



GAP Analysis for the Idaho State Health Innovation Program

Multi-Payer Strategies	Current System	Current Funding Sources	Shortcomings in Current System	Barriers to Change	Components of New Model	Proposed Funding Sources	Changes Needed for New Model	
Identify existing private participants (i.e., payers)	Blue Cross, Blue Shield, PacificSource, all the major players, Noridian, TPAs	Premiums, Employer Groups, Self-Insured, Medicare	Price, transparency, Medical Loss Ratio, Lack of coordination of care	Regulation, current contracts, coding structures, consumer expectations, plan designs,	Expansion of PCMH, as defined by NCQA criteria, with at least tier three level. PCMH providers will be given fixed pmpm for attributed members. Attribution models can shift from visits to visit and costs monthly. Attributed providers may be added as care integrates, the care team expands, the NCQA levels are added, and member attribution shifts. Prevention and wellness initiatives would be required.	Year one: grant funds and private investment used for PMPMs for PCCM attributed process. Years two and beyond: PMPM with a risk model such as gain-sharing based on better outcomes and better quality of care. Gain-sharing or shared-savings would require the PCMH to attain increasing levels of NCQA criteria as well as attain increasing attributed members to maintain funding. Funding will shift from FFS/PCCM to include more quality tiers and more chronic care (advanced PCMH) for enhanced payments (P\$P). PMPMs and levels of risk will vary by payer and region, but quality and member experience metrics will be consistent for dashboards, reports, and metrics.	Attribution Methodology. Reasonable PMPM up front for establishment of PCMHs	
Identify existing public participants	Medicare, Medicaid, CAP funds, state funds, charity.	Medicare, Medicaid, CAP funds, state funds, charity.	Price, transparency, Medical Loss Ratio, Lack of coordination of care, fragmentation	Regulation, Silo-ed care, time, copays, third-party payers are risk averse - don't want change, lack of incentives.			Shared savings baseline creation in year one and a component of risk in years 2 and 3.	
Identify largest participants	Medicaid, Medicare, Blues	Medicaid, Medicare, Blues	Access, lack of coordination of care, lack of mature wellness plans,	Regulation			Payers would fund PCMHs at varying levels of support for attributed members but as PCMHs become more mature, they will handle more complex members over time, integrate with specialists and hospitals, and move from FFS to a gain sharing model based on the triple aim - better care, better health and lower costs.	Quality criteria defined to ensure proper care and create efficiency.
Identify smallest participants	Everyone else		Access, lack of coordination of care	Regulation				
Identify predominant market construct (i.e., FFS, PPO, managed care)	FFS, PPO=95% roughly		Access, lack of coordination of care	existing contracts, regulation				
Identify state oversight responsibilities (by each topic, i.e., for Network - licensing, for Payer - DOI)	DOI, CMS, DOL		lack of integrated data	Regulation, funding				
Identify federal oversight responsibilities (by each topic, i.e., for Network - Stark provisions)	DOI, CMS, ERISA		lack of integrated data	Regulation, funding				



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Identify geographic impacts	Underserved state. Behavioral health was identified as 100 % underserved.		Access; Only 6 pediatric psychiatrists in the state.	Cultural issues: Patients may choose to forego treatment in order to save the family farm.			
Identify recent innovations and opportunities	Tele-health, PCMH, in-home paramedics program, burn-treatment of Univ. of Idaho.		Slow adoption of electronic medical records				
Identify recent successes in new delivery models/payments	Tele-health, Tele-psych, PCMH, in-home paramedics program, transition of care codes, Idaho Health Data Exchange		no wide-spread use of data exchange yet.				
Identify recent failures in new delivery models/payments	Pay for Performance programs -- many starts and stops. Reporting is too laborious		Reporting is too much of an administrative burden to make incentives worthwhile. Fragmented.				
Identify workforce issues	Shortages of every provider type in different pockets/geographic areas of state. 50 of 50 states in pediatrics and obstetric doc per capita in the country	Size of state cannot support a lot of pediatric specialty groups, i.e. oncology, cardiac etc.					
Identify patient engagement issues	Culture, geography, demographics, lack of access						
Identify trends that make impact	Tele-health, coordinated care for chronic conditions, lots of education available.						