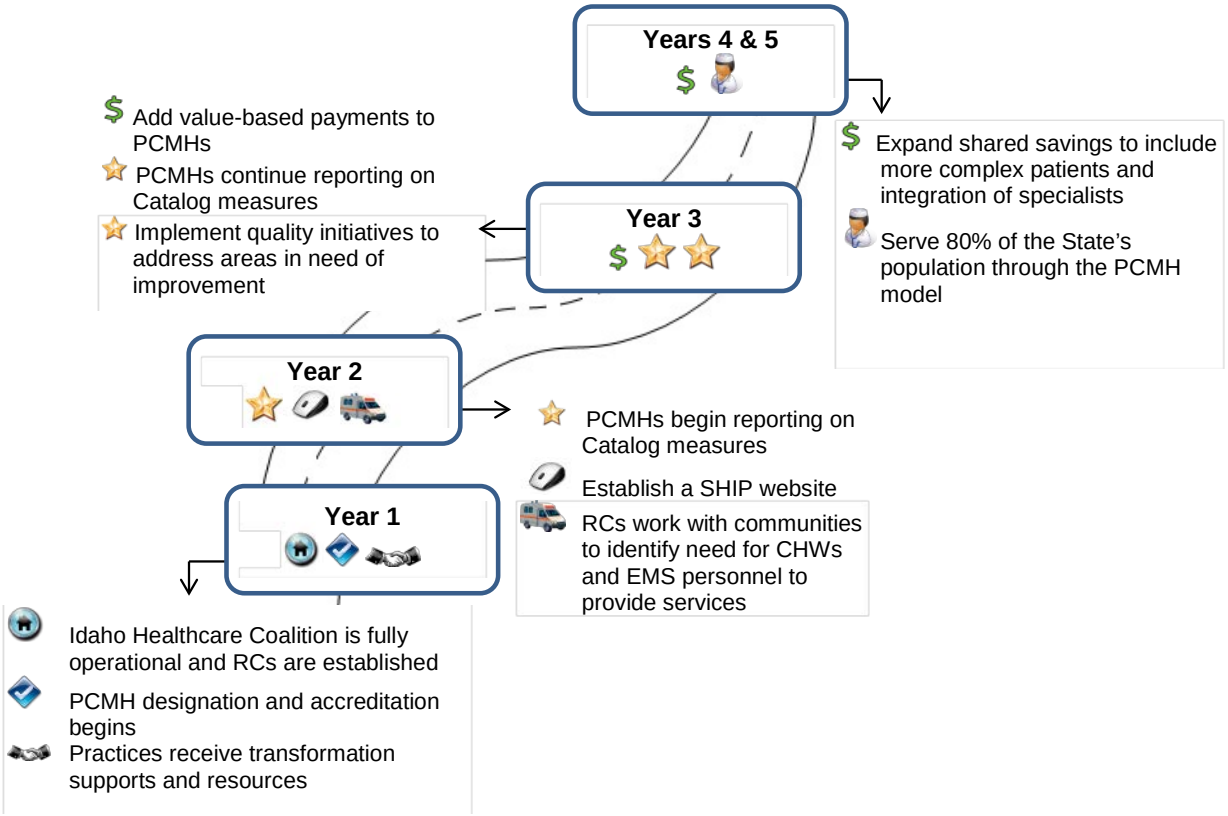
- Additional measures recommended in Year 2 by the IHC's quality committee are added to the Performance Measure Catalog

- At the end of Year 3, the IHC and RCs review performance results and select statewide performance reporting requirements from the expanded Catalog.

- The IHC publishes regional PCMH performance measure results through the SHIP website.

- The IHC and RCs identify additional performance measures to be reported by RCs within their region. Regional-specific performance measures are selected using performance data and results from community health assessments, and may vary from region to region.

Summary of General Roadmap to Model Implementation



3

Financial Analysis

The Populations Being Addressed and Their Respective Total Medical and Other Services Costs as PMPM and Population Total

Idaho's SHIP is designed to lower the overall cost of care for Idahoans, generating savings for the healthcare system. To determine that savings, the multi-payer workgroup began by classifying Idaho's population by payer type: Medicaid, Medicare, and commercial insurance. Medicaid was further divided into dual-eligible recipients, aged and disabled non-dual eligible recipients, children, and adults that did not fall into any other category. Commercial insurance participants were classified by the number of people on their policy: individual or family. Medicare participants were classified into dual-eligible, fee-for-service non-duals, and those with Medicare Advantage Part C coverage.

Medicaid

State projections show that Medicaid recipients are expected to cost nearly $1.4 billion in State Fiscal Year 2014 (SFY 14). 72% of Medicaid recipients in Idaho are children, but children represent only about 29% of the annual Medicaid expenses, or $203.21 monthly per member (PMPM). An area of high cost for this group includes Newborn Intensive Care Unit (NICU) costs for newborns needing neonatal care. A 3.6% annual growth trend, including inflation, would increase the cost of providing care to children to $242.27 PMPM by Year 3 of SHIP model testing without intervention.

The highest cost population among Medicaid recipients is the adult population that is dually eligible for Medicaid and Medicare (known as dual-eligibles), primarily due to the presence of chronic conditions. Costs projected for this population is $1,672.45 PMPM, and $8 million in total expenses in the base year which represents 18% of the Medicaid costs. The adult dual-eligibles are followed closely by the aged/disabled non-dual population, which cost $1,512.40 PMPM. The State projects that annual costs will rise for these populations by 5.1% and 2.6%, respectively, which increases costs to $1,940.17 PMPM and $1,635.73 PMPM in three years, respectively, without any intervention. These groups utilize Emergency Department services (ED) at a higher rate than normal, and have a higher rate of hospital admissions and high-end diagnostic services. Other cost drivers for the Medicaid population in general include behavioral health drugs. Roughly one-third of the total costs of Medicaid pharmaceutical drugs are spent on behavioral health drugs. The remaining adult Medicaid population projects a growth of 5.1%, going from $606.16 PMPM to $703.81 PMPM in three years without intervention.

Commercial Insurance

Commercial insurance expenses are projected to be roughly $940 million in SFY14. Commercial insurance costs are driven by specialty care, high-cost prescription drugs, radiology and laboratory services, outpatient care including surgeries, and inpatient maternity. Emergency room utilization growth, at 7%, is also a cost driver. Trends for both individual and family plans ran at 10.2% due to high emergency room usage, as well as high cost diagnostics. While individual plans make up approximately 17% of commercial insurance membership, only about 5% of the overall commercial insurance expenses can be attributed to this population. Without intervention, individual per capita costs are projected to grow from $80.24 to $107.30 PMPM over the three year testing period. Family per capita costs are projected to grow from $317.73to $424.89 PMPM over the same time period.

Medicare

Medicare is projected to spend $1.5 billion in SFY14. While ED usage was not available in the data, prescription drugs, home health, and inpatient hospital project aggressive growth for both fee-for-service Medicare and Medicare Advantage Part C membership from the base year to year 3 of the model testing period. Duals have a Medicare PMPM of 138.58 in the base year growing to $184.05 PMPM in year 3 without intervention – a 9.9% annual trend. Fee for service Medicare projects slightly lower trends of 7.9% growing from $674.54 PMPM to $847.09 PMPM by year 3 without intervention. Finally, Medicare Advantage shows a 9.9% trend with PMPM growth of $791.57 to $1051.31 without intervention over three years.

Estimated Cost of Investments to Implement the Plan

The overall budget projected to implement and test Idaho's PCMH model is $34,000,000 to $45,000,000. The budget includes costs to support implementation at all levels of the model as well as self-evaluation. More information regarding specific costs in the budget will be detailed in the Model Testing Proposal Budget Narrative.

Anticipated Cost Savings and Level of Improvement by Target Population

Savings Assumptions

By transitioning to a PCMH model of care, Idaho has the opportunity to eliminate expenses through proactive care and care coordination. While Idaho has historically spent less on healthcare as a percentage of the gross State product than the US average, there are certain trends evolving within the State that will escalate healthcare costs if left in the current state. For example, Idaho's share of the population aged 65 years and older is projected to increase to 18.3% of the total projected population in 2030, leading to increased healthcare spending in Idaho consistent with the US overall. Idaho's rate of adult smokers is also increasing. Idaho ranked third in lowest state smoking rate in 2004, but in 2010, 16.9% of the adult population were smokers (>187,000 individuals). This increase is significant because healthcare costs for smokers are as much as 40% higher than for non-smokers. Similar to much of the country, there is also a high prevalence of obesity and overweight in Idaho. In 2010, 62.9% of adults in Idaho were overweight, and 26.9% were obese. The increased costs of heart disease and diabetes-related care accounts for as much as 27% of per-capita health spending.

Strategies for Cost Reduction

Lowering and containing the cost of healthcare is a key goal of Idaho's transformation efforts. Idaho's PCMH model will not only change how healthcare services are delivered with a strong focus on primary and preventive care and more effective care management, but will also change how providers are reimbursed for the services they provide.

Strategies that will support cost-containment include but are not limited to:

- Increased access to PCMHs will reduce ambulatory-care sensitive hospital admissions and potentially avoidable ED visits.

- Coordination of care and transition management by PCMHs will reduce duplicative care and decrease hospital readmission rates.

- Alternative payment strategies, such as incentive payments tied to performance measure improvement, will reduce escalating physician costs by rewarding high quality care instead of high volume care, while also expanding access to care.

- Better informed consumers participating in shared decision making and using innovative health communication tools will have reduced ED visits through increased coordination with their primary care physician. An increase in the generic fill rate is also expected.

Cost Targets

The Multi-Payer work group identified five key categories of service as having the highest potential to yield cost savings. Targets were then set in each category of service:

Issue	Target	Target Phases	Mechanism to Reach Target
Appropriate Generic Drug Use	Generic fill rate of 85%	25% of target in Year 1 one, 50% in Year 2 and 25% in Year 3	Each 1% improvement in generic fill rates reduces total pharmacy spend (0.5%-1.0% in Medicaid and 2%–3% in commercial payer)
Re-hospitalizations	5%–10% reduction	10% of target in Year 1, 20% in Year 2 and 70% in Year 3	20% of all hospitalizations are preventable re-hospitalizations
Acute Care Hospitalizations	1%–5% reduction in total hospitalizations	0% of target in Year 1, 25% in Year 2 and 75% in Year 3	PCMHs reduce acute hospitalizations with IMPACT and IOCP training
Non-Emergent ED use	5%–10% reduction in total ED use	25% of target in Year 1, 50% in Year 2 and 25% in Year 3	10%–30% of ED visits are non-emergent (best in class commercial rates are 120-150/1000)
Early Deliveries (in weeks 37–39 of gestation)	20% improvement over baseline or all hospital report <5% 37-39 weeks	50% of target in Year 1, 50% in Year 2	1%–4% of total NICU admissions ($40-$70K/admit) are preventable with later deliveries

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									
	PMPM								
	Medicaid/CHIP				Private/Other		Medicare		
Categories of Services	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	-3.27%	-3.02%	-3.02%	-3.02%	-3.27%	-3.27%	-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)	-0.63%	-0.63%	-0.63%	-0.63%	-0.50%	-0.50%	-0.63%	-0.63%	-0.63%
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	0.00%	0.00%	-0.25%	0.00%	0.00%	0.00%	-0.25%	0.00%	0.00%
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)	-0.50%	-0.50%	-0.50%	-0.50%	-2.00%	-2.00%	0.00%	0.00%	0.00%
Total									

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 detailed in Sections 2 and 6.

Expected Total Cost Savings and Return on Investment

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.

The projected return on investment overall is 98% in total for three years and 115.8% for five years. The projected return on investment for Medicare and Medicaid only is 57.4% for three years and 58.6% for five years.

Plan for Sustaining the Model over Time

Idaho is similar to many states that desire to promote practice advancement under the PCMH model while respecting the long-standing culture of provider and payer autonomy. It is for this reason that Idaho chose to design its new delivery system through a massive stakeholder process that involved representatives of nearly the entire State's healthcare delivery system. The failures and strengths of the healthcare system are best understood by individuals receiving services, healthcare practitioners, patient advocates, and payers. For this reason, Idaho, in gathering stakeholder input, set out to include all communities in the State. This resulted in approximately 44 focus group meetings and multiple townhall engagements spread across the following locations: Boise, Coeur d'Alene, Twin Falls, Idaho Falls, Sandpoint, Salmon, Orofino, Moscow, Pocatello, and the Fort Hall Reservation. In addition, several virtual focus groups and ad hoc focus groups were held. Idaho's innovative approach began with the recognition that if healthcare system stakeholders came together to design *and* implement a new system, then true transformation and lasting change could be achieved. Through its grassroots process, Idaho has garnered the commitment of payers and providers to the model, eliminating dependence on legislative or executive mandates to require participation.

Idaho's expanded PCMH model establishes several new and innovative system elements that can support the long term funding and continued development of the system. The IHC will be financially sustained through membership fees paid by PCMHs. Upon designation as a PCMH, the practice will pay a membership fee to the IHC for continued support and resources to enhance its capacity and capability as a PCMH. The PMPM paid by payers will be sufficient to help offset the cost of the membership fee. IDHW and the IHC will work with CMMI and its evaluation team to ensure the model is designed and modified as necessary to generate sufficient revenue and funding to support continued activities.

Should Idaho not receive grant funds to support model testing, implementation of the model will proceed at an extremely limited level. Without grant funds, Idaho will be limited to implementing the model through expansion of the IMHC and its PCMH pilots. At the end of phase 1 of the IMHC pilots (January 2015), Idaho will evaluate whether the 36 pilots can support expansion beyond the chronically ill population they currently serve to include the non-chronically ill, i.e., healthy, individuals in the PCMH. At that time, IMHC will also evaluate whether they can expand the number of pilots beyond the original 36 that exist today. While Idaho is committed to moving forward with healthcare delivery system reform, the reality is, without the support of grant funds and CMMI assistance, Idaho will not be able to test its model and achieve statewide transformation and population health management that will improve the health of Idahoans.

4

Idaho Healthcare Workforce

Idaho's health system transformation is geared at achieving the Triple Aim of improved health outcomes, improved quality and patient experience of care, and lowered healthcare costs by addressing barriers and filling gaps in the current system. Primary among these barriers, as identified by the stakeholders in the model design process and noted previously in the SHIP, are severe workforce shortages in Idaho across professions and across geographic regions of the State that must be addressed in order to truly transform healthcare in Idaho. One hundred percent of Idaho is a federally-designated shortage area in mental healthcare, and 96.7% of Idaho is a federally-designated shortage area in primary care. Recognizing the access barriers presented by this shortage, Idaho has designed a model that maximizes the current workforce while designing comprehensive strategies to increase practitioners of all types throughout the system.

What follows is a description of the current healthcare workforce and its limitations, stakeholder deliberations in designing solutions to address these issues, and the recommendations included in Idaho's new model to strengthen Idaho's healthcare workforce to ensure its future ability to provide the best possible care for patients.

Current Provider Network

Physicians

The AAMC's 2011 State Physician Workforce Databook, which uses 2010 data, shows that in 2010 there were 2,873 active physicians in Idaho (184.2 per 100,000 residents), which includes 2,610 doctors of medicine and 263 doctors of osteopathic medicine. Of these, 987 were PCPs who self-reported that their practice type was direct patient care. Idaho ranked forty-ninth among the 50 states in terms of number of physicians per capita.[32]

Data compiled by Idaho's Department of Labor using physician counts provided by the Idaho Medical Association shows the following distribution of physician types:

Idaho's Physician Workforce		
Physicians	Count	Percent
Anesthesiologists	122	4%
Family Medicine and General Practice	758	25%
Internists	270	9%
Obstetricians and Gynecologists	155	5%
Pediatricians	145	5%
Psychiatrists	100	3%
Surgeons	367	12%
All Other Physicians	1,116	37%
TOTAL	3,033	100%

The Idaho Board of Medicine is the primary source for information on licensing, but does not have information on which physicians are active practitioners or where they are practicing. In 2012, the

[32] https://www.aamc.org/download/263512/data/statedata2011.pdf

Department of Labor, with a grant from Health Resources and Services Administration (HRSA), completed a study of Idaho's primary care workforce using licensure data and data from the Idaho Medical Association. The Board of Medicine and the Department of Labor are now working on a project to cross reference data by developing a new database that will capture information not only on the number of licensed physicians, but on which physicians are actively practicing and where they are practicing. This collaborative effort will provide critical data as the IHC partners with other State efforts to target workforce expansion in under-served areas of the State.

Federally Qualified Health Centers and Rural Health Clinics

Idaho has 13 non-profit community health centers (often referred to as FQHCs); 12 receive federal grant funding and the thirteenth has attained FQHC "look-alike" status. Idaho's FQHCs serve nearly 150,000 residents through 41 community sites and provide primary medical, dental, and behavioral health services. Idaho also has 46 rural health clinics (RHCs), which are family medicine clinics that provide outpatient primary care health services, including diagnostic and laboratory services. The clinics are staffed by mid-level practitioners 50% of the time the clinic is open.[33] RHCs are certified by the IDHW Division of Medicaid's Bureau of Facility Standards. To be certified as an RHC, a clinic must be located in a non-urban area as defined by the US Census Bureau and a federally-designated medically-underserved area (or a governor-designated shortage area) or serve a designated population group or geographic health professional shortage area.

Idaho's FQHCs are innovators in developing practice standards that are based on patient-centered, team-based care, often co-locating primary care and behavioral health services, and offering care coordination to patients. Several of Idaho's FQHCs participate in the FQHC Advanced Primary Care Practice Demonstration, operated by CMS in partnership with HRSA that will test the effectiveness of doctors and other health professionals working in teams to coordinate and improve care for Medicare patients. Participating FQHCs are expected to achieve Level 3 PCMH recognition, help patients manage chronic conditions, as well as actively coordinate care for patients. FQHCs are paid a monthly care management fee of $6.00 for each eligible Medicare beneficiary attributed to their practice to help defray the cost of transformation into a person-centered, coordinated, seamless primary care practice. This payment, which will be made quarterly, is in addition to the usual all-inclusive payment FQHCs receive for providing Medicare covered services. Based on their experience as leaders in patient-centered primary care, Idaho's FQHCs are well positioned to be a valuable resource to private practices in their efforts to build capacity around the components of the PCMH model. The IHC and its RCs will seek to leverage this expertise where possible by encouraging practice mentor opportunities to help practices learn from each other's lessons and prior experience.

Nurses, Nurse Practitioners, and Physician Assistants

Nurses and physician assistants (PA) are important participants in Idaho's team-based PCMH model. In 2011, there were 11,660 total employed registered nurses (RNs) in Idaho, or 736 per 100,000 residents and 658 nurse practitioners (NPs), or 42 per 100,000 residents.[34] There are 684 physician assistants with active licenses in Idaho.[35] PAs and NPs play a vital role in extending access to services in Idaho, particularly in rural communities. For this reason, many stakeholders were in favor of allowing PAs and NPs to, along with physicians, lead the PCMH in Idaho's model.

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[33] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RRHC.pdf

[34] Kaiser State Facts (http://kff.org/other/state-indicator/total-registered-nurses/

[35] https://isecure.bom.idaho.gov/BOMPublic/LicenseTypeCount.aspx?Board=PAC

Behavioral Health Professionals

The shortage of behavioral health professionals in Idaho creates substantial barriers for Idahoans with mental health conditions and substance use disorders. As of September 15, 2013, there are 427 substance abuse counselors in Idaho who have active certifications by the Idaho Board of Alcohol/Drug Certification[36] and 3,513 social workers with active licenses from the Idaho Board of Social Work Examiners.[37] There are 322 psychologists with active licenses from the Idaho Board of Psychologist Examiners. (Note: this does not include professionals with temporary psychology licenses or service extenders.)[38]

Telehealth is used to a limited extent in some rural communities to provide access to behavioral health services. Currently, Idaho Medicaid pays for specific behavioral health services delivered via telehealth technology. The policy allows behavioral health services provided via telehealth to be reimbursed if the following conditions are met:

Must be provided by a physician.
Covers the following behavioral health services:

- Psychiatric services for diagnostic assessments.
- Pharmacological management.
- Psychotherapy with evaluation and management services 20 to 30 minutes in duration.[39]

Stakeholders in both focus groups and the Network work group discussed the importance of expanding the use of telehealth services, particularly in rural and underserved areas of the State. It was recommended that the Idaho Medicaid and commercial payers expand their telehealth policies to include a broader array of reimbursable behavioral health services.

Additional information on Idaho's healthcare workforce, including numbers of other practitioner types and hospitals, can be found in the Appendix G.

The future of Idaho's healthcare workforce

Stakeholders noted that establishing good, basic primary care, particularly in rural and underserved areas, is the key to improving Idaho's healthcare system. To accomplish this goal, stakeholders recommended that strategies to improve the workforce target a range of professions, including physicians, behavioral health professionals, PAs, NPs, social workers, and nurses.

Stakeholders noted that this approach is being taken by the Idaho Health Professions Education Council (Council), established by executive order by Governor Otter in 2009. The Council has been working to develop healthcare workforce objectives for the State and recommend strategies to address healthcare shortage across a range of professions.[40] The Network work group recommended that many of the Council's recommendations be incorporated into the Idaho SHIP strategies for workforce improvement. While Idaho will not request Model Testing Grant funds for workforce strategies, the IDHW and the IHC will work closely with the Council during the model testing phase to ensure that SHIP activities, such as training opportunities for primary care practices and new data sharing arrangements, align with the Council's workforce development strategies and support their efforts wherever possible.

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[36] http://ibadcc.org/

[37] http://ibol.idaho.gov/IBOL/BoardPage.aspx?Bureau=swo

[38] http://ibol.idaho.gov/IBOL/BoardPage.aspx?Bureau=PSY

[39] IDAPA 16.03.09.502: http://adminrules.idaho.gov/rules/current/16/0309.pdf

[40] See the Idaho Health Professions Education Council, 2013 Annual Report to Governor C. L. "Butch" Otter, submitted August 13, 2013 available at http://gov.idaho.gov/HealthCare/PDF/2013%20IHPEC%20Annual%20Report.pdf

Stakeholders identified one serious challenge facing Idaho's future supply of physicians is that the current workforce is aging, and not enough younger physicians are establishing practices in Idaho to replace the physicians who are or will soon be retiring. The AAMC data shows that, of the total active physicians in Idaho in 2010, 23.3% were over 60, while only 13.9% were under 40. For this reason, Idaho's strategies include a strong focus on providing opportunities for young Idahoans to become part of the future workforce.

Idaho is extremely successful in retaining new physicians who graduate from residency programs in Idaho. In 2010, 56.9% of Idaho medical residents were practicing in-state, which was the eighth highest retention rate in the nation.[41] The State has also worked hard to increase graduate medical education opportunities by 56.4% from 2000 to 2010. A third family medicine residency program affiliated with the University of Washington Family Medicine Residency Network is expected to begin in 2014 in Coeur d'Alene. Building on Idaho's success in retaining medical residency graduates, the IHC will work with legislators, State officials and academic centers to further expand medical education in the State.

Based on recommendations made by the Network work group, the IHC, in partnership with the Council, will work on the following workforce expansion initiatives:

- Medical education – advocate for funding of residency programming including Family Medicine, Psychiatry, and Internal Medicine Residency Programs in addition to increased access to medical school education for Idaho students.

- Health education expansion – explore the feasibility of a statewide AHEC grant with three regional centers to promote enhancement and coordination of health education across disciplines and around the State.

- Nursing education – updating Idaho higher education articulation agreements between Idaho nursing education institutions to increase access and pipeline into advanced nursing degrees in Idaho to increase the number of Master and Doctoral prepared faculty members to ensure that schools of nursing are adequately staffed to continue educating nurses.

- Public health – support the training, recruitment, and retention of providers critical to the functioning of public health in Idaho including mid-level providers specifically working with local public health districts, registered dental hygienists, and registered dietitians.

- Social work – support the training, recruitment, and retention of key social work providers in Idaho including social work faculty as well as a rural social worker's program with an emphasis on behavioral health.

The Network work group agreed that equally important to having enough physicians is having the right physicians — those who are trained to provide services in a rural community. Rural family physicians deliver babies, provide emergency services, provide pediatric care, treat mental health conditions, and perform critical triage services. Focus group participants also noted that a significant challenge facing Idaho's healthcare workforce is an unequal distribution of providers between urban and rural settings.

[41] https://www.aamc.org/download/263512/data/statedata2011.pdf

Stakeholders agreed that expansion of medical school slots is needed to build the necessary and well-proportioned physician workforce in Idaho. Additional slots should be at medical schools with training tracks in rural healthcare, such as the University of Washington's Targeted Rural and Underserved Track (TRUST) program, and the slots should be designated for such programs. Students interested in working in Idaho's rural areas should be targeted for admission to the expanded slots. Work group members also agreed that medical school scholarships and loan repayment programs are valuable tools in recruiting students to medical professions and encouraging them to practice in Idaho. The suggestion was made that Idaho provide more substantial financial assistance to students in healthcare programs (e.g., medical, social work, nursing, dental school, etc.), who would be required to practice in Idaho for a set period of time upon their completion of the program. Another suggestion was to expand existing loan repayment funding (existing funding sources include the federal National Health Services Corps program and Idaho's own Rural Health Care Access Program (RHCAP) and Rural Physician Incentive Program) to encourage residency graduates to practice in Idaho.

Presently, Idaho ranks forty-ninth in the nation in the number of residency slots available. The work group agreed that State funding is needed to support an increase in residency slots that include a rural under-served area training track, as physicians who train in Idaho's rural areas as residents tend to stay for practice.

While some residency programs include learning opportunities for providing care in a rural setting, additional support and mentoring is needed as physicians establish their rural practice. The work group recommended having a preceptor program to enhance educational resources for PCPs at the community level. A central agency, such as the AHEC, could perform the function of linking preceptors to the primary care "learners." This agency would compile and maintain a database that includes preceptor information, such as: name, medical specialty, preference regarding learner type, e.g., practice, location, etc., the best way to contact the preceptor and a calendar of dates and times when the preceptor is available to volunteer his/her time to the learner. The agency would connect learners and preceptors to create a learning environment at the local level in addition to providing opportunity for preceptor development.

Stakeholders participating in focus groups recommended using alternative providers to supplement the healthcare workforce. The Network work group specifically recommended using CHWs as an alternative provider to expand the healthcare workforce. As discussed by the work group members and focus group participants, in workforce shortage areas it is most important that each healthcare professional work at the upper limits of their scope of practice. The recruitment and addition of CHWs in the PCMH is a valuable tool for both achieving community connections necessary for coordinated care but also for maximizing productivity of the State's healthcare workforce.

Focus group participants consistently reported that licensing requirements are burdensome and a barrier to efficient hiring practices. Some stakeholders reported that the licensing process was so lengthy that it was common to lose potential hires (physicians) because the individual would accept another position in another state before their license could be approved in Idaho. Stakeholders recommended that Idaho's State medical board consider broadening its conditions for allowing reciprocity of a medical license in other states and to streamline the licensing process.

Strategies for expanding Idaho's healthcare workforce

A substantial financial investment is required to expand Idaho's current healthcare workforce and overcome barriers to access. Currently, Idaho spends millions of dollars to pay for healthcare services based on volume. Improving care and improving health outcomes requires a shift in what and how Idaho purchases healthcare. For Idaho to shift from funding a volume-based healthcare

delivery system to a value-based system, there must be a commitment to expanding the primary care workforce upon which the value-based system is created. The IHC will work with the Council, AHEC, the Governor's Office, state agencies, the legislature and communities to advocate for appropriate funding levels and support the implementation of the strategies below.

Workforce Issues and Strategies

Issue	Strategy
Shortage of physicians, particularly in rural, underserved areas.	Fund residency programming, including family medicine, psychiatry, and internal medicine residency programs. Increase medical education slots at medical schools with training tracks in rural healthcare, such as the University of Washington's TRUST program, and target students interested in working in Idaho's rural areas for admission to the expanded slots. Fund medical school scholarship for Idaho students and require students receiving substantial financial aid to practice in Idaho for a set period of time upon their completion of their medical training. Expand existing loan repayment funding (available through the National Health Services program, Idaho's own RHCAP, and Rural Physician Incentive Program) to encourage residency graduates to practice in Idaho. Increase residency slots that include a rural under-served area training track. Establish a preceptor program to enhance educational resources for PCPs at the community level.
Nurse shortage.	Update Idaho higher education articulation agreements between Idaho nursing education institutions to increase access and pipeline into advanced nursing degrees in Idaho. Master level and Doctoral prepared faculty members are needed to ensure that schools of nursing are adequately staffed for educating nurses.
Limited public health services.	Support the training, recruitment, and retention of providers critical to the functioning of public health in Idaho including mid-level providers specifically working with local public health districts, registered dental hygienists, and registered dietitians.
Shortage of behavioral health practitioners.	Support the training, recruitment, and retention of key social work providers in Idaho including social work faculty as well as a rural social worker's program with an emphasis on behavioral health.
Overall shortage of healthcare workforce.	Increase financial assistance to students across healthcare educational programs (e.g., nursing, dental school, etc.), and require those who receive substantial financial aid to work in Idaho for a set period of time upon their completion of the program.

Issue	Strategy
Health education expansion.	Consider a statewide AHEC grant with three regional centers to promote enhancement and coordination of health education across healthcare disciplines.
Licensing barriers.	Encourage Idaho's State medical board to consider broadening its conditions for allowing reciprocity of a medical license in other states and to streamline the licensing process.

5

Health Information Technology

HIT enables a successful PCMH model by serving as the platform for which data is collected and made available to participants for purposes of extraction, patient collaboration, patient engagement, continuous quality improvement, reporting, and analytics. Through the use of advanced health technology, such as telehealth, EHRs, patient portals and clinical decisions tools, Idaho will reduce its barriers to access for those living in rural areas, improve provider collaboration and coordination, increase patient engagement, increase training and specialized care in geographically isolated areas of the State, and gather statewide data that informs the activities needed to improve the quality of care, control healthcare costs, and achieve improved health outcomes.

Idaho has not fully developed the capacity to collect and analyze statewide data largely due to the limited opportunities to coordinate data collection and analysis across payers and populations. A preliminary plan for data collection has been developed and presented in Idaho's SHIP but further analysis is needed to finalize the approach. During the first year of implementation and model testing, the IHC will analyze the current system capabilities and constraints regarding statewide data collection and reporting. The IHC will engage stakeholders in the discussion to ensure that a statewide solution is viable and acceptable to the different communities in Idaho. By the end of Year 1, decisions regarding construction of the statewide database and protocols for PCMHs to report on performance measures will have been developed.

Current state of Health Information Technology in Idaho

Electronic Health Records

EHR adoption is critical to enabling the exchange of clinical and other information between providers and other organizations. A key driver to EHR adoption in Idaho has been the Washington & Idaho Regional Extension Center (WIREC), which received funding from the Office of the National Coordinator for HIT (ONC) to help primary care providers adopt and use EHRs.[42] WIREC, led by Qualis Health, provides vendor-neutral HIT consulting services related to the successful adoption, implementation, and utilization of EHRs for the purposes of improving care. These services include 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 provides guidance to eligible healthcare professionals as they endeavor to achieve meaningful use of EHRs and qualify for CMS incentive payments. WIREC collaborates with Medicaid, Medicare, the statewide HIE, the Beacon Community, public health departments, stakeholders involved with workforce development, and the many professional organizations that support healthcare providers. WIREC's common goal is to ensure that healthcare providers have the information they need to successfully adopt EHRs.

The HIT work group, using broad-based stakeholder input, identified the following challenges and opportunities regarding the use of EHR technologies among providers in Idaho:

[42] http://www.wirecqh.org/AboutUs.cfm:

EHR Challenges and Opportunities

Challenge	Opportunities	Potential Next Steps
EHR adoption rate among Idaho providers needs improvement overall, especially among smaller providers.	Opportunity for WIREC to continue outreach activities with additional funding. The Medicaid EHR Incentive Program provides incentives to provider for EHR adoption.	IHDE continues to connect providers to the statewide HIT infrastructure and offer its virtual health record (VHR).
Providers who do not use EHRs in their practice reported in focus group meetings that they perceive EHR adoption to be a significant business risk to their organization.	Opportunity for education and outreach by the IHC, WIREC, IHDE, and/or the State of Idaho.	IHDE will promote statewide interoperability by recruiting non-participating providers to its VHR. IHDE will provide connectivity for providers already participating in one of the State's established HIT structures through the building of hubs and connections allowing push and pull functionality.
Disparate EHR solutions.	Promote standardization or lingua franca for EHR data to enable the creation of data hubs, data sharing, analytics, and reporting. The IHC, WIREC, IHDE, and/or the State could provide value-added consulting to assist with EHR implementation and integration efforts.	The IHC will promote the adoption of standardized EHR protocols and facilitate committees that will explore necessary HIT infrastructure changes to promote statewide population health management.
Meaningful use requirements.	Opportunity for education, consulting, and other value-added activities to help providers meet meaningful use requirements.	Providers may need assistance in understanding how to configure their EHR systems, make changes to workflow, and perform other activities to meet meaningful use requirements.
Increased reporting and data output requirements. Different EHRs have different ways to capture and report data. Data extraction can take time/effort. Proper data output requires correct data input.	Opportunity for IHDE to help integrate EHR systems into data hub. Opportunity for the IHC, through subcontracting to aggregate data in readily available forms for purposes of population health management.	IHDE will promote connectivity among providers not already connected to one of the larger HIT infrastructures in the State.

Challenge	Opportunities	Potential Next Steps
Costs related to initial implementation or changing to a new EHR solution.	The State or other payers could consider giving financial assistance to providers with their EHR implementation efforts.	Providers seeking to become PCMHs will have access to start-up funding and a PMPM to cover the costs of continued advancements within the practice as well as lump sum payments to offset costs related to becoming a PCMH.

According to ONC data for Idaho,[43] in 2012, 58% of hospitals, 42% of physician offices, 51% of PCPs, and 33% of small practices had adopted basic EHRs. While significant work is still needed to resolve barriers and achieve greater penetration of EHR adoption across Idaho's primary care practices, the Medicaid Provider Incentive Program has established a critical foundation for the work ahead.

Health Information Exchange

Idaho's statewide Health Information Exchange (HIE) is maintained by the Idaho Health Data Exchange (IHDE), which was created as a result of the efforts of the HQPC. IHDE, a 501(c) (6) nonprofit corporation, was established to govern the development and implementation of a HIE in Idaho. IHDE is governed by a Board of Directors that includes representation from both the public and private healthcare sectors. Initial funding for IHDE was appropriated by Idaho's Legislature and ongoing funding comes from participants in the Exchange.[44] IHDE also received a grant from ONC to develop and advance the HIE. Currently, connections to the HIE consist of 10 hospitals, six laboratories, three payers, and over 1,200 provider-group users.[45] These connected providers receive clinical results and are also able to conduct e-prescribing through the system. IHDE also offers clinical messaging, or clinical results delivery, to connected providers and a clinical data repository (which consists of laboratory, radiology, and hospital transcription information) through a portal called the Virtual Health Record (VHR). Through the VHR, providers are able to view continuity of care documents for their patients.

The HIT workgroup identified the following challenges and opportunities related to HIE in Idaho:

HIE Challenges and Opportunities

Challenge	Opportunities	Potential Next Steps
HIE (IHDE) participation rate has been steadily growing, but will need improvement to support future growth if added functionality and services are considered.	Opportunity for more providers to participate in IHDE. Opportunity for State to incentivize provider organizations regarding participation.	Staffing plan and budget will be included in Idaho's MTP.

[43] ONC Health IT Dashboard at http://dashboard.healthit.gov/data/

[44] http://www.idahohde.org/dsite/node/9 and State Medicaid Health Information Technology Plan (SMHP) Version 1.2 April 1, 2013.

[45] Health Quality Planning Commission Annual Report, Creating a Healthy Idaho, July 2013.

Challenge	Opportunities	Potential Next Steps
Current HIE data sharing administrative agreements allow for sharing of data for treatment purposes only.	Opportunity to expand current scope of IHDE participant organization data sharing agreements to support SHIP activities.	A review of IHDE's existing policies to accommodate such opportunities will occur.
Current IHDE system is not adequate to perform all SHIP activities.	Opportunity for IHDE to expand capabilities and system architecture to support SHIP needs.	Additional review of IHDE's existing policies to accommodate such opportunities will occur.
Current IHDE staffing levels not sufficient to perform expanded role required by SHIP.	Opportunity for IHDE to increase organizational capacity.	A review of IHDE's existing policies to accommodate such opportunities will occur. Organizational expansion will occur through IHDE revenue generation and MTP grant funding.
Current HIE functionality is limited.	Opportunity to expand EHR data integration and other functionality.	Next steps mentioned in table above.
Limited reporting performed by IHDE today.	Opportunity to advance analytic and reporting capabilities and provide value-added data analytics and reporting services to participants, the IHC and RCs.	Review opportunity for growth in analytic capability and the integration of those analytic capabilities into the larger IHC led analytic efforts.

Telehealth

The Idaho Telehealth Taskforce (ITT) was established in March 2013 to explore resources and barriers related to healthcare delivery via telehealth in our State. Over 50 participants with broad representation of the healthcare system across the State are committed to this endeavor. Since its creation, the ITT has launched important initiatives, such as the Idaho Telehealth Collaborative Program, to expand telehealth throughout Idaho.

The Idaho Telehealth Collaborative Program was designed by the AHEC and members of the ITT to focus specifically on the delivery of behavioral health and substance use disorder treatment services. This project model has been reviewed by the taskforce and several key leaders in government and healthcare. The project has letters of support, including letters from the governor, the director of Health and Welfare, the Idaho Association of Counties, and the IMHC. In August 2013, ITT requested funding for the Idaho Telehealth Collaborative Program through Round Two CMS Innovation Grant funding. The grant application asks for $2,299,531 for three years. The Idaho Telehealth Collaborative Program will address the identified barriers to telehealth adoption by providing education, mentoring and support to encourage behavioral health providers in Idaho to engage in telehealth. Additionally, experienced telehealth providers in other states will be encouraged to become licensed in Idaho. A specific model of "readiness for change" will be implemented that will provide customized plans to teams at critical access hospitals and other facilities throughout the State to assist them in the development of telehealth programs. Outreach and education to rural communities will be conducted to make consumers aware of the availability of telehealth as a resource for accessing behavioral health services. In addition to the specific behavioral health project addressed by the Idaho Telehealth Collaborative Program, the ITT

supports expansion of telehealth for other health care services not currently available in rural/frontier regions.

While substantial investments have been made in both expanding broadband availability and in supplying teleconferencing equipment, use of telehealth technology has not been fully embraced in Idaho to date. Key barriers to the development of a robust, coordinated system of telehealth technology that can serve all regions of the State include a lack of provider champions, discomfort with change from traditional methods of service delivery, and the lack of parity in reimbursement for telehealth from both public and private payers.

Stakeholders repeatedly noted that expanded utilization of telehealth could be a solution to address access barriers in geographically isolated areas. It was suggested that IDHW consider expanding its Medicaid telehealth policy to other specialty areas beyond mental health services, such as emergency department consultation in physician shortage areas. The State's telehealth policy could be expanded to allow for reimbursement of these services through the Medicaid program, and commercial payers should also reimburse for telehealth and non-traditional visits. In addition, telehealth programs (e.g., New Mexico Project ECHO) may offer a means to care for more intensive services on site rather than have patients drive miles for specialty care.

Idaho's new PCMH model will incorporate these recommendations to maximize the use of telehealth technologies to achieve the goals of the model. Notably, Idaho will use telehealth as a means to train CHWs and community EMS workers in rural and underserved areas of the state to increase access to coordinated primary care services through the virtual PCMH. To support telehealth initiatives for behavioral health services, the IHC will work with IDHW and other payers to explore maximizing reimbursable telehealth services.

Stakeholder deliberations regarding HIT

The HIT work group was responsible for evaluating current HIT assets and barriers in Idaho, and developing a framework that will support information exchange between stakeholders and facilitate processes for timely data collection and analysis in the future PCMH model. The HIT work group was comprised of a wide range of stakeholders, including public entities (i.e., local public health districts and Medicaid), federal entities (VA and IHS) as well as FQHCs and a diverse set of stakeholders from the private sector including healthcare providers and payers. The HIT work group had broad consensus on the recommendations listed below.

The HIT work group considered three general options related to the development of HIT to support the new PCMH model.

1. Leverage existing tools, technologies, and methodologies instead of expanding the infrastructure and capacity. This option was immediately rejected as Idaho does not have basic foundational HIT components needed to advance SHIP objectives such as adequate EHR market penetration among providers, a statewide multi-payer database, an HIE environment that allows for the sharing of data/information for non-treatment only purposes, or adequate HIE participation amongst providers.

2. Utilize disparate and siloed third-party vendors or other products to attempt a "distributed" approach to data aggregation, integration, and reporting. This option was rejected for the same reasons as item 1 above and because no controlling entity exists to (or has shown success with) coordinating HIT data in the State of Idaho.

3. Build integrated system capacity for the collection and dissemination of data and information.

The HIT work group recommended pursuing the third option because, given the current state of HIT in Idaho, the work group felt that a centralized approach would facilitate a faster and potentially more successful process of connecting providers, payers, and healthcare consumers via technology to support the goals of the SHIP. The work group also noted that laying the foundation of a data hub would not preclude future contributions by third-parties, consulting organizations, data vendors/aggregators, etc. and, in fact, would likely support these potential future-state activities.

Stakeholders noted that IDHW's Medicaid Provider Incentive Program has laid the groundwork for expansion of EHR adoption and establishment of quality measures for meaningful use. The quality measures are in alignment with National Quality Forum and Physician Quality Reporting Initiative definitions. Additionally, the Medicaid Provider Incentive Program has established a process to assure that EHRs adopted by providers requesting Medicaid incentive payments are certified EHR products. The HIT work group recommended that the IHC and IHDE work closely with IDHW to leverage resources and incentives of the Medicaid Provider Incentive Program to support further expansion of adoption and meaningful use of EHRs.

Highlights of the HIT work group's key recommendations, including major components of the new HIT model, are described below.

The future of HIT in Idaho

The future state of the HIT system will see IHDE enlarging its capabilities to reach out to more providers and connect more systems in the State. To accomplish this, IHDE will continue to build interoperability with data hubs in other parts of the Idaho HIT infrastructure. Sources of data required for reporting and analytics may include broad categories such as payer data (e.g., claims and payment information), clinical data (e.g., from EHRs and other clinical sources), and patient data (e.g., patient portal data, personal health records, social media, and biometrics). Robust analytic and reporting capabilities will likely also require integration of other data sources such as public health, Medicare, and Medicaid. The analytic and reporting platform will need to be flexible in order to support differing needs of the various participants throughout the system. To that end, IHDE is in a unique position to leverage its current efforts and increase partnerships to continue to grow as an important part of the overall State HIT solution. This is a significant area of innovation given the relatively undeveloped HIT infrastructure in Idaho compared to other states.

Connecting statewide data hubs that contain payer, clinical, and patient data is a critical precursor to developing a reporting architecture that is capable of integrating these disparate data sources. In the beginning years of the transformation, the statewide aggregation of data will occur via a quality vendor contracting with the IHC to establish statewide baselines and enable whole population health management. As the model matures, IHDE and other already established HIT infrastructures will provide aggregation and analytic support to the IHC to facilitate its population health management functions.

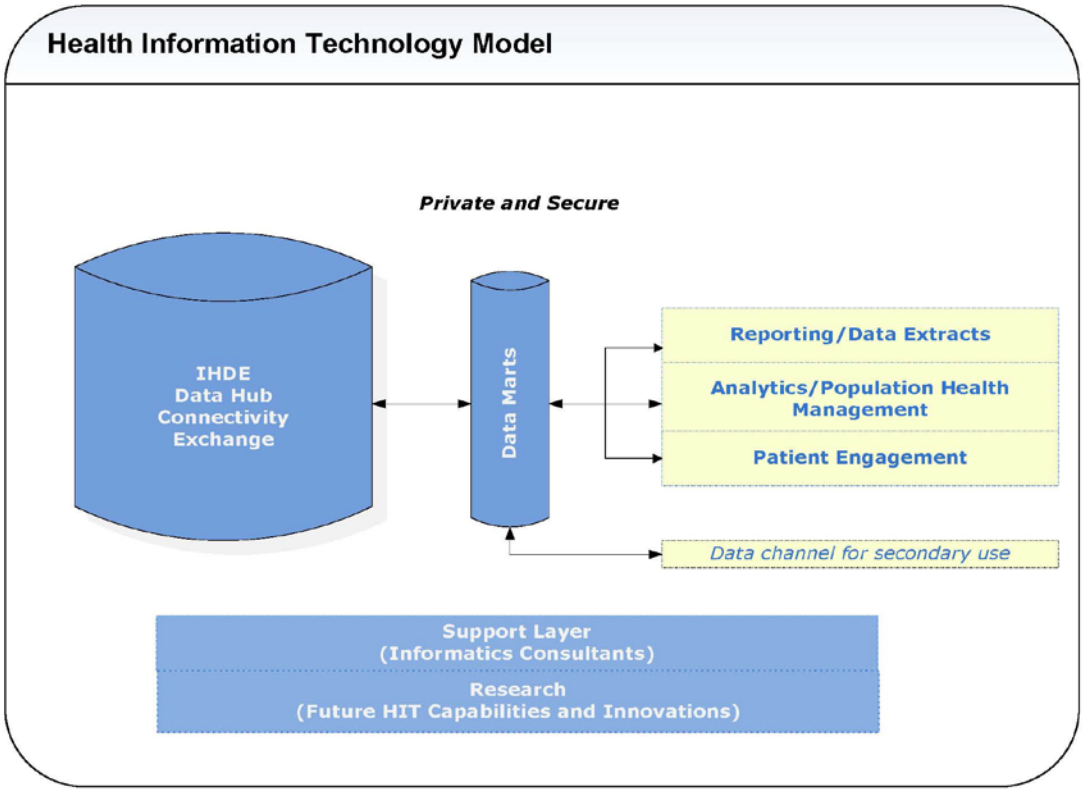
Access to the information outputs from IHDE will be segmented by need and other factors utilizing role-based security and other methodologies. Privacy and security protocols will be established and monitored to ensure protection of personal health information and other sensitive data in compliance with HIPPA requirements. Levels of reporting and access to data will need to be flexible and extensible in order to meet the various needs of PCMH providers and other system actors (e.g. the IHC or RCs). This flexibility and extensibility will likely require the ability to provide analytic and reporting capabilities and other services to connected organizations.

Provider participation rates will be increased through technical outreach, financial support through incentives, and possible policy changes. IHDE is a member-based organization and participant attraction and retention are key components of IHDE's mission.

In addition to providing data for use by providers, IHDE will develop the capability for the data to be used by other entities such as local public health districts for community health activities and other public health activities. The IHC will help facilitate the collaboration between IHDE and public health as this information will be important for the assessment of regional health needs.

Idaho recognizes that significant challenges may be encountered around infrastructure costs, the development of data sharing and use agreements, and ensuring connectivity for participating organizations. As such, federally supported internet broadband initiatives are underway to address connectivity issues in Idaho, e.g., www.linkIdaho.org. Expansion of the HIE functionality in Idaho is actively being managed by this group, and thus is not addressed further in this SHIP.

The following illustrates the HIT model described above.



As shown in the model above, IHDE will serve as a hub of connectivity for the State. Each of the otherwise not interoperable HIT Infrastructures (e.g. payer and hospital HIT systems) are represented here as "data marts." The already matured HIT infrastructures around the State will not be feeding data directly to the IHDE hub, but will instead be connected to allow end-users access to share EHR-specific information to better coordinate care. Initially, aggregation of data will occur via a quality vendor with the IHC; however, as IHDE and the interoperability of the system mature, the IHC may transfer some of these functions to IHDE.

Increasing patient engagement through HIT

Patient engagement improves patients' understanding of their health and healthcare conditions, enabling them to assume a more active role in their healthcare. This is a key element to the Triple Aim, healthcare innovation, EHR meaningful use requirements, and other aspects of healthcare delivery. IHDE can play a critical role in engaging patients and sharing broader population health information. This may include having a patient portal that different providers could use and the use of social media. The site could also include links to health initiatives, statistics, data, etc. Patient engagement activities could also include collecting biometric data from devices. Collaboration between IHDE and the IHC will direct how advances are made in the IHDE system to promote patient engagement.

Providing a mechanism for care coordination and collaboration

The current HIT Infrastructure in Idaho has several advanced HIT systems that are utilized exclusively by the payers and hospitals. The solution proposed here seeks to connect those

independent systems in a way that promotes care transition, coordination, management, and collaboration. In addition, IHDE, through increasing its participating provider footprint, will fill the gaps left by the independently constructed HIT Infrastructures around the State. Several enabling technologies are available today within the IHDE system that will improve care transitions across providers, making them safer, improving quality, and avoiding costly and unnecessary hospital readmissions.

Ensuring patient data privacy and security

Privacy and security are a main concern for patients, payers, and providers. A policy framework, physical and electronic security measures, and other privacy and security-related organizational and infrastructure items will need to be constructed to support the future state vision. Policies and procedures that govern privacy and a secure technical solution will need to be developed in tandem 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, substance use, and developmental disabilities.

Expanding reporting and analytic capabilities

Enhancements to current reporting capabilities will be implemented in phases. Initial reporting enhancements will be part of the expansion of the IHDE infrastructure and will include operational reports related to data handling, error routines, and balancing activities. Later phases will enhance analytics and end-user reporting through a variety of internally developed and possibly vendor-provided products providing both “drill down” and “slice and dice” capabilities through web interfaces with role-based and context-based security protocols.

Increasing the analytic and reporting capabilities of IHDE will ensure that otherwise unconnected participating providers are connected to a main HIT Infrastructure in Idaho. Because IHDE is available statewide and to any provider practice, this represents a critical innovation in the SHIP.

Coordinating with other statewide HIT initiatives to accelerate HIT adoption

Idaho has several other statewide HIT-related initiatives underway that support the activities outlined in the SHIP. Coordination between these various initiatives is essential for Idaho to maximize collaboration opportunities and value across the various initiatives. The IHC will have responsibility for advancing the success of the statewide HIT-related initiatives.

The HIT work group identified the following existing HIT initiatives, which will be leveraged in the new model:

The Idaho Telehealth Taskforce, which was discussed previously in this section.

- The Idaho HIT work group is focused on bringing players from all the facets of HIT in Idaho to the table and sharing ideas, challenges, and solutions. Members include providers, payers, technology companies, State government, federal government, and legislators. Recommendations from this work group were considered during the SHIP design process, and outputs from the work group will continue to be collected and considered during implementation of the SHIP. Cross-team sharing will occur as often as possible.

- The Time Sensitive Emergency (TSE) work group is tasked with presenting to the legislature a proposed TSE legislative bill to develop a statewide trauma, stroke, and heart attack system.

Members include providers, payers, State government, and legislators. Any resulting passed law will be incorporated into the SHIP.

- LINK Idaho is part of the Telehealth Taskforce, TSE, and HIT work groups and focuses on broadband access in Idaho. The IHC will consider how to leverage any technologies and agreements that are championed by LINK Idaho to further the efficient sharing of data, especially in rural communities.

- The WIREC has driven acceleration of HIT in the State. The WIREC's successes to-date on accelerating EHR adoption among hospitals, primary care providers, and other physicians, including small practices, has driven high EHR adoption. Section 3 provides additional information on WIREC and its success to-date facilitating EHR adoption by providers.

Provider engagement in adopting EHR technologies is critical to achievement of Idaho's healthcare delivery system transformation. The IHC and IDHW, through the Medicaid Provider Incentive Program, will partner with the above initiatives. Direct support of the PCMHs will ensure that providers are engaged in transition and continuity of care, data collection and dissemination, and patient engagement, which will serve to increase the wave of EHR adoption currently under way.

Reaching providers in rural areas, small practices, and behavioral health providers

The use of HIT and HIE technologies in the new model will have a statewide impact, including providers in rural areas, small practices, and behavioral health providers. The activities of the IHC and RCs, as outlined in Section 2, will ensure that HIT support will reach all providers, not just urban providers, large providers, or those providing primary care services.

As identified, one of the biggest barriers to adopting HIT among providers in rural areas and small practices is the cost associated with these systems. To help overcome this barrier, practices will be eligible for transition start-up payments provided through the IHC that can be used towards the purchase or upgrade of HIT systems and data registries. Technical assistance for practices in rural areas and small practices will also be available through the IHC and its RCs. The planned web-enabled reporting capability will allow the exchange of data between providers, IHDE, and the IHC, and back to providers regardless of location. Web-enabled reporting capability will provide easier access to provider reporting activities, and is thus especially attractive to rural and small providers that can afford "low-end" investments in their HIT infrastructure.

Cost allocation plan or methodology for any planned IT system solutions/builds funded In part by CMS or any other federal agency

The model in Idaho will rely on sustainability in a stand-alone capacity once start-up costs have been covered. Model Testing Proposal grant funds will be used to create infrastructure and cover startup costs related to connectivity, interoperability with other systems, and initial hardware purchases. Such investments will not likely use cost allocation plans, as in other information hubs or exchanges, as the initial costs will be grant funded through the Model Testing Proposal award.

Once the system is operational, practices will pay for use of the systems through fees based on costs and levels of services. These operating costs and fees will not be dependent on federal grants but instead on user contributions for the services they access. As such, no cost allocation plan would be required.

Impact on the Medicaid Management Information System

Medicaid and its Medicaid Management Information System (MMIS) will be a full and active partner in the project. IDHW will meet with all three vendors that comprise the Idaho MMIS to discuss how current functionality can support the future environment and also what additional enhancements each of their companies can offer (individually and collectively) that would assist Idaho in meeting the needs of the future as provided by the SHIP.

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 PCCM and updated in 2013 to meet the requirements of the health home initiative. It is anticipated that there will at minimum be a need for the Idaho MMIS to pass and receive data to/from other systems at the regional and State level. Data that could potentially be used includes claims, recipient, and provider data, in consideration of HIPAA and other regulations. The Medicaid Decision Support System aggregates claims and pharmacy data and may feed the proposed ‘data hub’ through a variety of mechanisms (flat file, web services, etc.). Required changes/modifications to the Decision Support System could include data filtering, data-specific aggregation, and transmission.

The planning and implementation timelines for changes to the MMIS are largely unknown until requirements have been developed and required changes are defined and prioritized. Any changes to the MMIS or related systems will likely require time/effort and possibly new resources as current IDHW resources are constrained by ongoing, non-SHIP related system changes, enhancements, and other activities, especially considering the priorities of the ACA and other initiatives.

6

Coordination with Existing State and National Health Programs and Healthcare Initiatives

Idaho's model of healthcare delivery and payment reform both builds off existing state and national healthcare initiatives and partners with those efforts to elevate their impact on the population. Below are key programs in Idaho that will be coordinated with the SHIP.

Coordination with Aging and Long Term Services and Supports

Community services for individuals with developmental disabilities, as well as elder care, community health, and home- and community-based services (HCBS) are available throughout Idaho, but often poorly coordinated. The Idaho Medicaid program currently has four Section 1915(c) waivers to provide HCBS to individuals who would otherwise require care in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/ID). These waiver programs are:

Act Early waiver	• For children age three to six who meet ICF/ID level of care and have an autism spectrum diagnosis and/or maladaptive behaviors
Children's Developmental Disabilities waiver	• Offers various HCBS to children up to age 17 who meet ICF/ID level of care and have autism, intellectual disabilities, and/or a developmental disability
Developmental Disabilities waiver	• Offers HCBS to individuals age 18 or older who meet ICF/ID level of care and have autism, intellectual disability, cerebral palsy and/or a seizure disorder
Aged and Disabled waiver	• Offers services to individuals who meet nursing facility level of care, and are either age 65 or older, or age 18 to 64 and have a disabling condition

The Administration on Community Living's Aging and Disability Resource Centers (ADRCs) and CMS' Money Follows the Person Program (MFP) are active in the State of Idaho. Idaho does not have an approved application for the Balancing Incentives Payment Program. The Idaho MFP Demonstration is known as Idaho Home Choice. The goal of the program is to help people transition from an institution (skilled nursing facility, intermediate care facilities or psychiatric facilities) to community living in an apartment, private home, or community setting such as a certified family home or residential assisted living facility. As of July 2013, the Idaho Home Choice program has helped 104 individuals transition from an institution back to the community.[46] There are six Area Agencies on Aging (AAAs) in Idaho, one in each of the State's Planning Service Areas,

[46] http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/IHCNewlsetter.pdf

that provide ADRC services to seniors in their service area, including options counseling to assist seniors in identifying community resources and supports to help meet their needs. The activities of the ADRCs are coordinated and governed by the Idaho Commission on Aging.

Patients with the highest need and patients at the highest risk of adverse health outcomes are often eligible for these public programs that provide case management, care coordination, and other resources to help ensure that the patient receives the right care in the right setting. However, poor coordination among those programs and with the patient's primary care team leads to the potential for these functions to be duplicated. At the same time, because these programs only serve those with the highest need, many patients who would benefit from case management and care coordination do not receive these needed services.

The Network work group considered the integration of institutional and community-based services for the aged and disabled populations in the PCMH model. The work group addressed the following questions:

1. Will the new model require any changes in the role of the HCBW waiver, MFP and ADRC programs? If so, what will their new role be?

2. What are the roles of each player (i.e., HCBS provider, MFP, ADRC, PCMH, and other agencies who provide LTC) in terms of case management and care coordination? How can we ensure that functions are not duplicated?

3. How will the model ensure coordination with facilities or home-based providers if the PCMH is not the primary deliverer of care (meaning the patient sees the provider who comes to them rather than choosing a PCP to go to see)?

4. How should end of life care be integrated into the system?

5. What role should the PCMH have in helping with transitions out of facilities in order to reduce readmissions?

Network and CQI work group members agreed that the PCMH model must include a strong element of coordination with long term care services that focuses on patient-centeredness and quality of care. The facilities and community-based organizations that serve the aging and long term care populations will be integrated into the new model to form a cooperative network of providers that work together to address the needs of the patient across his or her lifespan. These providers include: PCP, pharmacist, hospital, nursing home, residential assisted living facilities, home health/community care, physical therapist, occupational therapist, mental health provider, hospice, rehabilitation, substance use disorder provider, adult day care center, developmental disability center, social worker, and the community groups or facilities that provide meals either on site or home delivered. Stakeholders agreed that one of the goals of the new model should be to reduce facility readmissions, which can be achieved through greater care transition coordination among the facilities that participate in a patient's care. A key strategy for reducing facility readmissions is improving notifications of hospital/facility admissions (such as through EHR alerts) and careful care transition planning. Care transition will address critical components of effective care at home prior to the patient's discharge, including assistance with obtaining medicines, scheduled follow-up appointments, and at-home checks as needed.

The Multi-Payer work group recommended integrating complex cases into the new payment models through a value-based payment structure where payers will negotiate expanded PMPM payments to practices for the coordination of complex cases.

Restructuring Medicaid Supplemental Payment Programs

The Steering Committee also considered whether changes to Idaho's Medicaid supplemental payment programs will be necessary to support the new model. The supplemental payment program in Idaho is associated with hospital services. The proposed PCMH model focuses on creating a medical home, and the proposed payment strategies do not include inpatient or outpatient hospital services at this time. However, the longer range goal is to move toward total cost of care models with shared savings. At that point, the State might reexamine how the supplemental payment program could be utilized to aid in these strategies.

Coordination with Oral Health Services

The holistic approach developed by stakeholders recognizes the importance of oral health, in particular children's dental care, in attaining improved health status for Idahoans. Availability of dental care is a concern as there are 63 dental care health professional shortage areas in Idaho.[47] Workgroup members recommended that the RCs identify all dentists and organizations, e.g., public health, within the medical neighborhood providing dental care and work with them to establish formal mechanisms for communication and referrals.

Coordination with Idaho Community-based Quality Initiatives

Idaho is proud of its history of community initiatives supported at the local level by faith-based organizations, civic groups, local public health districts and nonprofit organizations, all of which will be harnessed in the new model to improve the health status of Idahoans across the State. Idaho's model builds off the experience and success of these local initiatives and supports the advancement of existing programs by partnering with these efforts to enhance and expand quality care. The IHC and its RCs will facilitate partnerships with local community-based initiatives to deploy evidence-based community health improvement strategies either developed locally or modeled from successful strategies used in other parts of the State or country. Community-based initiatives will vary by region to reflect local needs as identified through community needs assessments and align with performance measures.

Community initiatives listed here are examples of existing Idaho programs that share a common goal with the IHC and its RCs to respond to community health needs and improve the health of all Idahoans.

- Activate Treasure Valley is a multi-faceted healthy living initiative sponsored by the YMCA that encourages people to adopt healthier lifestyles. The initiative brings together health and wellness partners from across the region with the vision of making the Treasure Valley a model for active living and healthy eating in America.[48]

- The Cancer Awareness and Prevention Coalition of North Central Idaho planned and implemented a strategic plan to increase cancer screening rates and decrease cancer incidence

[47] *Idaho: Providers and Service Use*. The Henry J. Kaiser Family Foundation. http://kff.org/state-category/providers-service-use/?state=ID

[48] Treasure Valley YMCA, Activate Treasure Valley Website viewable at http://www.ymcatvidaho.org/programs/healthy-communities/activate-america

in the area. Their initiatives include the No Sun for Baby program that partners with local hospitals to educate new parents about the importance of protecting babies from the sun.[49]

- Let's Move Boise! is a community wide initiative to combat childhood obesity by increasing access to healthy food and physical activity. This initiative works in collaboration with the National League of Cities' Healthy Communities for a Healthy Future to impact child nutrition by educating child-care providers, raising awareness about nutrition programs, growing fruits and vegetables, and providing neighborhood based activities for kids and adults.[50]

- In the south central part of the State,[51] the local public health districts support a number of community health initiatives including the "Ask Me" program, a community-based education program utilizing volunteer partners to promote breast cancer screening with the goal of increasing the number of women receiving mammograms.

- Several grant funded programs are promoting dental health for children by providing fluoride varnish to children in Early Head Start in Twin Falls, Jerome, and Rupert. The local public health district also provides fluoride varnish to children in Migrant Seasonal Head Start and the Refugee Center.

- To help improve physical activity and nutrition, HEAL IDAHO and the local public health district have offered mini-grants to two elementary schools in Minidoka County to help increase access to nutritious foods or promote physical activity. These grants require schools to create and implement policy and/or environmental changes that will demonstrate how their project is sustainable.

- The Eastern Idaho Chronic Disease Partnership is a group of healthcare professionals who focus on reducing the burden of chronic diseases on individuals, families, and the community. The partnership meets every month and sponsors both professional development and community-based events.[52]

Coordination with National Campaigns and Health Promotion Programs

Many of the performance measures recommended by the CQI work group align closely with the tenets of a number of national campaigns and health promotion programs. Alignment of State efforts with national programs such as Healthy People 2020, the Million Hearts Campaign, the National Prevention Strategy, and the National Quality Strategy will allow the IHC and RCs to leverage large national health campaigns, in combination with localized efforts, to address some of the most important issues facing the health of Idahoans. Adoption of national campaigns can also be used as a first step to initiating programs and supports while recognizing resource limitations in some regions that might be a barrier to local initiative development. The IHC and RCs can leverage the outreach efforts of national campaigns such as Healthy People 2020 and the Million Hearts Campaign, while honing in on State and region-specific issues that pose the most significant concerns for individual regions. The combined efforts of national campaigns with State and regional engagement will amplify the effectiveness of outreach efforts at every level.

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[49] North Central Idaho Public Health District, Community Health Programs webpage, viewable at http://www.idahopublichealth.com/78-community-health/

[50] Let's Move Boise! Website viewable at http://www.letsmoveboise.com/

[51] South Central Idaho Public Health District, Community Health webpage viewable at http://www.phd5.idaho.gov/

[52] Eastern Idaho Public Health District web page viewable at http://www.phd7.idaho.gov/Health%20Promotion/Diabetes/diabetesmain.html

The Million Hearts campaign represents an opportunity for the IHC, RCs, public health districts, and the provider community to address a number of health concerns that contribute to some of the most significant causes of morbidity and mortality in Idaho. Through partnership and collaboration, the Idaho will be better able to achieve the goals of its Strategic Plan which align with the tenets of the Million Hearts Campaign, such as reduction in the use of tobacco products, promotion of healthy eating habits, and high rates of screening/management of cholesterol and blood pressure among Idahoans.[53] The adoption and reporting of a subset of these clinical quality measures, as well as data sharing with stakeholders also provides an opportunity for Idaho to align its SHIP with the Million Hearts Campaign and its goals.[54] Many of these goals and priorities also line up with goals established by the Healthy People 2020 program, which contains health-related goals spanning a wide range of specific criteria.

The alignment of goals, priorities, targets, and performance measures between IDHW, the IHC, RCs, local public health districts, and these national campaigns serves as an opportunity for cooperative efforts, meaningful dialogue, and information sharing. Many of the quality performance measures that will be collected, evaluated and reported as part of Idaho's SHIP align well with the targets and performance measures established by these and other national health campaigns. As such, Idaho has an opportunity to monitor the effectiveness of its targeted measures and programs as they pertain to specific health concerns and risk factors, as well as the opportunity to gauge Idaho's performance against a national benchmark. Idaho's participation in the data collection and discourse surrounding these national campaigns provides an opportunity to both improve the quality of health information gathered, as well as the care and service efficacy represented by those measures through the SHIP.

IDHW's efforts to promote health and quality healthcare and reduce costs also align with goals outlined by the Division of Medicaid's State Medicaid Health Information Technology Plan (SMHP) and the HQPC. Among the priorities of the SMHP is improving access to collaborative care, which is achieved through information sharing via the IHDE.[55] The SMHP specifically identifies program outreach and incentivized expansion of EHR utilization and connectivity. Furthermore, the SMHP establishes the IHDE as having a prominent role in the collection and reporting of meaningful use data, specifically clinical quality measures. Many of these measures, as described above, align with goals established in the SHIP, as well as the tenets of national campaigns such Healthy People 2020 and the National Quality Strategy.

Coordinating with Nonprofit Hospitals' Community Benefits/Community Building Plans

Stakeholders identified that the interaction between State and regional health efforts with community nonprofit hospitals represents a significant opportunity to assess and subsequently address some of the major health concerns in Idaho's regions. The ACA added new requirements for nonprofit hospitals, including the requirement to conduct a community health needs assessment and adopt an implementation strategy every three years. This is in addition to the community benefits analyses they were already required to perform pursuant to IRS regulations and Idaho's requirement that nonprofit hospitals with at least 150 beds report community benefits.

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[53] Idaho Department of Health and Welfare FY2013 – FY2017 DHW Strategic Plan. July 1, 2012. http://www.healthandwelfare.idaho.gov/Portals/0/Users/246/46/246/DHW%20Strategic%20Plan%20SFY%202013%20%20Final%20(2).pdf

[54] Wall, Hilary K. and Taylor, Erica. *Idaho Statewide Healthcare Innovation Plan Webinar Series for Model Design States – Aligning with Million Hearts.* Webinar presented July 25, 2013.

[55] Idaho Department of Health and Welfare Division of Medicaid. *State Medicaid Health Information Technology Plan*. April 1, 2013. http://www.healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/WebVersionSMHP.pdf

These assessments and analyses provide a valuable opportunity for nonprofit hospitals, which are integral components of the medical neighborhood, to cooperate with regulatory and health promotional agencies at the State and regional level in order to evaluate and address issues facing the health of Idaho's communities.[56]

Local public health districts have conducted community needs assessments similar to the requirements placed upon nonprofit hospitals, and the IRS has released an announcement that allows nonprofit hospitals and health departments to join efforts in conducting the community health needs assessments required by the ACA. Furthermore, the IRS allows nonprofit hospitals to work with outside agencies such as local, regional, and State health departments to develop implementation strategies for the community health needs assessments. The CQI work group discussed the challenge of integrating community assessment information from multiple sources. It was recommended that the IHC and RCs partner with local public health districts to conduct the community health assessments rather than duplicate the efforts. The work group noted that the IHC should also use the findings of these assessments to identify commonalities and differences among communities which have conducted assessments. The findings will educate the IHC, allowing it to create and administer programs that target the issues found to be common across Idaho communities.

The development of a standard approach to and follow-up from community assessments will be a process that involves the IHC, RCs, local public health districts, and other stakeholders in the Idaho healthcare delivery system. This standardization allows for benchmarking across regions and the identification of strengths and weaknesses of the healthcare delivery system both regionally and in the State as a whole. Furthermore, RCs can collaborate with nearby hospitals to identify further key measures that can be collected in addition to the Performance measure Catalog measures in order to shed light on region-specific concerns.

Although the collection of data for community health needs assessments will fall primarily on nonprofit hospitals and public health departments, PCMHs within the State will also benefit from this collaborative process. Several of the core PCMH measures should be in line with the measures being reported by hospital systems and local public health districts, so PCMHs can both provide data to and use data from community needs assessments to improve their patients' health status. For example, hospital readmission rates can serve as an indicator for poor discharge planning and/or coordination of care, providing PCMHs with data that can be used to improve their impact on community health. Also, PCMHs can refer their patients to health and wellness programs, health education classes and other benefits being provided by hospitals, local public health districts, and community agencies.

Integrating Early Childhood and Adolescent Health Prevention Strategies with the Primary and Secondary Educational System

Currently, early childhood and adolescent health prevention strategies are the shared responsibility of Idaho's Department of Education and IDHW. The Department of Education operates several programs—with federal and State funds—that are geared towards promoting health literacy and healthy behaviors as well as ensuring a healthy school environment for students. The Coordinated School Health program includes health education, physical education, school nurse services, nutrition services, school counseling, psychological and social services, programs to promote a healthy school environment, and school-site health promotion for school staff. Section 204 of Public Law 108-265 mandates that all school districts have a wellness policy that includes goals for

[56] *New Requirements for Non-profit Hospitals Provide Opportunities for Health Department Collaboration*. The Network for Public Health Law. Last Updated October 2011. http://www.networkforphl.org/_asset/fqmqxr/CHNAFINAL.pdf

nutrition promotion, nutrition education, and physical activity, as well as guidelines for foods available on school campuses.[57] A 2009-2010 evaluation of school wellness policies revealed high compliance with this requirement.[58]

IDHW also plays a vital role in early childhood and adolescent health prevention strategies through federal and State-funded public health programs as well as direct prevention services provided through the seven local public health districts.

There was significant discussion within the Network work group regarding how PCMH practices should be integrated with existing school services and the primary and secondary educational system. The work group addressed the following questions:

- How will the new model integrate with existing programs/services for early childhood and adolescent health?

- How should school-based providers be connected into a medical home to create a better, more complete medical/behavioral health treatment model and to educate each other on the child's welfare? In the future, could a school-based wellness center become part of a PCMH?

- How much of the information-sharing capacity with schools currently exists versus what would need to be built? What information can be shared under HIPAA provisions? Who would have access to the child's record at the school?

There were areas of consensus and disagreement in the discussion of these issues. Work group members agreed that schools are in a unique position to observe behavioral and development issues that may not be apparent to a provider. Schools should be involved in conducting ongoing behavioral and developmental assessments. When issues are identified by such assessments, those need to be incorporated into the child's treatment plan, with treatment options explored by the PCMH, and the school providing treatment services where such services are available. As such, the new model should promote information sharing and coordination of care between the school and the child's PCMH. The PCMH's electronic medical record should contain information received from the school in order to coordinate those aspects of a child's care, particularly as they relate to behavioral and developmental issues in which the school is involved.

Currently, Idaho schools do not provide comprehensive preventive and primary healthcare services. In the event that these types of school-based wellness centers (SBWCs) develop in the future, the work group addressed how their services would be integrated with the PCMH model. Some work group members felt that the PCMH needs to be the principal service-delivery team and that SBWC services have the potential of fragmenting care and weakening coordination. However, a majority of work group members felt that as long as good communication exists and data is shared between the two entities, there is a role for the PCMH and SBWCs to work together. The PCMH would be responsible for developing a treatment plan, and assuring the coordination of care. The SBWC would have a role in providing care as an extension of the PCMH.

Coordinating with Health Insurance Marketplace Activities

Since the three largest commercial payers have agreed to follow the payment model and attribute membership to PCMHs for all individual and group policies, including policies sold through the

[57] http://www.sde.idaho.gov/site/cnp/wellness/docs/Section204ofPublicLaw.pdf

[58] http://www.sde.idaho.gov/site/cnp/wellness/docs/StatewideResults.pdf

Health Insurance Marketplace, the work groups did not discuss additional options for coordinating with marketplace activities. These decisions will be made during the model testing phase.

7

Policy Considerations

While several states have used executive, legislative or regulatory authority as tools for implementing new healthcare delivery models, Idaho stakeholders rejected the idea of policy changes that mandate adoption of the model or any of its components. Work group members and focus group participants across the board stated that incentives should be used to garner the cooperation of practices to transform their practices to the PCMH model and participate in performance reporting. Likewise, stakeholders rejected the idea of changes to the law impacting payer payment methods or data collection and reporting. Stakeholders were clear in stating that mandates and penalties do not work in Idaho, but that real change could occur through the cooperation of payers, providers, and patients.

Stakeholders recognized that, in some instances, legislation and executive orders have helped advance the quality of Idaho's healthcare delivery system. However, as a general rule, stakeholders felt that not only were policy levers unnecessary to achieve change when there is collective support across providers, payers and patients but could, in fact, back-fire if appearing to be a mandate. As such, there was minimal discussion of potential policy levers to aid in model implementation. Policy considerations that were discussed in work groups are noted below.

Relevant Idaho Healthcare Policy Levers

In recent years, several key pieces of legislation and action by the Governor through executive order have supported the development of a model that provides quality, patient-centered care. For example, the Idaho Health Planning Act states:

> "It is the intent of the legislature to provide to all of Idaho residents a quality healthcare system for a reasonable cost and to prevent the deterioration of such system by the duplication of services or the introduction of new categories of services that are not necessary to their health. It is further the intent of the legislature to promote cooperation among healthcare providers in health planning activities and to provide access to necessary care for all who require it. It is hereby declared that it is in the public interest of the state, to provide for the relief from penalties of state and federal law, cooperative planning in healthcare that is likely to benefit the residents of the state."[59]

Other important enacted legislation includes HB 260, passed by Idaho's legislature in 2011. This legislation directed IDHW to develop a plan for Medicaid managed care with a focus on high-cost populations. Specifically noted in the legislation was that the Department consider ways to improve coordination of care through patient centered medical homes. IMHC, created by Governor Otter through Executive Order 2010-10, embodies the purpose and policy set forth in the State's Health Planning Act and carries out legislative direction established through HB 260. As noted previously, the IMHC was tasked with making recommendations to the Governor and the Department of Insurance (DOI) regarding policies and activities necessary to transform Idaho's healthcare delivery system to a PCMH model. On November 21, 2012, CMS approved a Section 2703 health home

[59] Idaho Code §39-4901

State plan amendment (SPA) for Medicaid participants with chronic conditions. The SPA enables the Idaho Medicaid program to participate in the IMHC. Stakeholders across the four work groups and the Steering Committee agreed that the model proposed through the Health Planning Act and embodied in the IMHC's PCMHs should serve as the foundation for the future healthcare delivery system.

Idaho is one of several states with an "any willing provider law." Enacted in 1994, Idaho's law requires insurers and managed care organizations to accept in their provider network any qualified provider willing to accept the terms and conditions of the contract.[60] Stakeholders noted that this law may bolster the availability of providers participating in the model and increase patient choice.

Idaho's Individual Health Insurance Availability Act[61] sets forth critical provisions regarding health insurer requirements, including rate review provisions. The law establishes that rate filing is required for increases above 10%. Insurers must file new and proposed rate changes with the Idaho DOI (for increases are above 10%), but do not need to receive formal approval before they can implement the rate or rate change. Stakeholders did not feel that the statute or other DOI requirements imposed any barriers on implementation of the proposed PCMH delivery and payment model.

The Steering Committee considered how the new model will align with State regulatory authorities. Through the gaps analysis process, stakeholders identified that at this time Idaho does not have a certificate of need program and an alternative program was not recommended during the stakeholder input process.

State Plan Amendment to Implement the PCMH Model for Medicaid and CHIP

In order to implement the PCMH model described in this SHIP for Medicaid and CHIP, Idaho will submit an Integrated Care Model (ICM) Medicaid State plan amendment. Idaho's ICM SPA will be developed in accordance with CMS' guidance regarding ICMs, including State Medicaid Director letters #12-002 and #13-005 and will include changes to both Attachment 3.1-A and Attachment 4.19-B. In addition to the ICM SPA, Idaho will submit any necessary conforming changes to its Title XIX (Medicaid) and Title XXI (CHIP) State plans. Idaho will begin preparing these SPAs upon notice of award of a Model Testing Grant. Idaho will also revise its administrative rules, provider manuals, etc. as needed to implement the PCMH model within six months of award.

Additional policy levers considered include the following:

- Stakeholders discussed the importance of EHR adoption and other HIT tools to support care coordination, patient engagement and performance reporting. However, stakeholders did not support using mandates, such as the Massachusetts approach of requiring EHR adoption by a specified deadline as a requirement of obtaining a medical license in the State. Instead, stakeholders recommended that it is important to understand existing and perceived barriers, and implement supports and incentives to help providers overcome barriers.

- Stakeholders felt that potential legislation that might be supported is a change to the law that would allow information from the Idaho Immunization Reminder Information System (IRIS), to become part of a centralized electronic health record for the patient. IRIS is the statewide

[60] Idaho Code §41-3927 and §41-2872

[61] Idaho Code §41-5206

population based information system that tracks vaccines by patient and provides patient specific reminders to help providers monitor their patient's vaccination schedule. Current Idaho law[62] allows IRIS to receive data from other systems but does not permit the system to transmit immunization data back to those systems, including electronic health records systems.

- Stakeholders considered whether legislation should be enacted to require providers to accept patients from all insurers but rejected this idea. There was concern that providers would be disadvantaged if forced to accept all forms of insurance.

- Stakeholders considered the policies of Maryland's PCMH program that require the State's major carriers of fully insured health benefits to participate in the program. Stakeholders rejected this approach, noting that it was important to work collaboratively with payers to form partnerships as legislation that would mandate their participation in the model would not succeed in Idaho.

- Anti-trust legislation was considered but was determined to be unnecessary to implement the model.

As the IHC takes form and collaboration in implementation of the model continues across payers, providers, communities and individuals, stakeholders may eventually 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 to a patient-centered, population health approach.

[62] Idaho Code §39-4803

8

Self-Evaluation Plan

Plans for Continued Improvement and Evaluation

Through the SHIP model design process, Idaho has created an initial evaluation plan that will be expanded and developed by the IHC in the first phase of model implementation. The final evaluation plan, as developed by the IHC in coordination with external evaluation consultants, is intended to provide Idaho with a process for tracking progress in implementing the SHIP and in achieving the aims of the SHIP. The evaluation plan will help Idaho monitor an overall picture of implementation activities, as shown in the driver diagram at the end of this section, so that areas of need can be quickly identified in order to make changes to activities and resources. The plan is a fluid document that will change and expand over time based on work plan objectives, accomplishments, and expectations.

Idaho will provide access to data to enable CMS to evaluate the extent to which Idaho's health system transformation plan was implemented and the results of the model. This will include but not be limited to providing performance measure baselines and results and sharing community needs assessments and initiatives implemented by the IHC and RCs. In addition, IDHW, the IHC, and the RCs will identify key stakeholders for CMS to interview and facilitate contact as needed.

Idaho's Self Evaluation Plan

The self-evaluation plan is intended to provide a process for tracking the State's progress in implementing and achieving the aims of Idaho's SHIP. The evaluation plan will also provide a roadmap of evaluation activities so that required staff time and resources can be identified. Details of the plan may change and expand over time based on work plan objectives, accomplishments, and expectations.

The evaluation plan is based on the stated objectives of Idaho's SHIP, and includes performance and process measures that reflect the key elements of a successful system transformation. Most measures were identified because they are currently collected by different providers, and thus, available to support evaluation early in the model testing period. Source identification did not reveal any overly burdensome collection processes.

The evaluation measures identified during the SHIP model design phase indicate key milestones and outcomes of the model, all of which are targeted to achieving the Triple Aim of improved health outcomes, improved quality and patient experience of care, and reducing overall healthcare costs. Idaho's evaluation plan focuses on 4 key areas: outcomes, costs, structure and care experience.

The Performance Measure Catalog, presented below and described in Section 2, identifies the outcome measures that Idaho will evaluate. Information regarding the requirements and timeframes for data collection and reporting on these measures is also found in Section 2.

Idaho's Initial Performance Measure Catalog

Measure Name (and Source)	Measure Description	Rationale for the Measure
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 SMI 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. This measure aligns with Healthy People 2020.
Measure pair: (a.) Tobacco use assessment.	Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period.	In Idaho, 16.9% of the adult population were smokers in 2010 (>187,000 individuals). Idaho ranks fifteenth in the country in prevalence of adult smokers and its smoking-attributable mortality rate is ranked eighth in the country.
(b.) Tobacco cessation intervention (SIM)	Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.	
Asthma 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) in Idaho was 8.8% in 2010, 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 in 2011), this measure is 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.
Avoidable emergency care without hospitalization (risk-adjusted).	Percentage of patients who had avoidable use of 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.

Measure Name (and Source)	Measure Description	Rationale for the Measure
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. 1,355 babies in Idaho had low birth weights in 2011, compared to 1,160 in 1997.
Adherence to antipsychotics for individuals with schizophrenia (HEDIS).	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 may be a reflection of improved access to care and patient engagement.
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 85th percentile, but below the 95th percentile for BMI by age and sex, while 9.2% were obese, i.e., at or above the 95th 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 Idaho had diabetes.
Access to care.	Percentage of members who report adequate and timely access to PCPs, BEHAVIORAL HEALTH, and dentistry (measure adjusted to reflect shortages in Idaho).	Idaho has a critical access shortage of primary care providers, behavioral health providers, and dentists across the State which impedes access to the appropriate level of care.

Measure Name (and Source)	Measure Description	Rationale for the Measure
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 43rd in the nation with an immunization rate of 87.33% in 2012. This measure aligns with Healthy People 2020.
Adult BMI Assessment.	The percentage of members 18 to 74 years of age who had an outpatient visit and who's BMI was documented during the measurement year or the year prior to the measurement year.	In 2010, 62.9% of adults in Idaho were overweight, and 26.9% of adults in Idaho were obese.
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).	From 2010–2011, Idaho had the fourth highest non-medical use of prescription pain relievers in the country among persons aged 12 or older at 5.73%.

The table below identifies the cost measures that Idaho will evaluate. These measures were identified by the Multi-Payer work group, as described in Section 3. The timeframes to achieve cost targets can also be found in Section 3.

Idaho's Cost Measures

Issue	Target	Target Phases	Mechanism to Reach Target
Appropriate Generic Drug Use	Generic fill rate of 85%	25% of target in Year 1 one, 50% in Year 2 and 25% in Year 3	Each 1% improvement in generic fill rates reduces total pharmacy spend (0.5%-1.0% in Medicaid and 2%–3% in commercial payer)
Re-hospitalizations	5%–10% reduction	10% of target in Year 1, 20% in Year 2 and 70% in Year 3	20% of all hospitalizations are preventable re-hospitalizations

Issue	Target	Target Phases	Mechanism to Reach Target
Acute Care Hospitalizations	1%–5% reduction in total hospitalizations	0% of target in Year 1, 25% in Year 2 and 75% in Year 3	PCMHs reduce acute hospitalizations with IMPACT and IOCP training
Non-Emergent ED use	5%–10% reduction in total ED use	25% of target in Year 1, 50% in Year 2 and 25% in Year 3	10%–30% of ED visits are non-emergent (best in class commercial rates are 120-150/1000)
Early Deliveries (in weeks 37–39 of gestation)	20% improvement over baseline or all hospital report <5% 37-39 weeks	50% of target in Year 1, 50% in Year 2	1%–4% of total NICU admissions ($40-$70K/admit) are preventable with later deliveries

Idaho will also evaluate model structure and patient experience of care measures. These measures, and their data sources, are presented in the table below.

Model Structure and Patient Experience of Care Measures

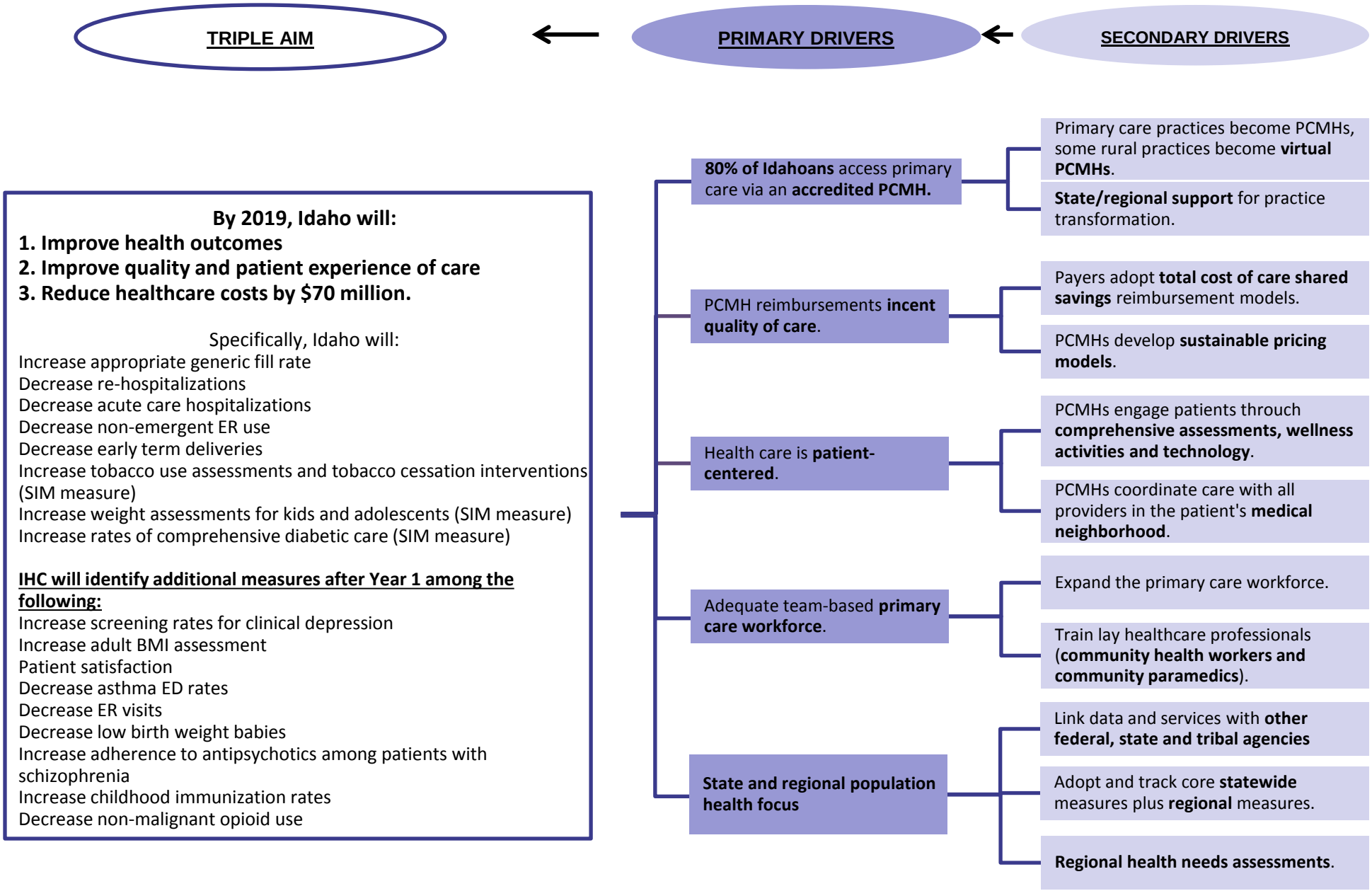
Evaluation Area	Performance Measure	Data Source	Performance Targets
Model Structure			
Establish PCMHs statewide.	Percent of practices that achieve PCMH designation and accreditation tier requirements in required amount of time.	IHC tracking.	• 300 PCMHs are established over five year project period (60 new PCMHs per year of model testing).
Patient enrollment in PCMHs.	Percent of Idahoans who enroll in PCMHs.	IHC tracking.	• 80% of Idahoans will be enrolled in a PCMH by Year 5 – Year 1: 10% – Year 2: 20% – Year 3: 50% – Year 4: 75% – Year 5: 100%.
Establish regional support for practice transformation through the establishment of RCs.	Percent of primary care practices desiring to transform to a PCMH that can receive assistance through an RC.	IHC tracking.	100% of primary care practices desiring to transform to a PCMH will be able to receive assistance through an RC.
Establish PCMH care coordination.	Percent of PCMHs who have established protocols for referrals and follow up communications with providers in their medical neighborhood.	RC tracking.	100% of PCMHs will have instituted referral and follow up communication protocols with providers in their medical neighborhood.
Establish Virtual PCMHS.	Percent of rural communities establishing a virtual PCMH following assessment of need.	IHC tracking.	TBD by IHC.

Evaluation Area	Performance Measure	Data Source	Performance Targets
Training of lay community health workers.	Number of new community emergency medicine personnel and community health workers trained.	IHC or its designee.	TBD by IHC.
Establish payment incentives.	Percent of payers who adopt total cost of care shared savings reimbursement models.	Payers and IHC tracking.	By Year 3 of model implementation, Idaho's major payers (public and private) participate in total cost of care shared savings reimbursement models.
PCMH integration of certified EHRs.	Percent of PCMH participants with active her.	PCMH registry.	TBD by IHC after consultation with IDHW's Medicaid Provider Incentive Program.
Care Experience			
Regional Health Needs Assessments.	Percent of PCMHs who receive results of community health needs assessments that can be used to guide development of quality initiatives within their practice.	IHC, RC and Public Health tracking tool.	75% of PCMHs will receive information from their regional community health needs assessments Year 1 – 5% Year 2 – 20% Year 3 – 40% Year 4 – 60% Year 5 – 75%.
Patient Engagement.	Percent of enrolled PCMH patients who report they are an active participant in their healthcare.	Patient satisfaction survey.	TBD by IHC.
Stakeholder Engagement.	Number of stakeholder forums occurring to inform, refine and improve delivery system model.	SHIP Steering Committee and later the IHC.	At least two stakeholder events, (e.g., townhalls, focus groups, online survey) will be held quarterly to assess patient and provider satisfaction with model implementation.

The Idaho evaluation plan measures, as identified in the tables above, will be used to monitor model implementation over time. The IHC will be responsible for the collection and analysis of measurement outcomes data, while relying on a combination of internal staff and vendors to perform these activities. In the implementation phase, the IHC and RCs will work with the State evaluator (chosen by the IHC and approved by CMMI) to develop a detailed work plan to launch the evaluation.

Idaho has several well suited entities in State that would be able to work through cooperative agreements to assist in program evaluation. These include the Idaho Rural Health Association, which is administered through the Idaho State University's Institute of Rural Health and the Center for Health Policy at Boise State University. The Center for Health Policy conducts health policy research and works with stakeholders around the State to develop innovative health policy. Another qualified entity that could provide program evaluation services is Qualis Health. Qualis Health is a nonprofit healthcare consulting organization that has worked with Idaho entities in monitoring and improving healthcare delivery and outcomes. The State evaluator will be selected during the implementation phase so that the evaluation plan can be initiated upon commencement of Year 1 model testing.

Idaho's Driver Diagram



9

Road Map for Health System Transformation

Milestones for Health System Transformation

Year 1 Milestones

- IHC is fully operational and provides resources and supports for primary care practices to transform to the PCMH model. Support is also provided to established PCMHs to further expand their capacity as a PCMH.

- RCs are established and are providing supports to PCMHs within their regions.

- Funds to assist practices with start-up costs for transformation are distributed by the IHC based on results of readiness reviews completed by practices. Practices receiving funds must meet requirements and milestones established by the IHC.

- Funds to assist established PCMHs in enhancement of the model within their practice are distributed by the IHC based on an assessment of need and established goals. Practices receiving funds must meet requirements and milestones established by the IHC.

- The IHC designates practices as PCMHs following determination that the practice has met core mandatory requirements of the PCMH, as established by the IHC. The IHC provides supports and guidance to PCMHs as they work toward accreditation from a nationally accrediting body.

- Begin PCMH mentoring program to assist practices through the transformation process.

- Begin to implement changes to provider payment models (provide start-up costs and a PMPM payment for ongoing PCMH activities as noted above) and continue to engage the participation and cooperation of payers.

- Collect baseline data on all measures in the Performance measure Catalog.

- Educate providers about data collection techniques and the Performance measure Catalog.

- Develop training program for CHWs and community emergency services personnel to increase opportunities for coordinated primary care in rural and underserved areas.

- Conduct outreach, education, and other supports needed to increase EHR adoption and expansion of telehealth use.

- Develop policies and technology for data sharing and reporting.

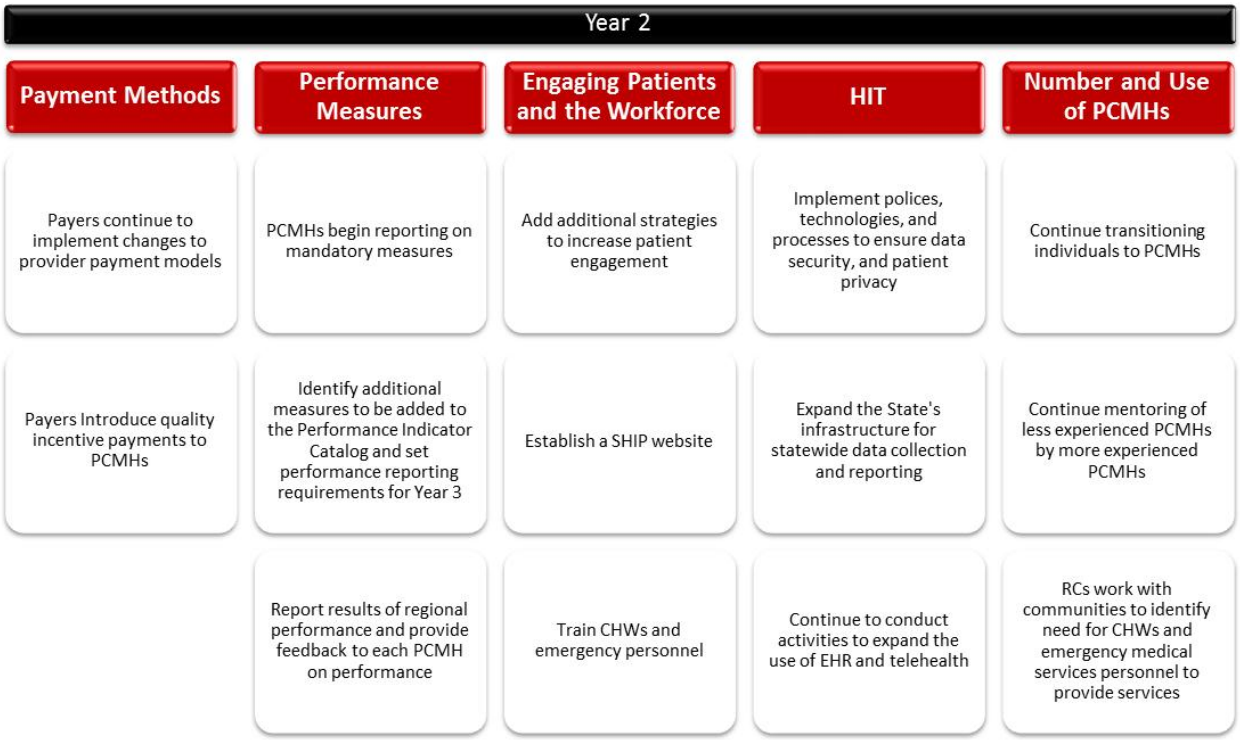
- IHC reviews baseline data, establishes reporting requirements for Year 2 by identifying mandatory measures from the Performance measure Catalog, and sets performance targets.

Year 1					
Structure	**Payment Methods**	**Performance Measures**	**Engaging Patients and the Workforce**	**Health Information Technology (HIT)**	**Number and Use of PCMHs**
Establish the Alliance and begin to provide resources and support for primary care practices to transform to the PCMH model	Begin to implement changes to provider payment models and continue to engage the participation and cooperation of payers	Collect baseline data on all measures in the Performance Indicator Catalog	Develop and implement strategies to increase patient engagement	Develop policies and technology for data sharing and reporting	IMHC pilot PCMHs begin to transition "healthy" individuals to their PCMH practice
Establish regional collaboratives (RCs) and begin to support PCMHs within their regions	Distribute funds to assist practices with start-up costs for transformation	Educate providers about data collection techniques and the Performance Indicator Catalog	The Alliance and RCs develop educational campaigns and community initiatives	Conduct outreach, education and other supports needed to increase EHR adoption and expansion of telehealth use	Begin PCMH mentoring program to assist practices through the transformation process
Establish PCMHs and provide support to established PCMHs to further expand their capacity as a PCMH	Distribute funds to assist established PCMHs in enhancement of the model	Alliance reviews baseline data, establishes reporting requirements for Year 2, and sets performance targets	Support the Governor's health council efforts to expand the workfoce	Expand reporting and analytics capabilities	Continue to expand the number of PCMH and the members in PCMHs

Year 2 Milestones

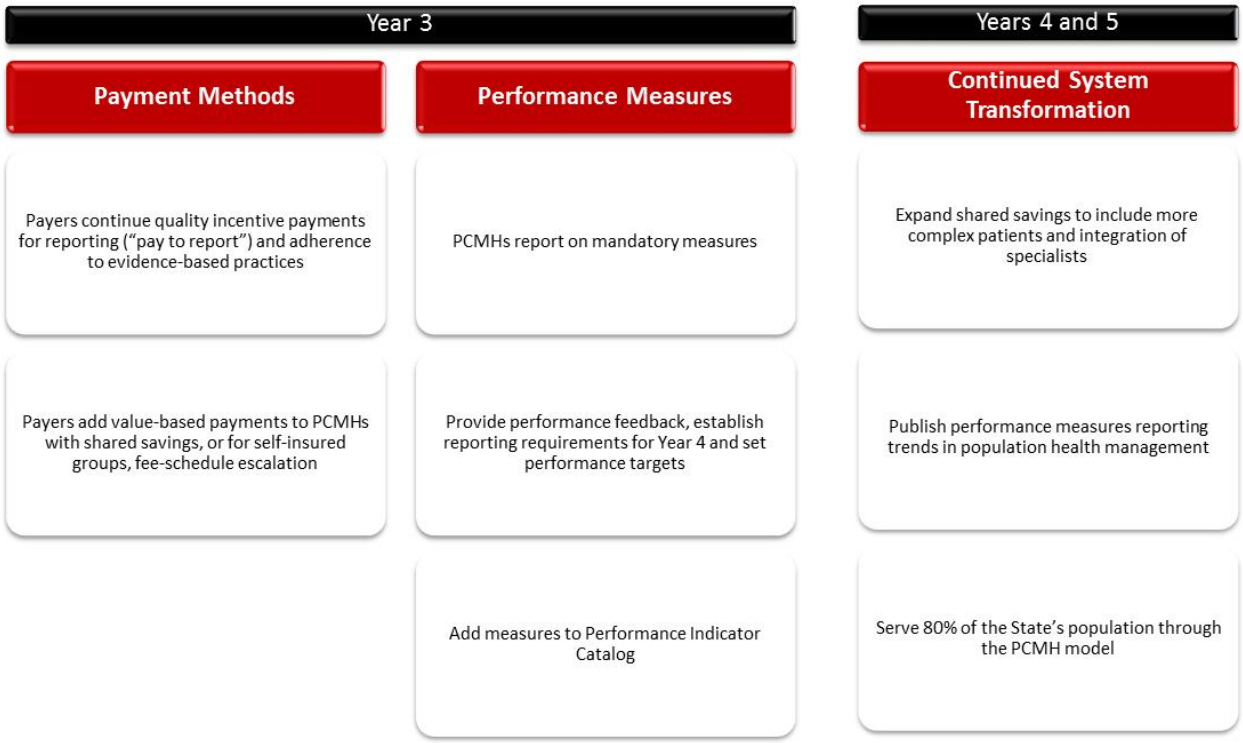
- Designation of PCMHs continues, with the IHC and RCs providing guidance to assistance practices through the transformation process.
- Assistance and supports are also provided to new and existing PCMHs to help them attain higher levels of accreditation and enhance their capacity as a PCMH.
- Continue to implement changes to provider payment models and introduce quality incentive payments to PCMHs.
- PCMHs begin reporting on four measures chosen by the IHC from the Performance measure Catalog for statewide performance reporting.
- Establish a SHIP website and use it as a mechanism to share information with consumers and providers regarding prevention, wellness, and other statewide campaigns.
- RCs and public health collaborate to assess community health needs.
- Implement quality initiatives to address areas in need of improvement.
- RCs work with rural, medically under-resourced communities to identify need for CHWs and EMS personnel to provide services.
- Continue to conduct activities to expand the use of EHR and telehealth.
- Determine regional results of regional performance and provide feedback to each PCMH on its performance.

- Implement quality initiatives to address areas in need of improvement.
- Identify additional measures to be added to the Performance Measure Catalog based on performance results, community health assessment findings and other clinical data.
- Identify performance reporting requirements for Year 3.



Year 3 Milestones

- IHC and RCs continue to provide support to practices in the transformation to PCMHs and to new and existing PCMHs.
- Add value-based payments to PCMHs.
- PCMHs report on statewide measures in the Performance Measure Catalog as identified by the IHC for Year 3 reporting.
- PCMHs report on regional specific measures as identified by the IHC and RCs based on regional performance, community health assessments and other regional clinical data.
- The IHC provides performance feedback to regions and PCMHs, establishes reporting requirements for Year 4, and set performance targets.
- Implement quality initiatives to address areas in need of improvement.
- Determine additional measures to be included in the Performance Measure Catalog.
- Use of EHR adoption and telehealth has increased.



Years 4 and 5 Milestones

- Expand shared savings to include more complex patients and integration of specialists.
- Continue to encourage and support increased levels of quality as demonstrated through higher levels of accreditation.
- Continue to expand evidence-based practices and patient engagement activities and tools to improve the patient's experience of care.
- Serve 80% of the State's population through the PCMH model.
- Conduct population health management through the evaluation of statewide data and continue to adjust performance targets and improve population health.

Appendix A

Key Terms

Agency for Healthcare Research and Quality (AHRQ) – An agency within the U.S. Department of Health and Human Services that funds research and development of reports, practical tools, and other resources to make care safer and better for people across the country. Audiences for AHRQ's resources and information typically include clinicians and other healthcare providers, consumers, policy makers at all levels of government, purchasers, and payers.

Area Health Education Center (AHEC) – Established by Congress in 1971, the network of AHEC organizations across the country was created to improve the distribution, diversity, and supply of the primary care health professions workforce who serve in rural and underserved areas. Idaho AHEC is a program of Mountain States Group Inc., a multi-service non-profit organization located in Boise. It is affiliated with the University of Washington Medical School WWAMI Program, which is a five state collaboration for medical education that takes its name from the first letter of each of the states who partner together: Washington, Wyoming, Alaska, Montana, and Idaho.

Attribution Methodology – The assignment of members to a PCHM to be held accountable for quality (and cost) of healthcare services to those members. These assignments are often based on data-driven factors and can employ a number of methodological approaches including patient-based attribution, episode-based attribution, single and multiple attributions, as well as prospective and retrospective attributions.

Behavioral Health – Mental health and substance use services.

Centers for Medicare & Medicaid Services (CMS) – An agency within the U.S. Department of Health and Human Services that provides administration and funding for Medicare, Medicaid and CHIP.

Center for Medicare & Medicaid Innovation (CMMI) – A component of CMS that supports the development and testing of innovative healthcare payment and service delivery models including the State Innovation Models initiative.

Children's Health Insurance Program (CHIP) – The joint federal/State program of medical assistance for uninsured children established by Title XXI of the Social Security Act, which in Idaho is administered by IDHW.

Commercial Insurance – Private health insurance including individual, small group, large group, and self-insured plans. Does not include public insurance programs such as Medicare or Medicaid/CHIP.

Data Hub – A platform for collaborating on gathering, sharing and using data.

Dual Eligible – An individual who is enrolled in both Medicare and Idaho Medicaid. Also referred to as a Medicare-Medicaid enrollee.

Electronic Health Record (EHR) – A record in digital format that is a systematic collection of electronic health information. Electronic health records may contain a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test

results, radiology images, vital signs, personal statistics such as age and weight, and billing information.

Federally Qualified Health Center (FQHC) – An entity that is receiving a grant under Section 330 of the Public Health Service Act; is an FQHC "look-alike" (i.e., the HRSA has notified it that it meets the requirements for receiving a Section 330 grant, even though it is not actually receiving such a grant); or is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under Title V of the Indian Healthcare Improvement Act.

Fee-for-Service (FFS) – A reimbursement model in which medical services are billed and paid individually as they are administered.

Health Professional Shortage Areas (HPSAs) – A geographical area, specific population or medical facility which has been identified by the U.S. Department of Health and Human Services as having a shortage of healthcare professionals. Identified shortage categories include Primary Care, Dental Care, and Mental Healthcare.

Health Quality Planning Commission (HQPC) – A committee established by Idaho legislation tasked with improving care quality and health outcomes through the use of health information technology and patient safety initiatives.

Healthy Connections (HC) – A PCCM program for Medicaid beneficiaries that establishes a PCP as coordinator for all services, including referrals to services not provided by the PCP. Providers in the HC program receive additional payments on a PMPM basis for the patients they serve.

Health Information Exchange (HIE) – The sharing of healthcare information among various entities and stakeholders within the healthcare delivery system. Information sharing generally occurs electronically through the integration of HIT.

Health Information Technology (HIT) – Any technology service or system used to house, distribute, or analyze health data.

Idaho Department of Health and Welfare (IDHW) – Idaho State agency responsible for the administration of various services pertaining to healthcare and social, and economic issues. Responsible for administering, among other programs, the State Medicaid and CHIP programs

Idaho Health Data Exchange (IHDE) – A nonprofit corporation established to develop and oversee the implementation of HIE in Idaho.

Idaho Medical Home Collaborative (IMHC) – Collaboration of various healthcare stakeholders to promote the development and implementation of a PCMH model of care statewide in Idaho.

Medicaid – The joint federal/State program of medical assistance established by Title XIX of the Social Security Act, 42 USC 1396 et seq., which in Idaho is administered by IDHW.

Medicare – Federal health insurance program for people who are 65 or older and certain younger people with disabilities

Medicare Advantage (MA) Plan – A health plan administered by a private company contracting with Medicare to provide Medicare benefits to beneficiaries.

Medical Neighborhood – The larger healthcare infrastructure in which a PCHM operates. The medical neighborhood includes the PCMS itself, along with the range of other healthcare providers, as well as State and local public health agencies and social service organizations.

National Committee for Quality Assurance (NCQA) – A private, nonprofit organization dedicated to improving healthcare quality.

Patient-Centered Medical Home (PCMH) – A model of care that emphasizes care coordination and communication to transform primary care and focuses on the core attributes and functions of comprehensive care, patient-centeredness, coordinated care, accessible services, and quality and safety.

Primary Care Provider (PCP) – A medical doctor or doctor of osteopathy or other licensed medical practitioner who, within the scope of practice, is responsible for providing primary care services to patients. A PCP shall include general/family practitioners, pediatricians, internists, and may include specialist physicians, physician assistants, and nurse practitioners provided that the practitioner is able and willing to provide primary care services in accordance with licensure requirements.

Regional Collaborative (RC) – The proposed entities across Idaho that will serve as the administrative hub of healthcare services in each defined planning and service area. Primary responsibilities will be ensuring community health needs are identified through assessments, and working with PCMHs to ensure individual and community health needs are met. This will occur through the dissemination of best and evidence based practice models, collection, and dissemination of performance metrics, and collaboration with providers to access needed community health services for residents when needed.

Rural Health Clinic (RHC) – Family medicine clinics that provide outpatient primary care health services, including diagnostic and laboratory services, and employ mid-level practitioners 50% of the time the clinic is open. To be certified as an RHC by IDHW, a clinic must be located in a non-urban area *and* a medically-underserved area or serve a designated population group or geographic health professional shortage area.

Shared Savings – A payment strategy that offers incentives for providers to reduce healthcare spending for a defined patient population by offering them a percentage of net savings realized as a result of their efforts. A shared savings methodology typically comprises four important concepts: a total cost of care benchmark, provider payment incentives to improve care quality and lower total cost of care, a performance period that tests the changes, and an evaluation to determine the program cost savings during the performance period compared to the benchmark cost of care and to identify the improvements in care quality. In Idaho's model, the specifics of the arrangements will be negotiated between the payers and the PCMHs through their regular contracting process

State – When capitalized, refers to the State of Idaho.

Statewide Health IHC (IHC) – A section 501(c) (3) organization that is responsible for supporting and overseeing a coordinated system of implementation and management of the PCMH model statewide, including activities of the RCs, assets and gaps of practices in all states of PCMH development, enabling integration with other healthcare services, assuring consistency and accountability for statewide metrics, and collection and distribution of performance measure results.

Triple Aim – A framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance based on the premise that new designs must be developed to simultaneously improve the health of the population, enhance the patient experience of care (including quality, access, and reliability) and reduce or at least control, the per capita cost of care. Adopted by CMMI to: aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our healthcare system.

Washington & Idaho Regional Extension Center (WIREC) – Funded by the Office of the National Coordinator for Health Information Technology (ONC), WIREC, led by Qualis Health, provides vendor neutral health information technology consulting services related to the successful adoption, implementation, and utilization of EHRs for the purpose of improving care.

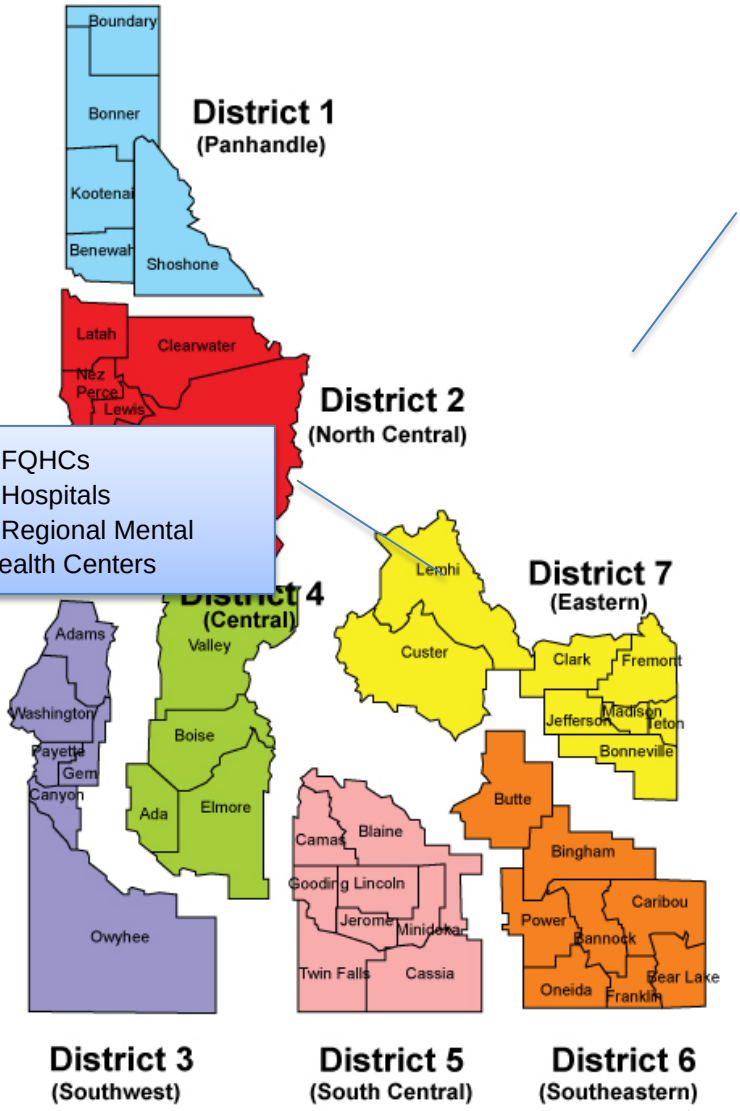
Acronyms

AAA	Area Agency on Aging
ACA	Affordable Care Act
ACO	Accountable Care Organization
ADRC	The Administration on Community Living's Aging and Disability Resource Centers
AHEC	Area Health Education Center
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CCNC	Community Care of North Carolina
CDC	Centers for Disease Control
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CMMI	Centers for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CQI	Clinical Quality Improvement
DOI	Department of Insurance
D-SNP	Duals – Special Needs Plan
ECHO	New Mexico's Project ECHO (Extension for Community Healthcare Outcomes)
EHR	Electronic Health Record
EMS	Emergency Medical Services
FFS	Fee for Service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HB	House Bill
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HMO	Health Management Organization
HQPC	Health Quality Planning Commission
HRSA	Health Resources and Services Administration
ICM	Integrated Care Model

IDHW	Idaho Department of Health and Welfare
IMHC	Idaho Medical Homes Collaborative
IOCP	Intensive Outpatient Care Program
IRIS	Immunization Reminder Information System
LDL	Low-density lipoprotein
MA	Medicare Advantage
MFP	Money Follows the Person Program
MMIS	Medicaid Management Information System
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NIHN	North Idaho Health Network
NP	Nurse Practitioner
NQF	National Quality Forum
ONC	Office of the National Coordinator for Health Information Technology
PA	Physician Assistant
PCCM	Primary Care Case Management
PCMH	Patient Centered Medical Home
PCP	Primary Care Physician
PFFS	Private Fee for Service
PHMG	Primary Health Medical Group
PMPM	Per Member Per Month
PPO	Preferred Provider Organization
PRATS	Pregnancy Risk Assessment Tracking System
RC	Regional Collaborative
RHC	Rural Health Center
RHCAP	Idaho's Rural Health Care Access Program
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SBWC	School Based Wellness Center
SED	Serious Emotional Disturbance
SHIP	Statewide Healthcare Innovation Plan
SIM	Statewide Innovation Model
SMHP	Idaho Division of Medicaid's State Medicaid Health Information Technology Plan
SPA	State Plan Amendment
SPMI	Severe and Persistent Mental Illness
TRUST	University of Washington's Targeted Rural and Underserved Track (TRUST) program
TSE	Time Sensitive Emergency
VA	Veterans Affairs
VHR	Virtual Health Record
WIREC	Washington and Idaho Regional Extension Center

Appendix B

Map of Idaho's Local Health Districts and Counties



- 2 FQHCs
- 5 Hospitals
- 3 Regional Mental Health Centers
- 2 Tribal Facilities

- 3 FQHCs
- 5 Hospitals
- 4 Regional Mental Health Centers

- 5 FQHCs
- 7 Hospitals
- 2 Regional Mental Health Centers

- 7 FQHCs
- 7 Hospitals
- 3 Regional Mental Health Centers
- 2 Tribal Facilities

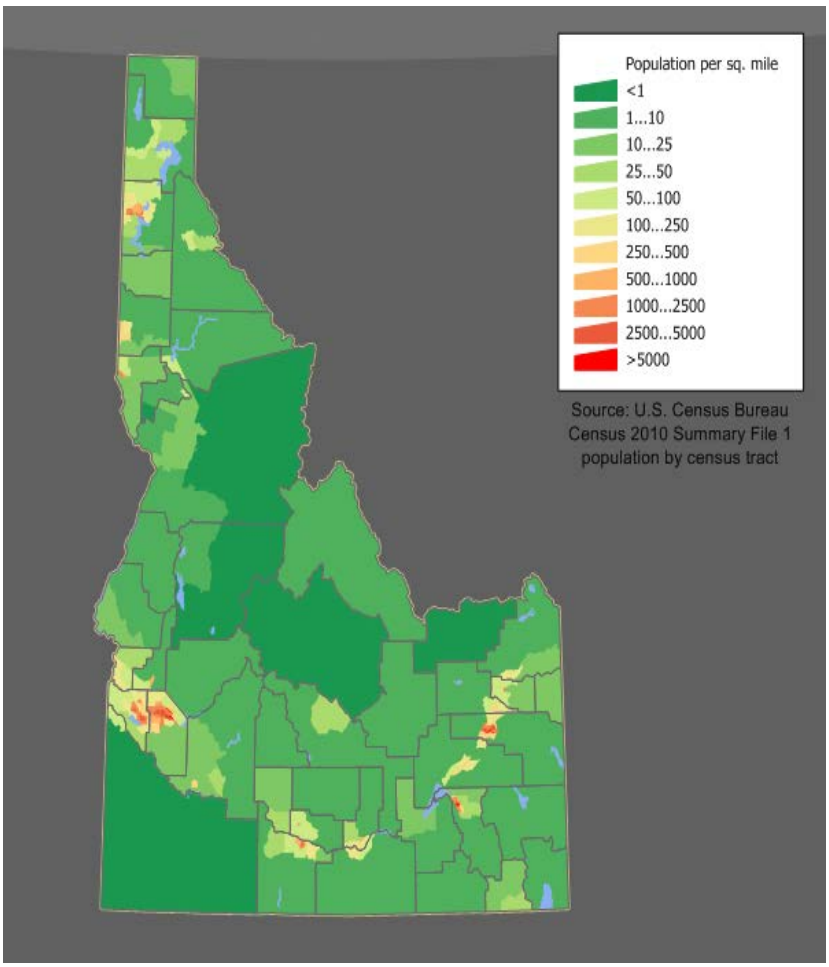
- 12 FQHCs
- 3 Hospitals
- 3 Regional Mental Health Centers

- 6 FQHCs
- 6 Hospitals
- 2 Regional Mental Health Centers

Appendix C

Idaho Population Information

Map of Idaho's Population per Sq. Mile



Idaho Demographics

- Total population of just over 1.5 million
- Idaho's population is approximately half male and half female
- Children under five years old represent 7.3% of the population, while those under 18 represent 26.7%. Persons 65 years and older represent 13.3% of the population
- The median household income was $46,890, which was nearly 9% below the national average
- Approximately half of all Idahoans obtain health insurance through their employer or the military
- Approximately a quarter of the State's residents rely on government-sponsored healthcare (Medicaid/CHIP, 14.8%; and Medicare, 15%),
- More than 18% of Idahoans are uninsured

Appendix D

Current Healthcare Delivery System Models

As noted in the SHIP, Idaho's current healthcare system includes a wide spectrum of model designs, ranging from private multi-facility integrated healthcare systems, to solo physician practices, to publicly funded healthcare systems both large and small and local public health districts. This appendix provides additional information on Idaho's current healthcare delivery system models.

Private Health System Models

Large private healthcare systems in Idaho, such as the Saint Luke's and Saint Alphonsus health systems, are becoming an increasingly prevalent system model in the State. These systems group together networks of hospital facilities and outpatient clinics located around the State. However, many Idahoans still receive care at smaller physician practices and solo practices, which are more common in rural parts of the State. Practice and referral patterns among Idaho's healthcare providers reflect the geographic characteristics of the State. In many communities, Idaho's mountainous areas serve as natural divisions that define regional networks of care as the area where patients can reasonably access services by car or other forms of transportation. In rural communities that border Washington, Oregon, Nevada, Utah, Wyoming, and Montana, providers often refer patients to facilities located in adjacent states; mostly for acute and specialty care. This practice has created patient retention challenges for providers, as patients who are referred to specialists or facilities outside the community sometimes do not return to primary care providers because, under the current FFS model, specialists have a financial incentive to continue seeing the patient for all services.

Public Health System Models

Like in many rural states, publicly-funded health systems are a foundational component of the current health model in Idaho, offering critical safety-net services to under-insured and uninsured Idahoans. Chief among these systems are Idaho's 13 non-profit community health centers, which provide outpatient health services to Idahoans at locations in 37 communities throughout the State. These 13 community health centers include 12 FQHCs and one FQHC "look-alike".[63] In 2012, the 12 FQHCs served 130,399 patients, half of whom were uninsured. The FQHCs provided medical services to 106,981 individuals, dental services to 30,193 individuals, mental health services to 7,488, substance abuse services to 427, and enabling services to 9,583 people.

The Veteran's Affairs (VA) health system also has a strong presence in Idaho, providing both inpatient and outpatients services to Idaho's active service members and veterans. The VA operates a large inpatient medical center in Boise, as well as ten outpatient clinics located throughout the state[64].

Idaho's public health programs and local public health districts are also important system components in the State, as they are responsible for coordinating initiatives that assess State and community health needs and respond to these needs by providing information, resources, linkages, and funding to support services that promote the health and wellness of all Idahoans. The agencies that comprise the IDHW provide a range of health and social services aimed at promoting and protecting the health and safety of Idahoans. At the State level, IDHW sets the vision and strategic

[63] http://www.idahopca.org/community-health-centers/about-community-health-centers

[64] http://www1.va.gov/directory/guide/state.asp?State=ID&dnum=ALL

plan for the public health system in Idaho and monitors progress towards goals. IDHW's total budget in State FY 2013 is $2.366 billion, which includes $610.16 million in State general fund appropriations, $1.5 billion in federal funds, $83.9 million in State-dedicated funds, and $164.4 million in receipts for direct services.[65]

Federal funding to IDHW comes primarily in the form of Medicaid match and grants through the Health Resources and Services Administration (HRSA), the Centers for Disease Control and Prevention (CDC), and other federal partners to implement health programs across the State. Many of these programs are implemented at the local level through contractual relationships between IDHW and the seven local health districts described below.

Statewide health initiatives are aimed at addressing the risk factors for chronic disease, increasing health literacy, and promoting healthy lifestyles. While coordinated and monitored at the State level, local implementation occurs through the seven health districts. These programs help communities address local barriers to health, help individuals make healthy decisions, and receive support and clinical care when they need it. A few program highlights include:

- The Healthy Eating, Active Living program brings together a voluntary network of organizations, agencies, businesses, and individuals to share information and resources to create an environment where all Idahoans value and have access to healthy food options and places to be physically active in their communities.

- The Idaho Prenatal Smoking Cessation program, targeted to pregnant women enrolled in the Women, Infants and Children (WIC) program, operates the Idaho QuitNow line, a free telephone counseling and internet service that uses evidence-based interventions including telephone counselors and online support to help women quit smoking. Free nicotine replacement products are also available to those who enroll in the QuitNow program.

- In response to the growing burden of diabetes in the State, IDHW has funded the Idaho Diabetes Prevention and Control Program, which encourages linkages and the development of coalitions and partnerships to promote clinical standards of care, reach patients in disparate populations, and provide professional education and training to reduce the risk of diabetes and the complications it causes. This program has been extremely successful in generating local, sustainable coalitions of community partners.

- The Adolescent Pregnancy Prevention Program uses an evidence-based curriculum to provide sexual health and risk avoidance education and activities to youth and their families and caregivers to reinforce healthy choices and development.

- To connect residents with care providers, the IDHW operates the 2-1-1 Idaho CareLine, a free statewide community information and referral service that provides callers with information about where to go to obtain free or low cost health and human services, including medical assistance, as well as social services.[66] In SFY 2012, the Idaho CareLine received 162,587 calls.

Local Public Health Districts

[65] Facts, Figures and Trends: 2012-2013. A publication of the Idaho Department of Health and Welfare. http://healthandwelfare.idaho.gov/Portals/0/AboutUs/Publications/FFT2012-2013LR.pdf

[66] http://www.idahocareline.org/

The public health infrastructure in Idaho includes seven local public health districts that operate independently of, but in close collaboration with, IDHW. The seven local public health districts are defined as: Panhandle, North Central, Southwest, Central, South Central, Southeastern, and Eastern. Each local public health district has a board of health appointed by county commissioners within that district. The local public health districts perform traditional public health functions such as environmental health and disease reporting, but also provide direct clinical care and public health services to their residents, playing a critical role as a service provider in the communities they serve.

Direct services offered by the local public health districts range from community health nursing and home health nursing to dental hygiene and nutrition. Many services are provided through contracts with IDHW, and are available for the community, including the uninsured, free of charge or for a nominal fee. All local public health districts provide immunizations, sexually transmitted disease counseling and services, family planning services, reproductive health and women's health services, child oral health services, a tuberculosis clinic, and services through the WIC program. Some local public health districts provide additional services such as school health services on a FFS basis, refugee health services, and cholesterol and heart risk screenings.

In 2011–2012, the public health districts used the CDC's Community Health Assessment and Group Evaluation tool to assess policies and practices in their communities that support healthy people and healthy communities. The districts are using the results of these assessments to make sustainable changes that will have a lasting impact on chronic disease in Idaho. One of the major focus areas to emerge from the assessment was addressing the underlying risk factors for chronic disease, including tobacco use, physical inactivity, and unhealthy eating. For example, health districts collaborated with IDHW and local partners to foster workforce wellness programs and school-based health education interventions.

Services Provided by Local Public Health Districts (FY2012)

- 8,761 communicable disease reports and investigations
- Reproductive health services to 22,306 individuals
- Tobacco use cessation education to 1,503 individuals
- Fluoride mouth rinse to 30,647 individuals
- Vaccines to 44,867 adults and 72,159 children

The health districts and the communities they serve are also local innovators in implementing community-based wellness programs that build on existing local resources, engage local partners, and respond to the particular needs of their local communities. These local programs are a vital part of the health infrastructure in Idaho, as they bring needed services and support to local communities throughout the State. A few examples of initiatives that are occurring at the local level are:

- Bonner County Emergency Medical Services has recently launched a community emergency medical service (EMS)/paramedicine program that leverages the free time that trained EMS personnel have between emergency calls to engage with patients before they need emergency services. The program sends EMS personnel to proactively visit the homes of patients who have been identified by their physician as being at high risk for a medical emergency.

- The North Central district operates the Cancer Awareness and Prevention Coalition, which assists in planning and implementing a strategic plan to increase cancer screening rates and decrease cancer incidence in the area. To prevent skin cancer in babies, the North Central district has partnered

with local hospitals to educate new parents about the importance of protecting their babies from the sun through a program called No Sun for Baby that gives new parents a sun hat for their infant and sun safety information. The North Central District also promotes a community garden to foster a culture of health for individuals and communities, improve food security, encourage healthy eating practices, and assist families and communities in becoming more resilient to disasters.

- The Panhandle district has implemented a Moving Minutes Challenge aimed at helping its residents maximize daily physical activity. The program encourages participants to make a daily log of the time spent each day doing physical activity, and the district awards prizes for those who submit their logs. Schools and employers are encouraged to enter as groups to motivate as many people as possible to join the initiative.

- The Central District provides cholesterol screening and cardiac risk assessments for a nominal fee to identify at-risk individuals and promote resource referrals.

The collaboration that would be fostered under Idaho's new PCMH model would encourage the sharing of ideas and promote adapting and replicating programs such as these.

Services for American Indians

The Indian Health Service (IHS) (an operating division of the U.S. Department of Health and Human Services) is the federal agency charged with the responsibility to provide healthcare to all enrolled members of Idaho Tribes. The Indian health system is very unique and is governed by a complex set of federal laws and regulations.

The IHS Portland Area Office oversees funding provided for tribal health programs in Idaho: the Shoshone-Bannock, the Northwest Branch of the Shoshone, the Nez Perce, the Coeur d'Alene, and the Kootenai tribes. Four tribes manage their own health programs under the Indian Self-Determination and Education Assistance Act (ISDEAA, P.L. 93-638) through contracts or compacts with the IHS. Ft. Hall Service Unit, which provides services to the Shoshone-Bannock tribe, is managed by an IHS. The Benewah Medical Center also receives HRSA funding through Section 330 of the Public Service Act. As such, the Benewah Health Center provides services to both American Indian and non-American Indian individuals. Tribally-operated health programs operated under the ISDEAA have also been statutorily designated as FQHCs under the Social Security Act.[67]

These IHS and Tribally-operated health programs provide basic ambulatory primary care services, limited pharmacy and laboratory services, traditional healing practices, dental care, eye care, and behavioral health programs. Some of the programs may offer physical therapy, ophthalmology, audiology, optometry, home health nurses, diabetes education, tobacco cessation education, registered dieticians, community health outreach, and youth programs.

[67] Social Security Act §1905(l)(2)(A)(iv).

Appendix E

Profiles of Larger Commercial Payers

General

Current commercial payer offerings include individual, small group, large group, and self-insured products. There are currently eight companies licensed by the Idaho Department of Insurance to offer individual health benefit plans. Regence BlueShield of Idaho is the dominant insurer with 41.5% of the market in 2011. The other seven companies are Blue Cross of Idaho Health Service Inc., Coventry Health & Life Insurance Co., John Alden Life Insurance Co., Mega Life and Health Insurance Co., PacificSource Health Plans, SelectHealth Inc., and Time Life Insurance Co.[68]

There are currently 13 companies licensed by the Idaho Department of Insurance to offer small employer health benefit plans,[69] with Regence BlueShield of Idaho covering 46.3% of the market in 2011.[70] The other 12 companies are Altius Health Plan, Best Life and Health Insurance Co., Blue Cross of Idaho Health Services Inc., John Alden Life Insurance Co., Madison National Life Insurance Co., PacificSource Health Plans, SelectHealth Inc., Sterling Life Insurance Co., Time Insurance Co., Trustmark Life Insurance Co., United Healthcare Insurance Co., and WMI Mutual Insurance Co.

In 2011, there were 14 large group carriers, with Blue Cross of Idaho being the largest carrier in this market.[71] There are currently 12 self-funded health plans licensed by the Idaho Department of Insurance. They are A-Plus Benefits Inc., Employee Benefit Trust of Idaho, Boise Fire & Police Trust, City of Boise Employee Healthcare Plan Trust, City of Caldwell Employee Benefit Trust, City of Nampa Employee Welfare Benefit Trust, Government Employees Medical Plan, Idaho AGC Self-Funded Benefit Trust, Idaho Interdependent Intergovernmental Authority, Independent School District of Boise City, Employee Dental Benefit Plan Trust, Snake River Sugar Company Member Benefit Plan, Timber Products Manufacturers Trust, and the University of Idaho Health Benefits Trust.[72]

In 2011, 40% of employers were self-insured. Firms consisting of 49 or fewer employees only composed 11.2% of the total, while those with 50 or more represented 66.7%. Nearly three in every five workers (59.6%) were in self-insured plans in 2011 with only 8.6% being employed by firms with 49 or less employees and 73% with those having 50 or more.

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[68] Idaho Department of Insurance, List of Individual Health Benefit Companies Referenced August 7, 2013 viewable at http://www.doi.idaho.gov/health/individual_list.aspx

[69] Idaho Department of Insurance, List of Small Employer Health Benefit Companies Referenced August 7, 2013 viewable at http://www.doi.idaho.gov/health/smempl_list.aspx

All information relating to the Idaho Patient Centered Medical Home Collaborative sourced from http://imhc.idaho.gov/MinimumRequirements.aspx

[70] December 2012 Report from the State Health Access Data Assistance Center (SHADAC) under contract with NORC. Funded by CMS & CMMI.

[71] December 2012 Report from the State Health Access Data Assistance Center (SHADAC) under contract with NORC. Funded by CMS & CMMI.

[72] Idaho Department of Insurance, Insurer by type page: http://www.doi.idaho.gov/insurance/TypeList.aspx?Type=SF

Blue Cross of Idaho

Blue Cross of Idaho had more than 708,000 members in 2011 and includes as network partners every hospital in the State and 96% of all physicians. The company reports an administrative cost ratio of 6.9%.[73]

Regence BlueShield of Idaho

Regence BlueShield of Idaho (Regence) is a nonprofit mutual insurance company and an independent licensee of the Blue Cross and Blue Shield Association that serves more than 150,000 Idaho residents. It processed approximately 2.4 million claims and paid out 79% of every premium dollar collected (medical loss ratio) in 2012.[74] In 2012, Regence began collaboration with St. Luke's Health System called the Healthy U CoPartner Program. In this innovative delivery model, physicians and nurses work closely with Regence patients who have multiple health conditions to increase patient engagement in their treatment plans and promote lifestyle adjustments. This highly personalized and coordinated care aims to avoid unnecessary duplication of services, reduce costs, and improve members' overall health.[75]

PacificSource Health Plans

PacificSource is a not-for-profit community health plan offering individual and group health insurance.[76] PacificSource participates in the IMHC by supporting participating clinics with a $22.50 PMPM for members who meet eligibility criteria, including diagnosis of SPMI/SED, diabetes and asthma, diabetes and a co-morbidity or specified risk factor, or asthma and a co-morbidity or specified risk factor.

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[73] Blue Cross of Idaho Annual Report for 2011 viewable at https://www.bcidaho.com/_assets/2011-Annual-Report.pdf

[74] The Year in Review: 2012 Regence BlueShield of Idaho viewable at http://www.regence.com/docs/overviews/overview-2012-id.pdf

[75] Id.

[76] PacificSource Health Plans: Idaho plan summaries web page. Referenced on August 2, 2013 viewable at http://www.pacificsource.com/agent/idaho/plan-summaries.aspx

Appendix F

Current Performance Measurement Data Sources and Idaho's National Health Care Quality Report Results

Idaho Department of Health and Welfare Data Sources

As noted in the SHIP, IDHW is a main source of healthcare data used for performance measurement in Idaho. The main State sources of healthcare performance data are the Behavioral Risk Factor Surveillance System (BRFSS), the Pregnancy Risk Assessment Tracking System (PRATS), Vital Records, and community health surveys conducted by Idaho's providers and public health districts using the CDC's Community Health Assessment and Group Evaluation tool. What follows is a description of these data sources.

Behavioral Risk Factor Surveillance System (BRFSS), Pregnancy Risk Assessment Tracking System (PRATS), and Vital Records

The BRFSS is a public health surveillance program developed and partially funded by the CDC.[77] It is designed to estimate the prevalence of risk factors for the major causes of morbidity and mortality in the United States. The survey provides State-specific estimates of the proportion of adults aged 18 and over with selected health risk behaviors. Questions on the BRFSS survey address numerous topics, including but not limited to, general health status, number of healthy days, healthcare access, sleep, exercise, diabetes, oral health, cardiovascular disease, asthma, disability, tobacco use, alcohol consumption, immunizations, falls, women's health, cancer screening, HIV/AIDS, emotional support and life satisfaction, public health issues, heart attack and stroke, and drug use. In addition to the standard static report, Idaho provides InstantAtlas dynamic reports.[78] The crude data reports provide risk factor prevalence estimates for the Idaho adult population in a given survey year. These data are useful for determining the number or proportion of a population affected by various health risk factors. The age-adjusted data reports present prevalence estimates that are age-adjusted using the 2000 US Standard Population. Age-adjustment removes the impact of age variations across years and geographical regions. These data are useful for providing a consistent basis for evaluating the impact of health interventions across several years of data.

Beginning in 1997, Idaho's seven public health districts partnered with IDHW to develop health district-level estimates from the BRFSS.[79] The districts' participation enabled IDHW to increase sample size and produce district-level health behavior estimates. Additionally, IDHW provided health districts the opportunity to add questions to the BRFSS addressing their specific data needs. In 2009 and 2010, five district sponsored questions were added to the BRFSS survey. Two questions concerned required immunizations for children, two concerned health and safety inspections of commercial food establishments, and one concerned the amount of children's school-time physical activity. The results for these five questions are included in a separate report.

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[77] *Idaho Behavioral Risk Factors: Results from the 2010 Behavioral Risk Factor Surveillance System*. Boise: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics, 2012. Available at http://healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/BehavioralRiskFactorSurveillanceSystem/tabid/913/Default.aspx

[78] http://www.healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/BehavioralRiskFactorSurveillanceSystem/tabid/913/Default.aspx#dynamic

[79] *Idaho Behavioral Risk Factor Surveillance System. Public Health District Sponsored Questions: Results, 2010*. Boise: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics, 2012. Available at http://healthandwelfare.idaho.gov/Portals/0/Health/Statistics/BRFSS%20Reports/BRFSS_Health_District_Report_2010.pdf

The PRATS is an annual survey of new mothers in Idaho regarding maternal experiences and health behaviors surrounding pregnancy.[80] It provides information on a variety of perinatal health topics, including unintended pregnancy, prenatal care, substance use, breastfeeding patterns, postpartum depression, and immunizations.

IDHW's Bureau of Vital Records and Health Statistics collects information regarding births, deaths, stillbirths, etc. The Vital Statistics Annual Report includes information on Idaho's population, including census, race, age, and sex; live births, including method of delivery (vaginal or Cesarean) and low birth weight live births; mortality, including leading causes of death, and infant deaths.

Community Health Surveys

Several public and private providers, including health districts and hospitals have conducted community health surveys, which are aimed at collecting data pertaining to the health of specific communities within the State. The surveys include questions pertaining to the identification of serious health concerns and risky behaviors in the community, as well as access to quality care and healthcare coverage status.[81]

Medicare Data Sources

The Medicare program is also a source of data used to assess current system performance. CMS measures and publicly reports on the quality of care provided at hospitals, nursing facilities, dialysis facilities, and home health agencies that participate in Medicare. CMS also publishes star ratings for MA plans that assess MA plan performance on more than 50 measures grouped into five categories: staying healthy (screenings, tests, and vaccines), managing chronic conditions, member experience, member complaints and issue resolution, and health plan customer service.[82] Star ratings are assigned by measures, category, and by an overall summary rating that summarizes all category measures into a single rating. The star ratings range from one star (worst) to five stars (best), and are intended to be used as a guideline for Medicare beneficiaries to select the MA plan that provides the best value. Two of the three major commercial insurers (BlueCross of Idaho and PacificSource) have one or more MA plans with a star rating of four, and Regence's MA plans have a star rating of three and a half.

Idaho's 2011 National Health Care Quality Report Results

Compared to other states, Idaho's quality of care measurement scores as reported by the 2011 NHQR for Idaho are considered to be average in most areas. But as of 2011, there was a noted trend of decreased quality of care scores in most areas. For instance, acute and hospital quality of care measures scored in the very strong range in 2010 (baseline year), but both were scored as only strong the following year. More importantly, the areas of preventive measures, maternal and child health and respiratory disease quality of care measure scores that were considered strong or average in 2010 were scored as weak in 2011. The following are Idaho results of the 2011 NHRQ. Note that there is missing baseline data for diabetes and ambulatory care[83]:

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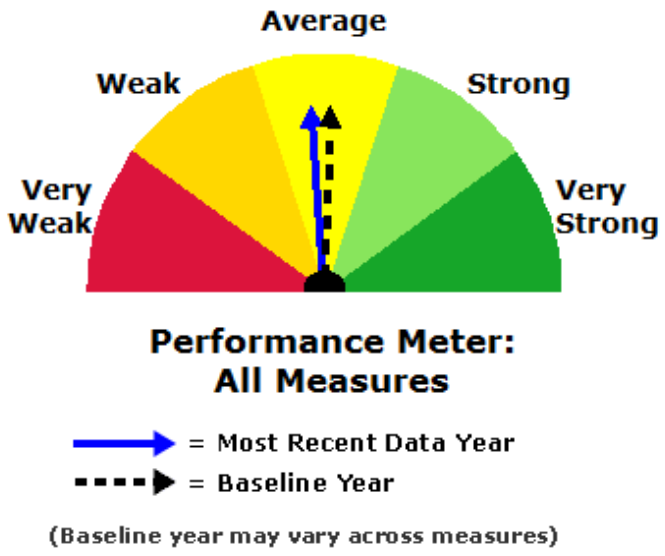
[80] http://www.healthandwelfare.idaho.gov/Health/VitalRecordsandHealthStatistics/HealthStatistics/PregnancyRiskAssessmentTrackingSystem/tabid/915/Default.aspx

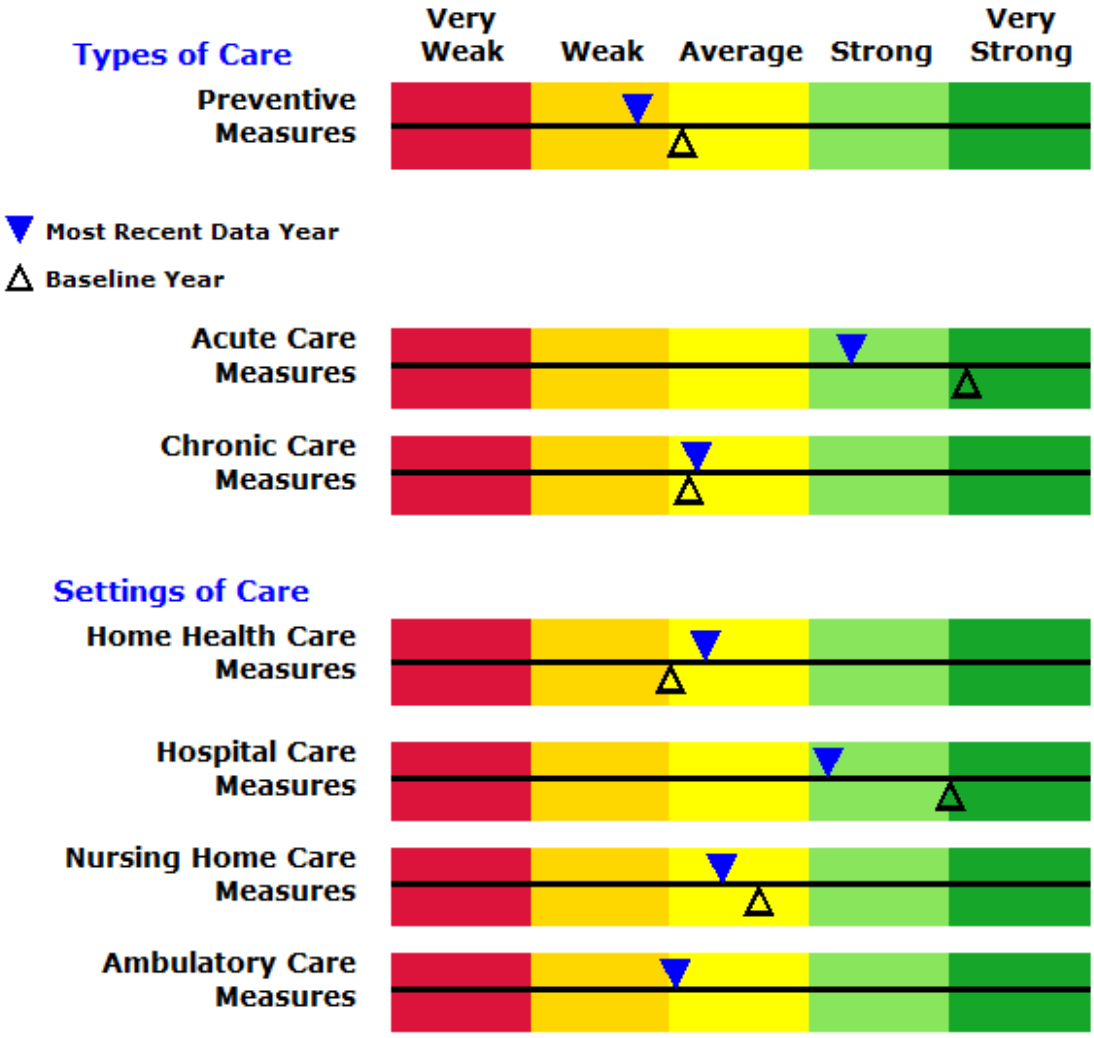
[81] See, e.g., Bonner County Community Health Survey Results 2012. Idaho Panhandle Health District. http://www.phd1.idaho.gov/home/documents/BonnerCoCombinedResults.pdf

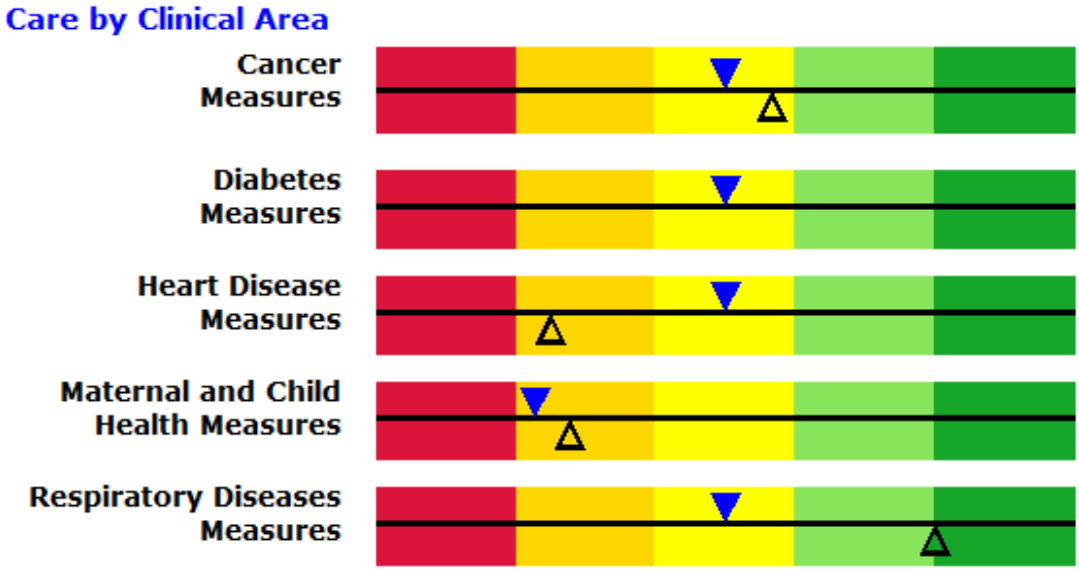
[82] Medicare Advantage 5 Star Enrollment. Updated July 2013. http://www.medicare.gov/Publications/Pubs/pdf/11226.pdf; http://www.medicare.gov/sign-up-change-plans/when-can-i-join-a-health-or-drug-plan/five-star-enrollment/5-star-enrollment-period.html



Source: National Healthcare Quality Report (NHQR) for Idaho, 2011

Current State 2011:





Source: National Healthcare Quality Report (NHQR) for Idaho, 2011.

[83] A missing arrow or triangle means there were insufficient data to create the summary measure. http://statesnapshots.ahrq.gov/snaps11/dashboard.jsp?menuId=4&state=ID&level=0

Appendix G

Additional Information Regarding Idaho's Current Healthcare Workforce

This appendix provides information regarding other classes of healthcare professionals and facilities not mentioned in the SHIP document.

Ancillary Providers

There are 27 outpatient physical therapy/occupational therapy/speech therapy (PT/OT/ST) centers distributed throughout the State. These centers are unevenly distributed around the State, with a higher concentration of 13 PT/OT/ST centers located in the Boise Region (Region 4) as compared to an average of two to three in the other regions.[83]

There are 26 dialysis centers, which are evenly distributed throughout the State.[84]

There are 85 home health agencies.[85]

Facilities

There are 51 hospitals in Idaho with a total of 3603 beds. This includes 27 critical access hospitals and six BEHAVIORAL HEALTH facilities (including inpatient drug/alcohol abuse centers and psychiatric hospitals). The table below[86] shows the distribution of hospitals and beds by region.

Region	Number of Hospital Facilities	Number of Beds
1	7	417
2	6	294
3	4	343
4	11	1328
5	7	313
6	10	459
7	6	449
TOTAL	**51**	**3603**

There are also 50 ambulatory surgical centers (47 of which are certified by Medicare) and 78 long term care/skilled nursing facilities (LTC/SNFs) in Idaho. The table below[87] shows the distribution of LTC/SNFs by region.

Region	Number of LTC/SNF	Number of Beds
1	11	958

[83] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/ROPT.pdf

[84] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RESRD.pdf

[85] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RHHA.pdf

[86] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RHospital.pdf

[87] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RLTC.pdf

Region	Number of LTC/SNF	Number of Beds
2	9	720
3	12	937
4	15	1345
5	11	797
6	12	645
7	8	558
TOTAL	72	5819

Idaho has 67 facilities with 508 beds for people with intellectual disabilities.[88] Like most specialty inpatient care facilities, these community homes, group homes, and treatment centers are clustered in the Boise Region (Region 4).

[88] http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RICF.pdf

Appendix H

Crosswalk of SHIP Standard and Special Terms & Conditions

SHIP Standard and Special Terms & Conditions		SHIP Section
A – State Goals		
1.	Vision Statement for health system transformation.	2
2.	Description of health system models in "current as is" and "future to be" conditions, including the level of integration of behavioral health substance abuse, developmental disabilities, elder care, community health, and home and community-based support services.	1, 2, Appendix D
3.	Description of delivery system payment methods both "current as is" and "future to be" payment methods.	2, Appendix E
4.	Description of health care delivery system performance "current as is" and "future to be" performance measures.	2, Appendix F
B – Description of State Health Care Environment		
1.	Description of population demographics and profiles of major payers in the state including number of residents covered by commercial insurers, Medicare, Medicaid and CHIP.	2, Appendix C, Appendix E
2.	Description of population health status and issues or barriers that need to be addressed.	2, Appendix F
3.	Report on opportunities or challenges to adoption of Health Information Exchanges (HIE) and meaningful use of electronic health record technologies by various provider categories, and potential strategies and approaches to improve use and deployment of HIT.	2, 5
4.	Description of the current health care cost performance trends and factors affecting cost trends (including commercial insurance premiums, Medicaid and CHIP information, Medicare information, etc.).	3
5.	Description of the current quality performance by key indicators (for each payer type) and factors affecting quality performance.	2, Appendix F
6.	Description of population health status measures, social/economic determinants impacting health status, high risk communities, and current health status outcomes and the other factors impacting population health.	2, Appendix F
7.	Description of specific special needs populations (for each payer type) and factors impacting care, health, and cost.	2, 6, Appendix D
8.	Description of current federally-support program initiatives under way in the state, including those supported by but not limited to CDC, CMMI, CMCS, ONC, HRSA, and SAMHSA.	6
9.	Description of existing demonstration and waivers granted to the state by CMS.	6
C – Report on Design Process Deliberations		

SHIP Standard and Special Terms & Conditions	SHIP Section
1. The Plan shall contain a report on the State's deliberations and its consideration of each of the levers and strategies enumerated in items (a) through (n) of the preceding section, "Scope of Model Design Project." This part of the plan should describe the options considered during the review of each item, evidence of stakeholder engagement, and any consensus reached, or disagreement that remained at the close of deliberations of each item.	Sections 2-7 include stakeholder deliberations by topic
D – Health System Design and Performance Objectives	
1. Description of delivery system cost quality and population health performance targets that will be the focus of delivery system transformation.	1, 2, 7
2. State's goals for improving care, population health and reducing health care cost.	1, 2
C – Proposed Payment and Delivery System Models	
1. The plan shall set forth the state's proposed payment and service delivery models including strategies that involve multiple payers that will move the preponderance of care in the state from fee for service to value-based payment systems. The plan should aim to move 80% of the state's total population to value-based payment and service delivery models within 5 years.	2
2. The plan will identify how the state proposes to use the executive, regulatory and legislative authorities to align multiple payers (including commercial) and providers for health delivery system transformation and, specifically, identify how the state will use levers in incentivizing stakeholders to engage in health care transformation, including but not limited to: • Academic medical centers. • Certificate of need (or, if not applicable, voluntary health capacity planning). • Practitioner licensing and scope of practice. • Purchasing of health care. • Health insurance regulation. • The Health Insurance marketplace. • Graduate medical education. • Medicaid supplemental payment programs. • Survey and certification of acute and post-acute health care facilities.	7
F – Health Information Technology	
1. How activities under the plan will coordinate with other statewide HIT initiatives to accelerate adoption of health information technology among providers.	5
2. How activities under the Plan will reach providers in rural areas, small practices and behavioral health providers.	4, 5
3. Cost allocation plan or methodology for any planned IT system solutions/builds funded in part by CMS or any other federal agency.	5
4. Any impact this project will have on the MMIS, and how the MMIS will be used to support the project, including whether there will be a need to add any new system functionality or enhancements to existing system functionality to support the effort. Please describe all MMIS claims, recipient, provider or other MMIS data and the specific MMIS business processes the state will utilize in support of this effort.	5
5. Estimated planning and implementation timelines for the needed changes to MMIS and how these timelines will dovetail with the SIM project.	5
G – Workforce Development	

SHIP Standard and Special Terms & Conditions	SHIP Section
1. The Plan should set forth a strategy to develop innovative approaches to improve the effectiveness, efficiency and appropriate mix of the health care work force through policies regarding training, professional licensure, and expanding scope of practice statutes, including strategies to enhance primary care capacity, and to better integrate community health care manpower needs with graduate medical education, training of allied health professionals, and training of direct service workers; and move toward a less expensive workface that makes greater use of community health workers when practicable.	4
H – Financial Analysis	
1. The Plan should contain a financial analysis describing (i) the populations being addressed and their respective total medical and other services costs as per member per month and population total, (ii) estimated cost of investments necessary to implement the Plan, including ongoing costs to providers, infrastructure costs including personnel and vendors, (iii) anticipated cost savings resulting from specified interventions, including the types of costs that will be affected by the model and the anticipated level of improvement by target population, (iv) expected total cost savings and return on investment during the project period for the overall state model and basis for expected savings (previous studies, experience, etc., and (v) a plan for sustaining the overall model over time.	3
I – Evaluation Plans	
1. Plans to provide access to data and stakeholders to enable CMS to evaluate the extent to which the state's delivery system reform plan was implemented, its effect on health care spending, and its impact on health care quality.	8
2. Identification of potential sources of data including provider surveys, Medicare administrative claims, state Medicaid and CHIP program information, beneficiary experience surveys, site visits with practices, and focus groups with beneficiaries and their families and caregivers, practice staff, direct support workers, and others (e.g. payers), for program evaluation.	8
3. Plans to play an active role in continuous improvement and evaluation, particularly in regard to Medicaid and CHIP benefits. Each state is encouraged to identify a research group, preferably within the state, that could assist in the CMS evaluation and develop in-state evaluation efforts continue after the model funding has ended.	8
J – Road map for Health System Transformation	
1. Provide a timeline for transformation.	9
2. Review milestones and opportunities.	9
3. Describe policy, regulatory and/or legislative changes necessary to achieve the State's vision for a transformed health care delivery system.	9
4. Describe any federal waiver or State plan amendment requirements and their timing to enable key strategies for transformation, including changes or additions required to position the Medicaid and CHIP program to take advantage of broad health care delivery system transformation.	9