State Innovation Models:
Round Two of Funding for Design and Test Assistance
Funding Opportunity Number: CMS-1G1-14-001
Budget Negotiation – Programmatic Questions

State	Idaho
Applicant	State of Idaho
Application #	1G12014000277
Type of Award Sought	Model Test
Amount Requested	$61,012,763

CMS QUESTIONS IN RED

9/8/14 IDAHO RESPONSE IN BLUE –final submitted/corrected

We have conducted a thorough programmatic and financial review of your Model Testing application. We have several outstanding questions, requests for clarification and budgetary issues that are listed below. You may use this document to provide your response – please include your answer immediately following each question. In addition, please complete the informational tables at the end of this document and submit a revised Financial Plan and SF424a. You do not need to resubmit any other parts of your application unless we specifically ask you to do so.

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1. Page 3 of the FOA states, "As a condition of the award, the state must commit to sustain its model after the design and/or test period." Further, stated on page 36, "States need to show how their models will be sustainable after the testing period is complete."

   Considering these requirements, please address the following:

   a. Describe the state's plan to sustain the innovation initiatives as described in your proposal, such as practice transformation support, beyond the SIM period of performance.

   As we described in the application/proposal we intend use the experience we gained through the Idaho Medical Home Collaborative in developing practice transformation support. We will use contractors to help kick start the process but will sustain the process through the Regional Collaboratives (RC). It will be the responsibility of the RC – working with the primary care practices and the medical neighborhood– to continue to evolve and improve the transformation process by identifying gaps and providing or arranging supports to fill those gaps.

   The goal of the Idaho Healthcare Coalition (IHC) is to move the current health care delivery system from a fee for service, volume based health care system toward an accountable health care system. Idaho now has all-payer commitment to PCMH model. If the average PCMH payment represents a $6 PMPM differential that's $94M of new revenue to PCPs or $104,000 per year for 900 providers. That represents a real market incentive to achieve and maintain PCMH. The practice transformation system has 4 years to demonstrate its value to practices, so that practices spend part of that new revenue purchasing services from the practice support system.

   b. Describe how the staffing level described in the proposal will be sustained after the SIM project period concludes.

   It is not anticipated that the staffing levels will need to be sustained at the same level when the SIM project period concludes. During the testing period, we expect to use new resources to increase medical home capacity across Idaho's entire healthcare system through initial training and technical assistance. Simultaneously, we will work to establish RCs across the state that will

provide any ongoing support and assistance required by primary care practices and the surrounding medical neighborhood. As the project periods concludes, the Idaho Healthcare Coalition, working with the RCs, will continually monitor and review staffing support requirements – both by type and number – to meet the needs of the primary care practices.

c. In the Operational Plan section of your proposal, you indicate the proposed use of contractors to perform significant activity under this cooperative agreement. Describe the state's plan to integrate the contractors' work following the SIM period of performance.
Contractors are being used to help facilitate the development of the model. Once the model is developed (ending the SIM period of performance), some of the contractor tasks will no longer be necessary and other tasks will be assumed by the RCs, IHC and providers

(See Revised Idaho Operations Plan, Sustainability Plan, page 31-32)

2. Page 3 of the FOA states, "funded proposals must articulate both a broad vision for state-wide health care transformation and describe ambitious, realizable programs in identified areas." Explain how the individual elements described in the proposal will scale to statewide implementation during the SIM period of performance. Include a timeline for scaling specific elements of the proposal
Idaho's PCMH Model Test proposes to build 60 Nationally Recognized PCMH practices each year of the program implementation period (including 75 Virtual PCMHs), culminating in 180 practices by the end of the Model Test. Practices are defined as practice sites with an estimated average of 5 providers each of whom serves a panel of 1425 patients, on average. From the beginning to the end, practices will be selected representationally from each of the 7 Health Districts in Idaho. Therefore, the program will be statewide from the beginning, building to capacity in a steady rate throughout the Model Testing period. By the fourth quarter of each year, including the pre-implementation period, an additional 60 PCMHs at minimum (25% of the target) will have joined the program by becoming designated as a PCMH for purposes of transformation and recognition. PCMHs will be recruited and designated at a rate of 15 per quarter beginning on January 1 of 2016. To the extent possible, the rate of recruitment will vary only in the pre-implementation year, when the initial 60 are recruited between July 1 and December 31, 2015. The initial 60 will be recruited from among a known group of practices currently striving for, or having achieved, PCMH recognition status (see the Timeline for Statewide Scale-Up below).

As PCMHs become level 1 recognized, the proportion of Idahoans who become attributed patients of a recognized patient-centered medical home will increase by the same rate. The initial group of recognized practices is expected to be small (about 15). However, by the fourth quarter of the first Model Test year, the first 60 PCMHs will meet the milestone of at least level 1 NCQA recognition. Note that practices will be able to use a variety of Idaho Healthcare Coalition (IHC)-approved national PCMH recognition/accreditation programs to achieve these goals. Because an additional 15 practices enter the program every quarter of each Model Test year, 15 additional practices are expected to be recognized every quarter beginning in Model Test Year 2. By the end of Model Test Year 3, 180 practices (100% of target) will have reached at least level-1 recognition; 75% will have reached recognition status greater than level 1. 50% of Idaho's beneficiaries (641,250) will be attributed to PCMHs by quarter 1 of Model Test Year 2. 80% of Idaho's beneficiaries, 1,282,500 Idahoans, will be attributed to PCMHs by the last quarter of Model Test Year 3.

Upon designation, and until the end of the Model Test period, PCMHs will receive technical assistance from PCMH contractors, from Idaho Health Data Exchange, and from the Regional Collaboratives. The PCMH contractors will help the initial 60 practices during the pre-implementation year and 15 new practices each quarter during the Model Test years, to complete a PCMH readiness assessment within the first quarter following designation, and establish transformation goals and business plans that will guide their activities for the program during the Model Test. The PCMH contractor will be responsible for distributing appropriate technical assistance financial incentives. Beginning in the first quarter of each designated PCMHs participation, IHDE and its sub-contractors will provide technical assistance to practices to establish EMR's and to connect those to the IHDE. The group from which the initial 60 practices will be recruited in the pre-implementation year are already mostly connected, but some additional work will be done then as needed. Connecting 15 new PCMHs per quarter beginning January 1, 2016 is expected to be a reasonable goal. As such 50% of designated PCMH's are expected to have active EMR's by quarter 2 of 2016, and all PCMH's are expected to have EMRs by the fourth quarter of 2017. Essentially, HIT connectivity in PCMHs will keep pace with PCMH designation.

The permanent Regional Collaborative infrastructure will be established in each of 7 regional health districts by July 1, 2015. They will begin to provide medical neighborhood integration and quality improvement services to the initial 60 practices during the pre-implementation year. The goal will be to ready the initial 60 practices to be fully engaged in transformation by January 1, 2016. Every practice that is designated as a PCMH will immediately be able to utilize the services of the local/regional RC. Thus, 50% of designated PCMHs will have access to RC services by the second quarter of Model Test Year 1. All of the PCMH designees (100% of target) will have continuing access to their RCs by quarter 4 of Model Test Year 2. Within the quarter that they are designated, each PCMH practice will be expected to establish a protocol for communicating with the other medical services within their medical neighborhood, including hospitals, in order to coordinate care transitions.

As PCMHs are designated and begin transformation, 75 practices will be recruited to become Virtual PCMHs at a planned rate of 6 per quarter beginning in January 2017, and finishing up in quarter 4, 2018. At that same rate, Virtual PCMH practices will be trained on use of Telehealth technology and standards, the infrastructure of which will be established in 2015 and 2016. They will be expected to be using Telehealth practices routinely within the quarter in which they are trained. Virtual PCMH practices will be established in remote and rural communities where the medical workforce is sparse.

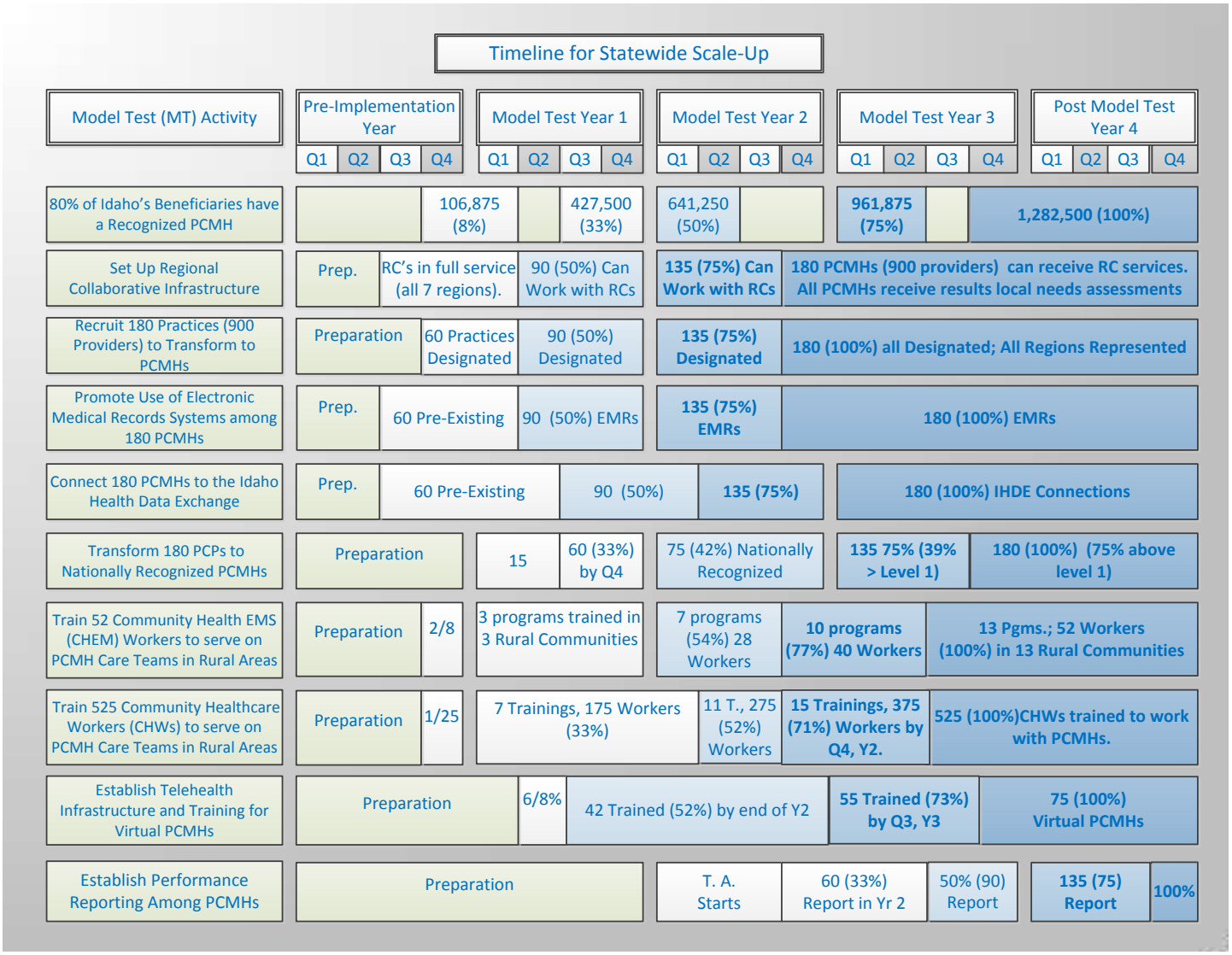
By the end of 2018, the preparation of Community Workers (Community Health EMS (CHEMS) workers & Community Health Workers (CHWs)) will be well underway, with 54% (28 CHEMS workers) and about 52% (275 CHW workers) trained. The workers will serve on Virtual PCMH care coordination teams. The remaining community health workers will be trained by the third quarter of Model Test year 3, and will be able to work on PCMH teams established during the Model Test, and those established after the Model Test. The PCMH training for Community workers will be provided by the RCs as needed beyond the Model Test.

During the second Model Test Year, 2017, designated and recognized PCMH practices will begin to receive technical assistance for performance reporting. The first practices, the 60 which were designated in 2015, will be expected to report on identified quality measures by quarter four of that year. By quarter 3 in 2018, 50% of the PCMHs will be reporting, and by the end of the Model Test (2018), 75% of the PCMHs will be reporting. Reporting will continue for the model test into 2019; 180 (100%) of the recognized PCMHs will be reporting in

quarter 4. In sum, there will be three rounds of performance reporting, with greater numbers of providers reporting each time.

In summary, all of the elements of Idaho's Model Test will be in place by the end of the Model Test, with only performance reporting lagging behind by 25%. At least 80% of Idaho's beneficiary population will be served by a recognized PCMH (75% above level-1 recognition) by that time, and will be receiving patient-centered care coordinated across their medical neighborhoods.

Note. The Timeline for Statewide Scale-Up shows 50%, 75% and 100% milestones for each Model Test activity. Unless indicated otherwise, the milestone shows the current status at the beginning of the milestone box. For more detail and metrics, see the individual quarterly target tables for the related activity.



(See Revised Operations Plan, pages 25-28)

3. Page 3 of the FOA states, "States may propose to use SIM funds for the implementation of specific technology, software, applications, or other analytical tools as part of state infrastructure development to support the Model Test as long as the state provides a clear strategy for how, if applicable, the technological approach will be financed in addition to SIM, how it will not supplant other funding sources, and how it will be sustained after the cooperative agreement period has ended." Describe how the health IT investments described in the proposal will meet these conditions. Specifically, indicate how the SIM investments will align with statewide or regional HIE efforts to expand the availability and interoperability of health information.

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

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

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

(see Idaho Revised Project Narrative, Page 23)

4. Page 6 of the FOA states, "CMS encourages applicants to propose payment models that directly align with one or more existing Medicare programs, demonstrations, and/or models, such as accountable care organizations (ACOs), primary care medical homes, and bundled payment programs." Please identify the alignment of proposed ACO and PCMH payment models with the Medicare Shared Savings Program and the Comprehensive Primary Care Initiatives, respectively, using Appendices A & B.

Please see Appendix B, attached for Idaho response regarding the PCMH model that has been developed in Idaho and will be applied during the Model Test.

Please address the following related to your payment model and/or service delivery model:

a. Please describe in further detail the methodology to be used to determine patient attribution and the per-member-per-month amount.

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

Attribution

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

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

Reimbursement

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

Development of common payment methodology / definitions of patient categories / quality measures / etc. are critical to where SHIP is trying to take Idaho, making Idaho an all-Idahoan, all-payer PCMH state. SHIP and now IHC is using 'from the practice perspective' in its discussions, and payers seem to be getting this point – asking a practice to segregate its patient panel into several different approaches, based on payer (or for the uninsured, non-payer) is very problematic.

b. The application describes a "Phase 2" in which the state plans to pay shared savings. Please indicate the target date for the implementation of shared savings. Has the state received a commitment from commercial payers to offer shared savings?

Although Idaho is almost completely fee for service in both the commercial and public sectors – there are some small shared saving programs in the commercial sector. There has been a commitment by all payers to move from the current Fee for Service reimbursement system to reimbursement models that move toward paying for value/quality. The Payment Reform workgroup used the CMS reimbursement model chart and agreed that our objective is to

continue to move reimbursement from the left side of the chart (Fee for Service) to the right side of the chart (Accountable System of Care including shared savings). The tentative target date for implementation of shared savings is July 2015, as the first MTP PCMHs are activated.

c. Please describe how the state expects the PCMH model will engage and integrate care coordination efforts between upstream and downstream providers such as hospitals or skilled nursing facilities. Are there future plans to engage these providers by moving successful PCMHs into ACO or capitated models?
The Regional Collaboratives will have lead responsibility for developing the Medical Neighborhood and establishing strong care coordination mechanisms between PCMHs and other areas of the healthcare system. There is consensus to move from the volume based Fee for Service reimbursement model to more comprehensive payment models that reward providers for quality and outcomes – this includes continuing the evolution of payment models beyond PCMH to shared savings and capitated models.

Does the state have any state-owned facilities that would be directed to coordinate care with PCMHs? Our two State hospitals would coordinate care with the PCMHs as appropriate.

c. Please describe plans the state might have, if any, to provide long-term services and support to patients attributed to a PCMH.
An integral part of our model is to develop the medical neighborhood which will include access and information for long-term services and supports. Work currently underway to support primary care providers efforts in coordinating care for their patients with long-term service and support needs includes the community resource centers administered by the Idaho Commission on Aging, a variety of information and patient engagement opportunities available through Public Health, the pediatric medical home portal (www.medicalhomeportal.org), and development of increased access to telehealth services and community paramedicine.

(See Revised Project Narrative, Idaho's Transformed Payment Model pages 15-16).

5. Page 6 of the FOA states that the proposed Payment and/or Service Delivery Model must address: "One or more specific payment and/or service delivery models that include, but are not limited to, the state's Medicaid population, state employee population, and/or commercial payers' populations. The payment and/or service delivery models must identify the targeted populations, the number of beneficiaries served, the number of participating providers, and the services to be delivered."

Considering these requirements, please address the following:

d. Indicate the number of commercial payers committed to participate in your payment model.
Idaho has a simple commercial market. The three commercial payers participating in our payer model represent the vast majority of commercial covered lives in Idaho. Idaho state employees are covered under Blue Cross of Idaho, one of the commercial payers participating in this effort. As the new payment model evolves we anticipate that commercial products will migrate towards it.

e. Describe the percentage of non-Medicare revenue in your state that will be in your payment model

We anticipate that savings bu payor (revenue) would be a direct reflection of payor expense. We project that 58.4% of our expense and revenue would be non-Medicare and 41.6% would be Medicare.

c. Indicate the number of providers participating in your model.

Medicaid currently has 364 primary care providers servicing 53 locations throughout the state who participate as Medicaid Health Homes. There are 279 primary care providers servicing 33 locations throughout the state participating in the Idaho Medical Home Collaborative. The majority, if not all, of these practices will be the initial model participants. There are numerous additional targeted medical home efforts underway that involve additional providers across the state. These efforts include initiatives by the Idaho Primary Care Association, Regence Blue Shield, the Children's Healthcare Improvement Collaboration, and the Title V Maternal and Child Health Program. It is our goal to add 60 practices (300 primary care providers) per year during the demonstration. We anticipate that at the conclusion of the SIM project we will have an additional 900 primary care providers in 180 practices across the state participating in the model.

(See Revised Project Narrative, Idaho's Transformed Payment Model page 16).

6. Page 9 of the FOA states, the state must "describe 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 and basis for expected savings (previous studies, experience, etc.)" and "describe expected total federal cost savings and return on investment during the project period for the overall state model."

Considering these requirements, please address the following:

f. Describe the amount of Medicare and Medicaid savings expected to be produced under your proposal.

	3 Year				
Assumptions (Savings) Table:	Medicaid/CHIP	Commercial	Medicare	Total	
Increase in Generic Rx Usage	$(1,220,771)	$(8,826,073)	$ -	$(10,046,844)	**
Re-hospitalizations	(8,813,372)	(5,495,734)	(25,500,450)	(39,809,556)	
Acute Care Hospitalizations	(13,153,062)	(12,849,045)	(35,355,636)	(61,357,743)	
Non-Emergent ER Usage	(758,247)	(545,946)	-	(1,304,193)	**
Early Delivery	(1,037,141)	(1,373,933)	-	(2,411,075)	
Shift from PPO to managed care providers:	(3,747,099)	(6,741,569)	(2,486,694)	(12,975,362)	
PCMH operational payment	17,212,869	8,606,435	12,909,652	38,728,956	
Net (Savings)	$(11,516,823)	$ (27,225,865)	$(50,433,128)	$ (89,175,817)	
FMAP = Federal medical assistance	71.75%		100.00%		

percentage effective 10/1/2014.*					
Federal Savings with Medicaid at 71.75%	$(8,263,321)		$(50,433,128)	$(58,696,449)	
*http://aspe.hhs.gov/health/reports/2014/FMAP2015/fmap15.pdf					
The standard FMAP is used. No adjustment has been made for the enhanced FMAP for CHIP or for any other differences for services or populations.					
**Note: Medicare generic fill rates were not available in the base data					
**Note: Medicare ED utilization was not available in the base data					

	5 Year			
Assumptions Savings Table:	Medicaid	Commercial	Medicare	Total
Increase in Generic Rx Usage	$(2,545,776)	$(19,259,575)	$ - **	$(21,805,350)
Re-hospitalizations	(18,573,942)	(12,062,622)	(55,564,214)	(86,200,778)
Acute Care Hospitalizations	(27,591,620)	(28,279,363)	(76,387,421)	(132,258,403)
Non-Emergent ER Usage	(1,565,373)	(1,276,760)	- **	(2,842,133)
Early Delivery	(2,185,073)	(3,015,656)	-	(5,200,729)
Shift from PPO to managed care providers:	(8,226,420)	(14,924,262)	(5,273,043)	(28,423,726)
Added cost to Primary Care	42,462,779	21,231,389	31,847,084	95,541,252
Net Savings	$(18,225,424)	$(57,586,849)	$(105,377,593)	$(181,189,867)
FMAP = Federal medical assistance percentage effective 10/1/2014.*	71.75%		100.00%	
Federal Savings with Medicaid at 71.75%	(13,076,742)		$(105,377,593)	$(118,454,335)
*http://aspe.hhs.gov/health/reports/2014/FMAP2015/fmap15.pdf				

g. Please describe the quality targets that you expect to achieve for the both the Medicare and non-Medicare populations, such as readmission rates.

(See Revised Financial Analysis, pages 4-5)

7. Page 32 of the FOA states, "The applicant must also establish accountability targets for the project, including specific quarterly milestones and metrics associated with each investment or activity that would be financed in whole or in part by this award. Projected quarterly targets for the test period should indicate the number and/or proportion of health care providers, hospitals, and beneficiaries that will be engaged by each Model Test component." Identify quarterly accountability targets and thresholds the state will use to measure the success of the innovation project. Specifically, identify discrete metrics (include numerator/denominator, where possible) and corresponding timelines that will gauge the success of the state's initiatives and allow for CMS to monitor the award throughout the SIM performance period.

Goal 1: Establish the PCMH model of care throughout the State by building 180 PCMH primary care practices (including Virtual PCMHs) that have reached at least level-1 PCMH recognition or accreditation within their first year of participation in the Model Test. Practices are defined as a clinic site. The total number of PCP's will reach about 900 primary care providers serving 1.3 Million Idahoans based on an estimated panel size of 1425 (80% of the population) by the end of the Model Test Period.

IDAHO'S RESPONSE: Below are quarterly accountability targets and thresholds the state will use to measure the success of the innovation project for this activity. The number and proportion of health care providers, hospitals and beneficiaries engaged by each component are indicated. Discrete metrics have been identified, including numerators and denominators. The timeline for meeting each related milestone is shown in the table. [Green indicates a milestone.]

Measures	**Pre-Implementation Year – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of primary care practices recruited to transform to PCMH. ***Model Test Target 180.***	No activity yet	30 (17%)	60 (33%)	75 (42%)
CUM # (%) of Practices designated PCMH ***– Model Test Target 180.***	No activity yet	No activity yet	30 (17%)	60 (33%)
CUM # (%) designated PCMHs that have completed a PCMH readiness assessment and goals for transformation. ***Model Test Target 180***	No activity yet	No activity yet	30 (17%)	60 (33%)
CUM # (%) of designated or recognized PCMHs receiving PCMH Technical Support and transformation incentives. ***Model Test Target 180***	No activity yet	No activity yet	30 (17%)	60 (33%)
CUM # (%) of designated PCMHs that have achieved Level 1 National PCMH recognition –	No activity yet	No activity yet	10 (6%)	10 (6%)

Model Test target 180.				
CUM # (%) of designated PCMHs that have achieved Level 2 National PCMH recognition. ***Model Test target 75 (42%).***	No activity yet	No activity yet	3 (2%)	3 (2%)
CUM # (%) of designated PCMHs that have achieved Level 3 National PCMH recognition. ***Model Test target 62 (33%).***	No activity yet	No activity yet	2 (1%)	2 (1%)
CUM # (%) of Idahoans who enroll in a recognized PCMH (each practice estimated to have 5 providers, each with panel of 1425). ***Model Test Target – 1,282,500 (80% of Idahoans).***	No activity yet	No activity yet	106,875 (8%)	106,875 (8%)
CUM # (%) of enrolled PCMH patients reporting they are an active participant in their healthcare. ***Model Test Target – 1,282,500 (80% of Idahoans).***	No activity yet	No activity yet	106,875 (8%)	106,875 (8%)
CUM # (%) of hospitals that have an established protocol for follow up communications with designated PCMHs regarding hospitalizations. ***Model Test Target – 52 (100%)***	No activity yet	No activity yet	26 (50%)	52 (100%)
Measures	**Model Test Year 1 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**

CUM # (%) of primary care practices recruited to transform to PCMH.	90 (50%)	105 (58%)	120 (67%)	135 (75%)
CUM # (%) of practices designated PCMH.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) designated PCMHs that have completed a PCMH readiness assessment and goals for transformation.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of designated or recognized PCMHs receiving PCMH Technical Support and transformation incentives.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of designated PCMHs that have achieved Level 1 National PCMH recognition	10 (6%)	10 (6%)	15 (8%)	45 (25%)
CUM # (%) of designated PCMHs that have achieved Level 2 National PCMH recognition.	3 (2%)	3 (2%)	10 (6%)	10 (6%)
CUM # (%) of designated PCMHs that have achieved Level 3 National PCMH recognition.	2 (1%)	2 (1%)	5 (3%)	5 (3%)
CUM # (%) of Idahoans who enroll in a recognized PCMH (each practice estimated to have 5 providers, each with panel of 1425).	106,875 (8%)	106,875 (8%)	213,750 (17%)	427,500 (33%)
CUM # (%) of enrolled PCMH patients reporting they are an	106,875 (8%)	106,875 (8%)	213,750 (17%)	427,500 (33%)

active participant in their healthcare.				
# (%) of hospitals that are using established protocol for follow up communications with designated PCMHs re: hospitalizations.	52 (100%)	52 (100%)	52 (100%)	52 (100%)
Measures	**Model Test Year 2 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
CUM # (%) of primary care practices recruited to transform to PCMH.	150 (83%)	165 (92%)	180 (100%)	No further recruitment
CUM # (%) of practices designated PCMH.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) designated PCMH practices that have completed a PCMH readiness assessment and goals for transformation.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of designated or recognized PCMHs receiving PCMH Technical Support and transformation incentives.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of designated PCMH practices that have achieved Level 1 National PCMH Recognition.	60 (33%)	75 (42%)	75 (42%)	60 (33%)
CUM #/% of designated PCMHs that have achieved Level 2 National PCMH recognition.	10 (6%)	10 (6%)	15 (8%)	45 (25%)
CUM # (%) of designated PCMHs that have achieved Level 3 National	5 (3%)	5 (3%)	15 (8%)	15 (8%)

PCMH recognition.				
CUM # (%) of Idahoans who enroll in a recognized PCMH (each practice estimated to have 5 providers, each with panel of 1425).	534,375 (42%)	641,250 (50%)	748,125 (58%)	855,000 (67%)
CUM # (%) of enrolled PCMH patients reporting they are an active participant in their healthcare.	534,375 (42%)	641,250 (50%)	748,125 (58%)	855,000 (67%)
# (%) of hospitals that are using established protocol for follow up communications with designated PCMHs re: hospitalizations.	52 (100%)	52 (100%)	52 (100%)	52 (100%)
Measures	**Model Test Year 3 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
CUM # (%) of primary care practices recruited to transform to PCMH.	Activity Completed	Activity Completed	Activity Completed	Activity Completed
CUM # (%) of practices designated PCMH.	Activity Completed	Activity Completed	Activity Completed	Activity Completed
CUM # (%) designated PCMH practices that have completed a PCMH readiness assessment and goals for transformation.	Activity Completed	Activity Completed	Activity Completed	Activity Completed
# (%) of designated or recognized PCMHs receiving PCMH Technical Support and transformation incentives.	180 (100%)	180 (100%)	180 (100%)	180 (100%)
CUM # (%) of designated PCMH practices that have achieved Level 1 National PCMH	60 (33%)	60 (33%)	60 (33%)	45 (25%)

Recognition.				
CUM #/% of designated PCMHs that have achieved Level 2 National PCMH recognition.	60 (33%)	75 (42%)	75 (42%)	75 (42%)
CUM # (%) of designated PCMHs that have achieved Level 3 National PCMH recognition.	15 (8%)	15 (8%)	30 (17%)	60 (33%)
CUM # (%) of Idahoans who enroll in a recognized PCMH (each practice estimated to have 5 providers, each with panel of 1425).	961,875 (75%)	1,068,750 (83%)	1,175,625 (92%)	1,282,500 (100% of target; 80% of population)
CUM # (%) of enrolled PCMH patients reporting they are an active participant in their healthcare.	961,875 (75%)	1,068,750 (83%)	1,175,625 (92%)	1,282,500 (100% of target; 80% of population)
# (%) of hospitals that are using established protocol for follow up communications with designated PCMHs re: hospitalizations.	52 (100%)	52 (100%)	52 (100%)	52 (100%)

Goal 2: Improve care coordination by improving real-time communication between PCMHs, their patients, and other entities across the healthcare system (e.g., hospitals and specialty care) through adoption and use of EHRs and IHDE connections among the 180 PCMHs, as well as building statewide capacity for data exchange across the system. The model requires PCMHs to obtain and use an Electronic Health Record. Practice is defined as a clinic site with an estimated averages provider size of 5 and an estimated panel size of 1425.

IDAHO'S RESPONSE: Below are quarterly accountability targets and thresholds the state will use to measure the success of the innovation project for this activity. The number and proportion of health care providers, hospitals and beneficiaries engaged by each component are indicated. Discrete metrics have been identified, including numerators and denominators. The timeline for meeting each related milestone is shown in the table. [Green indicates a milestone.]

Measures	Pre-Implementation Year – Quarterly Targets			
	Q1	Q2	Q3	Q4
Cumulative (CUM) # (%) of designated PCMH practices with active Electronic Health Records. ***Model Test Target is 180.***	No Activity	No Activity	52 (29%)	60 (33%)
CUM # (%) of patients having an electronic medical record in participating PCMH designated practices. ***Model Test Target is 1,282,500 (80% of Idahoans)..***	No Activity	No Activity	370,500 (29%)	427,500 (33%)
CUM # (%) of designated PCMHs with an active connection to the Idaho Health Data Exchange (IHDE) and utilizing the clinical portal to obtain patient summaries, etc. ***Model Test Target is 180.***	No Activity	No Activity	52 (29%)	60 (33%)
CUM # (%) hospitals connected to the IHDE. ***Model Test Target is 52.***	No Activity	No Activity	15 (29%)	19 (37%)
Measures	**Model Test Year 1 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated PCMH practices with active Electronic Health Records.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of patients having an electronic medical record in participating PCMH designated practices.	534,375 (42%)	641,250 (50%)	748,125 (58%)	855,000 (67%)
CUM # (%) of		75 (42%)	90 (50%)	105 (58%)

designated PCMHs with an active connection to the Idaho Health Data Exchange (IHDE) and utilizing the clinical portal to obtain patient summaries, etc.				
CUM # (%) hospitals connected to the IHDE.	23 (44%)	27 (52%)	31 (60%)	35 (67%)
Measures	**Model Test Year 2 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated PCMH practices with active Electronic Health Records.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of patients having an electronic medical record in participating PCMH designated practices.	961,875 (75%)	1,068,750 (83%)	1,175,625 (92%)	1,282,500 (100%)
CUM # (%) of designated PCMHs with an active connection to the Idaho Health Data Exchange (IHDE) and utilizing the clinical portal to obtain patient summaries, etc.	120 (67%)	135 (75%)	150 (83%)	165 (92%)
CUM # (%) hospitals connected to the IHDE.	39 (75%)	43 (83%)	47 (90%)	52 (100%)
Measures	**Model Test Year 3 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated PCMHs with active Electronic Health Records.	180 (100%)	180 (100%)	180 (100%)	180 (100%)
CUM # (%) of patients having an electronic medical record in participating PCMH	1,282,500 (100%)	1,282,500 (100%)	1,282,500 (100%)	1,282,500 (100%)

designated practices.				
CUM # (%) of designated PCMHs with an active connection to the Idaho Health Data Exchange (IHDE) and utilizing the clinical portal to obtain patient summaries, etc.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) hospitals connected to the IHDE.	52 (100%)	52 (100%)	52 (100%)	52 (100%)

Goal 3: Support the integration of each PCMH with the local Medical Neighborhood by creating the Regional Collaborative Infrastructure. RCs will support practices in PCMH transformation and will link the PCMHs to the Medical Neighborhood to facilitate coordinated patient care through the entire provider community.

IDAHO'S RESPONSE: Below are quarterly accountability targets and thresholds the state will use to measure the success of the innovation project for this activity. The number and proportion of health care providers, hospitals and beneficiaries engaged by each component are indicated. Discrete metrics have been identified, including numerators and denominators. The timeline for meeting each related milestone is shown in the table. [Green indicates a milestone.]

Measures	**Pre-Implementation Year – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
# (%) of RC's established and providing regional quality improvement and medical neighborhood integration services. ***Model Test Target, one RC team in each of the 7 health districts.***	No Activity Yet	No Activity Yet	7 (100%)	7 (100%)
Cumulative (CUM) # (%) of PCMH designated or recognized primary care practices that can receive assistance through an RC. ***Model Test Target – 180.***	No Activity Yet	No Activity Yet	30 (17%)	60 (33%)
CUM # (%) of	No Activity	No Activity	30 (17%)	60 (33%)

designated or recognized PCMHs who are using established protocols for referrals and follow up communications with service providers in their medical neighborhood to manage care transitions. ***Model Test Target – 180.***	Yet	Yet		
CUM # (%) of patients enrolled in a designated or recognized PCMH whose health needs are coordinated across their local medical neighborhood as needed. ***Model Test Target – 1,282,500 (80% of Idahoans).***	No Activity Yet	No Activity Yet	213,750 (17%)	427,500 (33%)
# (%) of Hospitals providing information regarding enrolled patient hospitalizations to designated or recognized PCMHS. ***Model Test Target – 52.***	No Activity Yet	No Activity Yet	52 (100%)	52 (100%)
Measures	**Model Test Year 1 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
# (%) of RC's established and providing regional quality improvement and medical neighborhood integration services.	7 (100%)	7 (100%)	7 (100%)	7 (100%)
CUM # (%) of PCMH designated Primary Care practices that can receive assistance through an RC.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of designated or recognized PCMHs who are using established protocols for referrals and follow up communications with	75 (42%)	90 (50%)	105 (58%)	120 (67%)

service providers in their medical neighborhood to manage care transitions.				
CUM # (%) of patients enrolled in a designated or recognized PCMH whose health needs are coordinated across their local medical neighborhood as needed.	535,375 (42%)	641,250 (50%)	748,125 (58%)	855,000 (67%)
# (%) of Hospitals providing information regarding enrolled patient hospitalizations to designated or recognized PCMHS.	52 (100%)	52 (100%)	52 (100%)	52 (100%)
Measures	**Model Test Year 2 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
# (%) of RC's established and providing regional quality improvement and medical neighborhood integration services.	7 (100%)	7 (100%)	7 (100%)	7 (100%)
CUM) # (%) of PCMH designated or recognized primary care practices that can receive assistance through an RC.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of designated or recognized PCMHs who are using established protocols for referrals and follow up communications with service providers in their medical neighborhood to manage care transitions.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of patients enrolled in a designated or recognized PCMH whose health needs are coordinated across their	961,875 (75%)	1,068,750 (83%)	1,175,625 (92%)	1,282,500 (100% of target; 80% of population)

local medical neighborhood as needed.				
# (%) of Hospitals providing information regarding enrolled patient hospitalizations to designated or recognized PCMHS.	52 (100%)	52 (100%)	52 (100%)	52 (100%)
Measures	**Model Test Year 3 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
# (%) of RC's established and providing regional quality improvement and medical neighborhood integration services.	7 (100%)	7 (100%)	7 (100%)	7 (100%)
# (%) of PCMH practices that can receive assistance through an RC.	180 (100%)	180 (100%)	180 (100%)	180 (100%)
# (%) of PCMH practices that are using established protocols for referrals and follow up communications with service providers in their medical neighborhood to manage care transitions.	180 (100%)	180 (100%)	180 (100%)	180 (100%)
# (%) of patients enrolled in a designated or recognized PCMH whose health needs are coordinated across their local medical neighborhood as needed.	1,282,500 (100%)	1,282,500 (100%)	1,282,500 (100%)	1,282,500 (100%)
# (%) of Hospitals providing information regarding enrolled patient hospitalizations to designated or recognized PCMHS.	52 (100%)	52 (100%)	52 (100%)	52 (100%)

Goal 4: Improve patient access to PCMH – based care in geographically remote areas of Idaho by developing 75 Virtual PCMHs; the model includes training of Community Health Workers and Integrating Telehealth infrastructure.

IDAHO'S RESPONSE: Below are quarterly accountability targets and thresholds the state will use to measure the success of the innovation project for this activity. The number and proportion of health care providers, hospitals and beneficiaries engaged by each component are indicated. Discrete metrics have been identified, including numerators and denominators. The timeline for meeting each related milestone is shown in the table. [Green indicates a milestone.]

Measures	Pre-Implementation Year – Quarterly Targets			
	Q1	Q2	Q3	Q4
CUM # (%) of Virtual PCMHs established in rural communities following assessment of need. ***Model Test Target - 75***	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
CUM # (%) of regional Community Health EMS Services (CHEMS) programs established. ***Model Test Target – 13.***	No Activity Yet	No Activity Yet	No Activity Yet	2 (15%)
CUM # (%) of CHEMS program personnel trained for Virtual PCMH coordination. ***Model Test Target – 52 (4 per program)***	No Activity Yet	No Activity Yet	No Activity Yet	8 (15%)
CUM # (%) 2-day Virtual PCMH training events for Community Health Workers. ***Model Test Target – 21 regional locations.***	No Activity Yet	No Activity Yet	No Activity Yet	1 (5%)
CUM # (%) of new community health workers trained for Virtual PCMH coordination. ***Model Test Target – 525 (25 per training).***	No Activity Yet	No Activity Yet	No Activity Yet	25 (5%)
CUM # (%) of continuing education	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet

conferences held for CHW and CHEMS Virtual PCMH Staff. ***Model Test Target – 2 for 577 community health workers.***				
CUM # (%) of designated or recognized Virtual PCMH practices that have completed training and technical assistance for using Telehealth tools. ***Model Test Target – 75.***	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
CUM # (%) of designated or recognized Virtual PCMH practices that routinely use Telehealth tools to provide specialty and behavioral health services to rural patients. ***Model Test Target – 75.***	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
Measures	**Model Test Year 1 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
CUM # (%) of Virtual PCMHs established in rural communities following assessment of need.	6 (8%)	12 (16%)	18 (24%)	24 (32%)
CUM # (%) of regional Community Health EMS Services (CHEMS) programs established.	3 (23%)	4 (31%)	5 (38%)	6 (46%)
CUM # (%) of CHEMS program personnel trained for Virtual PCMH coordination.	12 (23%)	18 (31%)	20 (38%)	24 (46%)
CUM # (%) 2-day Virtual PCMH training events for Community Health Workers.	2 (10%)	3 (14%)	5 (24%)	7 (33%)
CUM # (%) of new community health	50 (10%)	75 (14%)	125 (24%)	175 (33%)

workers trained for Virtual PCMH coordination.				
CUM # (%) of continuing education conferences held for CHW and CHEMS Virtual PCMH Staff.	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
CUM # (%) of designated or recognized Virtual PCMH practices that have completed training and technical assistance for using Telehealth tools.	No Activity Yet	6 (8%)	12 (16%)	18 (24%)
CUM # (%) of designated or recognized Virtual PCMH practices that routinely use Telehealth tools to provide specialty and behavioral health services to rural patients.	No Activity Yet	6 (8%)	12 (16%)	18 (24%)
Measures	**Model Test Year 2 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
CUM # (%) of Virtual PCMHs established in rural communities following assessment of need.	30 (40%)	36 (48%)	42 (56%)	48 (64%)
CUM # (%) of regional Community Health EMS Services (CHEMS) programs established.	7 (54%)	8 (62%)	9 (69%)	10 (77%)
CUM # (%) of CHEMS program personnel trained for Virtual PCMH coordination.	28 (54%)	32 (62%)	36 (69%)	40 (77%)
CUM # (%) 2-day Virtual PCMH training events for Community Health Workers.	9 (43%)	11 (52%)	13 (62%)	15 (71%)
CUM # (%) of new community health	225 (43%)	275 (52%)	325 (62%)	375 (71%)

workers trained for Virtual PCMH coordination.				
CUM # (%) of continuing education conferences held for CHW and CHEMS Virtual PCMH Staff.	1 (50%)	No Activity	No Activity	No Activity
CUM # (%) of designated or recognized Virtual PCMH practices that have completed training and technical assistance for using Telehealth tools.	24 (32%)	30 (40%)	36 (48%)	42 (56%)
CUM # (%) of designated or recognized Virtual PCMH practices that routinely use Telehealth tools to provide specialty and behavioral health services to rural patients.	24 (32%)	30 (40%)	36 (48%)	42 (56%)
Measures	**Model Test Year 3 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
CUM # (%) of Virtual PCMHs established in rural communities following assessment of need.	55 (73%)	62 (83%)	69 (92%)	75 (100%)
CUM # (%) of regional Community Health EMS Services (CHEMS) programs established.	11 (85%)	12 (92%)	13 (100%)	13 (100%)
CUM # (%) of CHEMS program personnel trained for Virtual PCMH coordination.	44 (85%)	48 (92%)	52 (199%)	52 (199%)
CUM # (%) 2-day Virtual PCMH training events for Community Health Workers.	17 (81%)	19 (90%)	21 (100%)	21 (100%)
CUM # (%) of new community health	425 (81%)	475 (90%)	525 (100%)	525 (100%)

workers trained for Virtual PCMH coordination.				
CUM # (%) of continuing education conferences held for CHW and CHEMS Virtual PCMH Staff.	1 (100%)	No Activity	No Activity	No Activity
CUM # (%) of designated or recognized Virtual PCMH practices that have completed training and technical assistance for using Telehealth tools.	48 (64%)	55 (73%)	62 (83%)	75 (100%)
CUM # (%) of designated or recognized Virtual PCMH practices that routinely use Telehealth tools to provide specialty and behavioral health services to rural patients.	48 (64%)	55 (73%)	62 (83%)	75 (100%)

Goal 5: Build a statewide data analytics system to measure and improve performance and population health.

CMS Comment: Identify quarterly accountability targets and thresholds the state will use to measure the success of the innovation project. Specifically, identify discrete metrics (include numerator/denominator, where possible) and corresponding timelines that will gauge the success of the state's initiatives and allow for CMS to monitor the award throughout the SIM performance period.

IDAHO'S RESPONSE: Below are quarterly accountability targets and thresholds the state will use to measure the success of the innovation project for this activity. The number and proportion of health care providers, hospitals and beneficiaries engaged by each component are indicated. Discrete metrics have been identified, including numerators and denominators. The timeline for meeting each related milestone is shown in the table. [Green indicates a milestone.]

Measures	**Pre-Implementation Year – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated or	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet

recognized PCMH practices that have received technical assistance to establish performance reporting capacity. ***Model Test Target - 180 by 2020. 60 prepared to report on measures in year 2, 120 in year 3 and 180 in 2019***				
CUM # (%) of % of designated or recognized PCMH practices that report on identified measures. ***Model Test Target - 180 by 2020.***	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
CUM # (%) of % of designated or recognized PCMH practices that receive from an RC the results of their community health needs assessment, which can be used to guide their quality improvement initiatives. ***Model Test Target – 180.***	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
Measures	**Model Test Year 1 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated or recognized PCMH practices that have received technical assistance to establish performance reporting capacity.	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
CUM # (%) of % of designated or recognized PCMH practices that report on identified measures.	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
# (%) of % of designated or recognized PCMH practices that receive	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet

from an RC the results of their community health needs assessment, which can be used to guide their quality improvement initiatives.				
Measures	**Model Test Year 2 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated or recognized PCMH practices that have received technical assistance to establish performance reporting capacity.	15 (8%)	30 (17%)	45 (25%)	60 (33%)
CUM # (%) of % of designated or recognized PCMH practices that report on identified measures.			30 (17%)	60 (33%)
# (%) of % of designated or recognized PCMH practices that receive from an RC the results of their community health needs assessment, which can be used to guide their quality improvement initiatives.	No Activity Yet	No Activity Yet	No Activity Yet	No Activity Yet
Measures	**Model Test Year 3 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated or recognized PCMH practices that have received technical assistance to establish performance reporting capacity.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of % of designated or recognized PCMH practices that report on identified			90 (50%)	120 (67%)

measures. .				
# (%) of % of designated or recognized PCMH practices that receive from an RC the results of their community health needs assessment, which can be used to guide their quality improvement initiatives.	Assessment being conducted.	Assessment being conducted.	Assessment being conducted.	180 (100%)
Measures	**Post- Model Test Year 4 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) of designated or recognized PCMH practices that have received technical assistance to establish performance reporting capacity.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of % of designated or recognized PCMH practices that report on identified measures.			150 (83%)	180 (100%)
# (%) of % of designated or recognized PCMH practices that receive from an RC the results of their community health needs assessment, which can be used to guide their quality improvement initiatives.	Completed	Completed	Completed	Completed

Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value. Practice is defined as a clinic site with an estimated averages provider size of 5 and an estimated panel size of 1425.

IDAHO'S RESPONSE: Below are quarterly accountability targets and thresholds the state will use to measure the success of the innovation project for this activity. The number and proportion of health care providers, hospitals and beneficiaries engaged by each component are indicated. Discrete metrics have been identified, including

numerators and denominators. The timeline for meeting each related milestone is shown in the table. [Green indicates a milestone.]				
Measures	**Pre-Implementation Year – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) Payers representing at least 80% of the beneficiary population that adopt new reimbursement models. ***Model Test Target – 4 (100%).***	4 (100%)	4 (100%)	4 (100%)	4 (100%)
CUM # (%) of recognized PCMH Practices who are under contract with one to 4 payers to receive alternative (non-volume based) reimbursements. ***Model Test Target – 180.***	No Activity Yet	No Activity Yet	15 (8%)	15 (8%)
CUM # (%) of beneficiaries attributed for purposes of alternative reimbursement payments. ***Model Test Target – 1, 282,500 (80% of Idahoans).***	No Activity Yet	No Activity Yet	106,875 (8%)	106,875 (8%)
Measures	**Model Test Year 1 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) Payers representing at least 80% of the beneficiary population that adopt new reimbursement models.	4 (100%)	4 (100%)	4 (100%)	4 (100%)
CUM # (%) of recognized PCMH Practices who are under contract with one to 4 payers to receive alternative (non-volume based) reimbursements.	15 (8%)	15 (8%)	30 (17%)	60 (33%)

CUM # (%) of beneficiaries attributed for purposes of alternative reimbursement payments.	106,875 (8%)	106,875 (8%)	213,750 (17%)	427,500 (33%)
Measures	**Model Test Year 2 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) Payers representing at least 80% of the beneficiary population that adopt new reimbursement models.	4 (100%)	4 (100%)	4 (100%)	4 (100%)
CUM # (%) of recognized PCMH Practices who are under contract with one to 4 payers to receive alternative (non-volume based) reimbursements.	75 (42%)	90 (50%)	105 (58%)	120 (67%)
CUM # (%) of beneficiaries attributed for purposes of alternative reimbursement payments.	534,375 (42%)	641,250 (50%)	748,125 (58%)	855,000 (67%)
Measures	**Model Test Year 3 – Quarterly Targets**			
	Q1	**Q2**	**Q3**	**Q4**
Cumulative (CUM) # (%) Payers representing at least 80% of the beneficiary population that adopt new reimbursement models.	4 (100%)	4 (100%)	4 (100%)	4 (100%)
CUM # (%) of recognized PCMH Practices who are under contract with one to 4 payers to receive alternative (non-volume based) reimbursements.	135 (75%)	150 (83%)	165 (92%)	180 (100%)
CUM # (%) of beneficiaries attributed	961,875 (75%)	1,068,750 (83%)	1,175,625 (92%)	1,282,500 (100% of target; 80% of

for purposes of alternative reimbursement payments.				population)

(Please see Operational Plan, Accountability Targets pages 7-25)

8. Page 55 of FOA states, "States are expected to cooperate in the evaluation process and provide the necessary data to evaluate state models. This data will be shared with the state evaluator team and with Innovation Center evaluation contractors." Continued on page 56, "The State evaluation contractor will be expected to create State evaluations relevant to all populations and payers involved in the State initiative."

Considering these requirements, please address the following:

h. What is the state's ability to provide current identifiable, individual Medicaid claims data to the federal evaluator/CMS for beneficiaries affected by SIM?
This should not be an issue – data available through Medicaid Management Information System.

i. What is the state's ability to provide individual-level commercial claims data to the federal evaluator/CMS for beneficiaries/providers affected by SIM? Include a description of current data infrastructure that would support this data request, such as an all-payer claims database.
The three commercial insurers that have agreed to participate in the model have also agreed to make available needed information and data for monitoring and evaluation of the model. So as long as the information/data requests are reasonable and useful commercial payers will participate.

j. What is the state's ability to provide Medicare identifiers to the federal evaluator/CMS for beneficiaries affected by SIM?
Not an issue – information is available in the current system.

d. Are there any laws and/or regulations preventing the disclosure of necessary records or data to the federal contractor performing the evaluation of SIM?

Provided that all data does not include Personal Identification Information (PII) or Personal Health Information (PHI), there are no Idaho laws or regulations that would prohibit disclosure to the federal contractor.

Is the state prepared to fully cooperate with the contractor performing the federal evaluation? This includes, but is not limited to the following:

i. Sharing identifiable data from any available payer (public or private) concerning beneficiaries and providers affected by SIM to coordinate primary and/or secondary data collection activities to reduce participant burden;
The state intends to fully cooperate with the federal contractor conducting the evaluation by producing any non-PII or non-PHI data from any public payer and will secure the necessary permissions to release any non-PII or non-PHI data from private payers for the purpose of the evaluation and to coordinate data collection activities in an expeditious manner.

i. Allowing CMS to review and comment on methods and results from the state evaluation before publication of results.
The state agrees to delay publication of the methods and results of the state evaluation until CMS completes its review and comment.

(See Revised Project Narrative, Monitoring and Evaluation Plan, page 32)

9. Describe how the proposed Payment and/or Service Delivery Model will be integrated with the Plan for Improving Population Health. Additionally, describe proposed collaboration across state agencies in addressing social determinants of health.

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

To address the social determinants of health, work must be done to address policy, systems and environmental change to increase access to healthy choices, access to health care, and local and state policy that provide equitable opportunities and eliminate barriers for people despite income, geography, etc. Policy, systems and environmental changes prevent people from falling over the cliff of good health where primary, secondary and tertiary interventions are needed, thus reducing health care spending and improving health outcomes. These activities and interventions are typically done by non-healthcare sector partners, i.e., worksites, schools, community organizations, public health, etc. These are the partners comprising the medical neighborhood and surrounding communities. The work they do and the policies they create impact what is being done in the medical neighborhoods that support the success of the local PCMHs and the Regional Collaboratives. Currently in Idaho, there are multiple state agencies that work together on a regular basis to address issues affecting Idahoans. For example, the Division of Public Health routinely works with the local public health districts, universities, the Department of Education, Board of Education, Department of Agriculture, Department of Environmental Quality, Department of Corrections, Idaho State Police, Idaho Commission on Hispanic Affairs, and many other state agencies. Additionally, there are many state entities with which the Division routinely works: the Idaho Medical Association, Idaho Hospital Association, American Heart and American Stroke

Association, American Cancer Society, American Lung Association, Idaho Chapter of the American Academy of Pediatrics, just to name a few. Each division within the Idaho Department of Health and Welfare has their own slate of state agencies and entities with which they routinely work to do their work and address social determinants of health and policy change aimed at better health outcomes for Idahoans. The Director of the Department of Health and Welfare participates regularly in cabinet level meetings with other state agency officials to discuss priorities affecting the population of the state. Compared to clinical interventions, changing the context to make individuals default decisions healthy in addition to addressing socioeconomic factors, those policy, system and environmental changes, have the largest impact on a persons' health.

(See Revised Project Narrative, Section 3, Payment and Service Delivery Model, pages 11-12)

10. Please describe any metrics the state might use to assess practice transformation, i.e. number of physicians paid on salary as opposed to productivity.

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

(See Revised Project Narrative, PCMH section, page 10)

11. Identify the recruitment process – including hiring entity – and training along with timeframes for staff the state will hire to implement the proposal.

State Hiring Process: The State of Idaho utilizes a competitive hiring process. Interested applicants apply through the Idaho Division of Human Resources. Job announcements include the job responsibilities as well as the minimum qualifications for that classification. Applicants demonstrate meeting those minimum qualifications by completing an online exam. The exam allows the applicants to provide supporting documentation to verify the education and/or experience required of the position.

All applications are scored by a Subject Matter Expert (SME), someone who has either been in that position or supervised such. Their identity is kept confidential and they are not involved in the hiring process. The SME scores the exams based on pre-determined grading criteria and an exam score is identified. Once all exams are scored, a hiring list is created, which includes those who passed the exam and are ranked in order of their exam score. The hiring list is used by the hiring managers to identify candidates for consideration. The new hire must have been an applicant who scored within the top 25 ranked applicants.

Recruiting Resources: Additional recruitment may be needed for positions that are determined difficult in filling, particularly those with very specific skill-sets. Recruiting resources may include numerous online, free or paid sources including universities, local or national websites, professional organizations and/or other industry specific entities such as CareerBuilder.

Required Training Courses: There are a number of standard training courses that all Department employees must take. They include:

(1) *New Employee Orientation* (classroom session 3-1/2 hours)

(2) *IDHW Employee Benefits for NEW and CURRENT Staff* (online version approx. 1 hour)

(3) Respectful Workplace for New Employees (classroom session 2 hours)

(4) Privacy and Confidentiality Course (online version approx. 30-45 minutes)

(5) IDHW Strategic Plan Orientation (online version approx. 30-45 minutes)

(6) IDHW Customer Service Plan (online version approx. 30-45 minutes)

(7) Region IV Programs & Services Orientation (classroom session 3-1/2 hours)

(8) Emergency & Evacuation Procedures (online version approx. 1 hour)

(9) User and Approver I-Time Training (online version approx. 1 hour)

(10) Securing the Human (online version approx. 1-1/2 hours)

In addition, during New Employee Orientation policies and procedures are covered and employees are advised to read and have an understanding of such. A few of the required include: Nondiscrimination policy, Employee conduct, Use of Department Resources, Employee Internet Use, Discipline, Due Process and Appeals.

Recruitment Timeframe

(1) IDHW publishes announcements for a minimum of five business days, with the ability to extend. However; depending on the position and additional recruitment that may occur, the announcement may run longer to allow for additional candidates to apply.
(2) Typically, from the time the announcement is posted to the time a hiring manager receives a hiring list is 2 – 3 weeks, depending on the number of candidates and how long it takes the SME to review and score the exams.
(3) The hiring manager receives the hiring list, completes a thorough review and schedules interviews.
(4) Interviews are conducted, selections are made and offers are accepted.

(See Revised Operations Plan, Organizational Capacity, page 2-3)

12. Describe the plan to address the shortage of key medical providers in your State (e.g. primary care physicians, nurse practitioners, psychiatrists). Specify the state's strategies for increasing providers/care team staff and how the state will work with universities, professional education programs or other existing training organizations to meet the workforce needs in the State.

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

(1) Expansion of family medicine residency programs: the successful expansion of existing family medicine residency programs and the establishment of a new program. Idaho increased the number of family medicine residency program graduates by 71% over the last 4 years by expanding the size of existing programs and adding a new family medicine residency program this year.
(2) New internal medicine residency programs: Idaho previously had zero internal medicine residency programs and, within the past three years, two new residencies were established. These two programs produce 14 internal medicine graduates per year. Within the past three years, Idaho also established a psychiatry residency which trains three residents per year in years 3 and 4 of their residency.
(3) Increase in state-supported medical school seats at the University of Washington and University of Utah: Idaho's governor, legislature, and board of education support access to medical school education for residents by providing state funding for medical school seats. Over the past four

years, ten new state-supported medical school seats have been added with plans to continue to grow these programs annually.

(4) Primary care physician workforce summit on September 17, 2014: the purpose of the summit is to identify gaps in current and future workforce needs, develop strategies to improve recruitment and retention, and create an action plan to increase Idaho's primary care physician workforce. The event is sponsored by sponsored by the Division of Public Health, Idaho Academy of Family Physicians, and Idaho Primary Care Association, and participants include leadership from residency programs, University of Washington and University of Utah medical schools, Idaho Department of Health and Welfare, State Board of Education, and various stakeholder organizations with workforce expertise.

(5) Idaho Health Professions Education Council: this governor-appointed workgroup includes leadership from state universities, residency programs, and the Idaho Department of Labor, and makes recommendations for funding appropriations and healthcare program growth. The council's recommendations are based in the context of evidence-based evolving workforce needs in Idaho, use of technology, curricular and field changes of key providers, within the overall strategy for care delivery by healthcare teams. The strategies are designed to address efficient and effective use of health professionals, with input from educational institutions, to plan for Idaho's future workforce needs.

(6) Rural Training Tracks: Idaho has two well-recognized and successful Rural Training Track (RTT) residency programs to train physicians for rural practice. A high proportion of RTT graduates provide healthcare in designated shortage areas for underserved populations and at least half of graduates remain in rural areas after graduation.

(7) Expansion of Physician Assistant and Nurse Practitioner training programs: these university-based programs continue to grow to help meet the increasing primary care needs of Idaho residents. This workforce is particularly critical in rural and underserved communities to staff Rural Health Clinics and Federally Qualified Health Centers.

(See Revised Project Narrative, PCMH section, pages 9-10)

13. Given Idaho's unique medical education program, please describe any plans the state might have to improve and modernize medical education to prepare doctors for a value-based practice of medicine.

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

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

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

(See Revised Project Narrative, PCMH section, page 10)

14. Describe recent or developing legislative and policy initiatives underway in the State that may enhance the proposed health care transformation efforts. Describe how these initiatives would be integrated into the proposal.

The outstanding policy initiative related to healthcare in Idaho is the question of expanding Medicaid. Idaho estimates that 78,000 Idahoans are below 100% of poverty and have no access to health care coverage. An estimated total of 104,000 Idahoans are below 138% of poverty and would qualify for Medicaid under expansion. There is tremendous advocacy support for expanding Medicaid in Idaho and it will be a hotly debated topic during the mid-term elections this fall. The Idaho legislature will be strongly pushed to consider expansion during the 2015 session beginning in January. Linking Medicaid expansion to the State Healthcare Innovation Plan (SHIP) will be essential to the potential success of an expansion initiative. State policy makers are leery of expanding 'traditional Medicaid' which is widely viewed as an entitlement program that does not hold recipients accountable and does not provide sufficient efficiencies. However, policy makers do strongly support the principles of the Idaho SHIP which envisions a total transformation of Idaho's healthcare system. When Medicaid expansion is described as an initiative that would provide access to coordinated, efficient, cost effective healthcare for the uninsured population the case for support is viewed as much stronger in this state.

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

(See Revised Project Narrative, Leveraging section, page 19)

15. Currently, the state of Idaho has chosen not to expand Medicaid coverage, raising the concern that the state's plan will not be able to reach 80% of Idaho's citizens. Please describe future plans the state might have to provide value-based care to uninsured Idahoans.

Idaho presently has 78,000 uninsured adults under 100% of FPL who are not eligible for Your Health Idaho, Idaho's state-based insurance exchange and are not covered by Medicaid, due to the state not yet expanding. This represents 5% of the state population. While it is not optimal to have this population ineligible for healthcare coverage, Idaho should be able to reach the goal of 80% of the population being covered by a PCMH even if Idaho were not to expand Medicaid coverage. Idaho's 13 community health centers currently

serve 153,000 individuals, providing primary care, behavioral health services and dental services. 49% of the CHCs' patients are uninsured, representing 75,250 individuals. The CHCs cannot turn away uninsured and are reimbursed on a sliding fee scale. Idaho's CHCs were early adopters of the PCMH model (participants in the Commonwealth Fund's Safety Net Medical Home Initiative from 2009-2012) and are committed to providing care within the PCMH model to all their patients.

(See Revised Project Narrative, Leveraging section, page 19)

16. Idaho has chosen to implement a state-based insurance exchange. Please describe any future plans to require health plans participating in the exchange to implement a PCMH model as described in the application.

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

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

(See Revised Project Narrative, Leveraging section, pages 19-20)

17. Please describe the role of cabinet level officials (other than the senior health official) in the successful implementation of the state's plan, such as cabinet-level officials responsible for housing, education, corrections, etc.

Idaho's small population is truly an advantage when working within the state system for change. Cabinet members in a small state often work together on initiatives, and the governor is also well-versed in emerging initiatives such as the SHIP. The Director of the Department of Health and Welfare has been deeply involved in the development of the SHIP, and is an active member of the Idaho Healthcare Coalition.

As the SHIP evolves over the next four years other cabinet members will become involved as healthcare system transformation touches on their areas of responsibility. For example, the Director of the Dept of Insurance will become involved as we work to align payment models of Idaho's major private payers and address insurance payment models. The Director of Corrections and the Director of Juvenile Corrections will become involved as we address how best to coordinate healthcare delivery for individuals moving between the corrections system and the private healthcare system. This will be especially critical for those individuals who suffer from chronic conditions including behavioral health diagnoses. The State

Superintendent of Education will become involved in strategies to promote coordinated healthcare delivery in school settings. In addition, local members of these fields of responsibility will be encouraged to participate in the Regional Collaboratives, representing their areas of expertise. For example, the superintendent of a rural school district with access to care challenges could be a key member of the Regional Collaborative, identifying linkages to school personnel and opportunities others would not be aware of.

(See Revised Operational Plan, Key personnel, page 1)