Idaho Medicaid – Healthy Connections Value Care White Paper
Version 5, September 2017

This document provides a framework for the Idaho Department of Health and Welfare's efforts to develop community based, accountable care programs. These initiatives support national reform efforts and build upon Idaho's successful medical home program. The payment innovations described herein will be implemented within the Division of Medicaid beginning mid-2018 and are voluntary.

Three key messages:

- How we pay for care strongly influences how care is delivered
- Healthy Connections Value Care transforms Idaho providers away from a focus on volume and complexity by linking payments to improved performance
- Healthy Connections Value Care payment reform delivers better care for patients, better health for communities and lower costs for Idaho

The need for this change comes from an understanding that fee-for-service payment methods work contrary to the transformation we are seeking. Experience over past decades highlights the need to implement payment systems that align payments to clinical and cost outcomes.

In proposing this transformation, we encourage the adoption of principle-centric changes that incorporate successful elements from many reform options and adapt them to the Idaho healthcare environment.

While the details provided here generally speak to shared-savings programs, they also apply to shared-risk programs that will be implemented in later years. We welcome input in all areas.

Program Goals:

- Deliver to the triple-aim of better care for patients, better health for communities and lower costs
- Patient-centered care that is highly coordinated
- Local governance by those who deliver care
- Payment methodologies that reward accountability, quality, efficiency and access
- Low administrative costs
- Community involvement to address local health priorities through advisory groups
- Support for community initiatives that advance population health

Overview:

In 2018, Idaho Medicaid will expand the existing Healthy Connections program to cover a broad range of healthcare transformation activities and population-based care management initiatives. Several programs are envisioned for the 2018 implementation year:

- Healthy Connections Regional Care Organizations
- Healthy Connections Patient Centered Medical Home Shared Savings
- Healthy Connections Episodes of Care

Healthy Connections Regional Care - This program is designed for physicians, hospitals, and other partners who form a cooperative structure with their region to accept accountability, and transform care. While participation within the RCO is voluntary, physicians, hospitals and other providers within a

region will need to collaborate on the submission of a single RCO proposal for their area. Three to five value-care regions are anticipated within Idaho. These Regional Care Organizations (RCOs) will establish local governance, and in turn, contract with Idaho Medicaid on behalf of their care-delivery network. Patient membership within the RCO will include those Medicaid participants who select a primary-care provider who participates with the RCO. Medicaid patient volumes will grow as RCOs recruit primary-care practices to their organization. Collaboration within the provider and hospital community will be essential.

Through the RCO program, shared-savings payments will be available for the control of healthcare costs to include primary care, specialty care, hospital, imaging, surgical facility, and other services for attributed Medicaid beneficiaries. Idaho Medicaid will administer shared-savings programs directly with the RCO who will distribute payments among their members following previously approved criteria. More details are provided in the Financial Settlements section of this document and in a template RCO contract available separately.

Patient Centered Medical Home (PCMH) providers who are members of their local RCO will continue to receive core PMPM payments from Medicaid; however, the shared-savings component of their payments will be comingled with the RCO's shared-savings program.

RCOs may be eligible to receive per member per month funding for population-management activities. If approved, these payments will help support population-management activities for primary-care clinics that have not been awarded tier 3 or tier 4 PCMH status. To apply for these funds the RCO must demonstrate advanced population-management abilities consistent with Idaho Medicaid's PCMH requirements.

Idaho Medicaid is targeting January 2018 for the release of an open and ongoing request for applications from RCO's. IDHW will review candidate RCO applications and accept those that meet contract application requirements. The application will include, among other items, the candidate RCO's proposed model of care, a plan to address health priorities within their region, the RCO's governance structure, a listing of participating providers, and details of the RCO's capabilities for network management, clinical coordination, and data analysis. Once the readiness review is complete, the candidate RCO may proceed with their request to contract. The expected effective date for the first RCO contract is July 2018.

Healthy Connections Patient Centered Medical Home Shared Savings Program – This program is designed for qualifying primary-care providers who elect to contract directly with Idaho Medicaid for a shared-savings program. Their alternative option for a shared-savings program will be to contract through the RCO active in their area. The Healthy Connections PCMH Shared Savings program will integrate with and expand upon the PCMH activities currently administered through Medicaid's Healthy Connections program and the Idaho State Healthcare Innovation Plan (SHIP) with the additional feature of shared-savings for the successful management of their attributed patient population. In future years, this program may include a voluntary option for clinics to accept financial risk consistent with the requirements of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Primary care providers who select this program track will contract directly with Idaho Medicaid; however, it will be important for these practices to work collaboratively within their geographic area even though they are not formal members of their local RCO.

Medicaid's 2017 Healthy Connections program includes four PCMH program tiers with per member per month (PMPM) payments ranging from $2.50 to $10.00 based on the participant's Medicaid eligibility

and the clinic's PCMH capabilities (tier level). In 2018, this program will be enhanced to include shared-savings opportunities for Tier 3 and Tier 4 PCMH practices. Monthly PMPM payments for tier 1 and 2 clinics will continue at their present levels to support clinics that have not achieved formal PCMH status but wish to continue developing those capabilities.

Beginning in 2018, Idaho Medicaid will monitor and communicate quality and cost effectiveness with all primary-care providers; however, only those primary care practices participating in an RCO or as a PCMH Tier 3 or 4 clinic will be eligible for shared-savings.

Healthy Connections Episodes of Care – This program will be designed for specialists and other providers who deliver certain discrete clinical episodes such as surgery, oncology and maternity care. Through this program specialists will benefit as they deliver high-quality, cost effective care within predefined episodes.

Healthy Connections Episodes of Care can be implemented as a stand-alone program between specialists and Idaho Medicaid or integrated within the RCO program track for specialists who elect to participate with a regional care organization.

Other Methods of Care Delivery:

RCO's and PCMH practices are encouraged to integrate community health workers, community emergency medical services, telehealth and other non-traditional services within their clinical work flows. The implementation of this full-community approach to care is believed by many to be an important structural element for payment reform as it expands the availability of care that is more timely, more convenient, more personal, and lower cost.

Patient Attribution:

With few exceptions, all participants of the Idaho Medicaid program are attributed to a primary care provider intended to function as their usual source of care[1]. Idaho Medicaid has a well-developed primary care attribution model that connects participants to a primary care provider of their choice with over 70% of Medicaid participants selecting their own PCP. If the participant declines to choose, Idaho Medicaid assigns a PCP based on past claims, proximity to provider locations, and other relevant factors.

Under the Healthy Connections approach, benefits delivered by providers unaffiliated with their primary care provider may require either a referral or a prior authorization to help ensure clinical continuity.

Risk Arrangements & MACRA:

Through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), congress established a roadmap for the implementation of value-based payment reform within Medicare. Under MACRA, clinicians have two options for payment reform: a Merit-Based Incentive Payment System (MIPS) or an Advanced Alternative Payment Model (APM). In designing its payment program options, Idaho Medicaid is proposing a financial risk structure consistent with the APM standard of "more than nominal financial risk", allowing participating clinicians to pursue the Advanced Alternative Payment Model with Medicare, if this is their preference.

[1] Members with dual Medicare / Medicaid eligibility, long-term institutional care residents, and certain other participants are excluded from this program or can opt out of primary care assignment.

Payment Streams:

The RCO and Episodes of Care programs will include two payment streams. The first payment stream will be composed of fee-for-service payments administered by Medicaid through systems currently in place. The second payment stream will include an annual lump-sum payment[2] administered through a settlement process described below.

For PCMH providers in the shared-savings program, three payment streams will occur. The first two payment streams include fee-for-service payments and PMPM case-management payments now in place. The third payment stream will be an annual lump-sum administered through a settlement process similar in nature to the process for regional care organizations.

Financial Settlements & Program Cost Metrics:

A design element common to all three shared-savings payment programs (RCO, PCMH Shared Savings & Episodes of Care), is the comparison of actual cost to expected costs to calculate positive or negative savings. Idaho Medicaid will use past claims data, cost trend assumptions, and a predictive risk model as the primary variables for predicting future healthcare costs (setting annual budgets).

The risk model uses demographic and diagnosis data to predict the relative healthcare needs for a population of participants. To provide an example, a participant with relatively modest clinical needs, say a child with no chronic conditions, might receive a risk score of 0.25 while an adult with more complex needs might receive a risk score of 4.0. In each case the risk score would be multiplied by the forecasted cost for an individual with "average" healthcare needs (i.e. a person with a risk score of 1.0).

The following table demonstrates how projected costs would be calculated for the above two examples.

Projecting Future Costs

	Risk Score	Normalized Cost	Projected Cost
Child Example	0.25	$300	$75
Adult Example	4.0	$300	$1,200

At the end of each program year projected costs will be compared to actual costs to calculate positive or negative savings under the program. We propose a simple formula:

Projected cost of care – Actual cost of care = Savings (or Negative Savings)

In the case of a shared-savings program, the provider's share of any positive savings will be identified within their contract. The amounts and calculations used in the settlement process will be supported through an externally vetted actuarial process. Idaho Medicaid already has access to a sophisticated model for predicting future costs based on patient demographic characteristics and past claims experience. Using this model will shorten the start-up time for these programs.

[2] In the event of a surplus this would be a payment from Medicaid, in the event of a deficit this would be a payment to Medicaid.

Within shared-savings programs, certain expenses will be excluded due to federal regulatory complexities, because they are managed through other programs, or for other reasons. The breakout of included and excluded costs is provided below.

Included Costs:
Diagnostic services (lab tests, imaging, etc.)
Durable medical equipment
Emergency medical transport
Hospice and home health
Hospital inpatient and outpatient
Inpatient behavioral health
Outpatient facilities including ambulatory surgery
Professional services (primary care, specialty care, physical therapy, speech therapy, etc.)
Skilled nursing facility (note, long-term institutional care residents are excluded from this program)
All other costs not specifically excluded

Excluded Costs:
Dental (premiums and claim expenses related to the Idaho Smiles program)
Intermediate Care Facilities for the intellectually disabled
Long-term supports and services (e.g. supported living and employment)
Medicare related costs (Medicare cross-over claims)
Non-emergency medical transportation (premiums and claim expenses from NEMT contractor)
Outpatient behavioral health (premiums and claim expenses related to the Idaho behavioral health contractor)
Pharmacy
School-Based Services (claim expenses related to Medicaid public school providers)
Waiver and home and community based services (for individuals who would otherwise need institutional care)

Shared-Savings Program Quality Metrics:

A minimum level of performance against quality metrics must be achieved before providers become eligible to participate in shared-savings payments. Quality metrics will generally be selected from national sources for alignment, to the extent possible, with other quality improvement efforts occurring in the state.

Each year Idaho Medicaid will publish the set of core quality metrics that will apply to all providers in the state. In addition, community advisory groups in each region will work with their local RCO to propose a set of supplemental quality metrics, drawn from the same national and state sources, to help address regional health issues. Additional details regarding the role of community advisory groups is described later in this document. Please reference the exhibits for a listing of proposed quality metrics.

Geographic Program Design:

Three to five geographic value care regions are expected within the state. Idaho Medicaid will develop the specific geographic boundaries following a review of care patterns, patient attribution counts, and dialogue with physicians, health systems, and other parties.

Each geographic region will contain a single RCO shared-savings program and a single community advisory group. Many PCMH and Episodes of Care programs can exist within each region.

Governance:

Healthy Connections Value Care participating organizations will range from independent PCMH practices to sophisticated health systems. Formal governance systems will be required of RCOs to promote development of a collaborative provider environment that is responsive to community needs and emphasizes the overall well-being of patients under their care. Shared responsibility for program governance, or equal-voice relationships, will be necessary to ensure no single provider entity dominates the governance role.

Physicians, hospitals and other providers within a region will need to collaborate on the submission of a single RCO proposal for their area. RCOs can determine their own governance structure so long as certain core expectations of Idaho Medicaid are met. These expectations may include a democratic process for electing leadership, balanced representation of their network participants, participation from non-risk partners such as public health, and guarantees of transparency to their full membership on appropriate topics. Governance arrangements for RCOs are subject to Idaho Medicaid approval. A Medicaid representative will maintain a key role in the RCO governance structure.

The governing committee for RCOs will establish network participation requirements, will recruit providers for participation and will determine how shared-savings payments will be distributed within their membership. RCOs can establish additional quality and cost management requirements of their membership beyond what is required by Medicaid. In this way RCO's can make their networks available to other payers as they build capacity and capabilities.

RCOs, while not governed by community advisory groups, will be expected to consider and act upon advisory-group recommendations. A representative appointed by the CHOICe advisory group will serve as a voting member of the RCO governing board. IDHW will provide initial administrative support to the CHOICe advisory group then, once established, the RCO will assume this function. In addition, the RCO will be required to provide a portion of shared savings to support community advisory group recommendations and community investments in sustainability.

Community Advisory Groups:

Community advisory groups called Community Heath Outcome Improvement Coalitions (CHOICe), will be established to advise each RCO. CHOICe groups will be comprised of representative stakeholders and leaders within the community that hold a common interest in improving health and wellness, creating health equity and addressing the social determinants of health in their communities. CHOICe provides an opportunity to address the behavior change aspects of health and wellness outside the doors of the healthcare clinic and bridge the gap between healthcare delivery and community initiatives that improve population health through better health outcomes.

CHOICe will accomplish this by:

- Helping to align services and resources within the medical-health neighborhood in partnership with local public health and other entities doing similar work
- Ensuring local transparency and accountability
- Supporting local and statewide initiatives such as practice transformation, value-based purchasing and the alignment of performance measures
- Recommending supplemental annual quality improvement targets through collaboration with Idaho Medicaid
- Reviewing information from a variety of sources such as clinical data, claims (including Idaho Medicaid data), population health data, feedback from participants and stakeholders, and quality and outcome data
- Making recommendations to RCO's about quality improvement targets, care management and population health issues
- Advising RCO community investments if RCO shared savings are realized;
- Advising on policy, system and environmental change for their communities

These goals will be communicated through an annual CHOICe health priority plan which will utilize information sourced from regional health assessments and other local data as well as through collaboration with the Healthy Connections Value Care program participants, local public health and providers in the area. The activities of CHOICe will flow through two primary channels, a Clinical Channel and a Community Channel.

Through the Clinical Channel, CHOICe will influence quality improvement benchmarks and initiatives by working collaboratively with the Idaho Medicaid program, RCOs, PCMH practices, behavioral health, dental, and dual eligible managed care plans as administered through Idaho Medicaid. CHOICe will independently monitor providers against those benchmarks, and compare local experience with statewide experience using data provided by Idaho Medicaid. CHOICe will also make recommendations about quality initiatives designed to improve performance. All providers will be graded on the identified quality measures, which will also determine RCO eligibility for shared savings. Follow-up on these findings and recommendations will be the responsibility of the participating RCO providers.

Through the Community Channel, CHOICe will partner with existing entities such as local public health to support their medical-health neighborhood and clinical-community partnerships. These partners include medical, social and public health supports necessary to enhance health and the prevention of disease. In this capacity, each CHOICe advisory committee will help set local health improvement goals for their community and potentially make recommendations about statewide health improvement goals in concert with other CHOICe groups across the state.

Each CHOICe group will conduct or utilize existing regional health assessments and input from their membership to inform their recommendations for Clinical Channel and Community Channel activities and will develop annual, regional health priority plans, that focus on strategic activities to improve the health of their community. The health assessment and health priority plan must consider the needs of Idaho Medicaid participants.

After the establishment of the initial RCO in the program, CHOICe advisory groups will be administratively supported by the RCOs. Shared savings above RCO contract provisions will be directed towards community health improvement efforts as advised by CHOICe and with oversight by the Department of Health & Welfare. These funds will help supplement community initiatives that advance population health (see Exhibits). Examples of potential shared savings recipients may include crisis

centers, institutions that assist with housing needs, behavioral-health organizations, public health programming and other services that meet community needs. The RCO will be responsible for distributing these funds.

Additional details on the CHOICe advisory group and Advancing Population Health are provided in the Exhibits.

Exhibit 1 – Proposed Quality Metrics

Shared-savings programs will include core and supplemental quality metrics generally selected from national sources to reinforce established quality improvement efforts. Each year Idaho Medicaid will publish a set of quality metrics that will apply to all participating providers in the state.

A minimum level of performance against quality metrics must be achieved before PCMH clinics and RCOs become eligible to participate in shared-savings payments.

The following table includes example quality metrics that may be adopted for professional providers.

Sample Professional Quality Metrics

- Adult HbA1c Testing
- Pediatric HbA1c Testing
- Acute Depression Treatment
- ADHD New Drug Follow-Up
- Well-Care children 15 months
- Well-Care children 3 to 6 months
- Well-Care children 12 to 21 months
- Breast Cancer Screening
- Colon Cancer Screening
- Influenza Vaccination

Sample Hospital Quality Metrics

- Adverse drug events to focus on at least the following three medication categories: opioids, anticoagulants, and hypoglycemic agent
- Central line-associated blood stream infections (CLABSI) in all hospital settings, not just Intensive Care Units
- Catheter-associated urinary tract infections (CAUTI) in all hospital settings, including avoiding placement of catheters, both in the emergency room and in the hospital
- Clostridium difficile (C-diff) bacterial infection, including antibiotic stewardship
- Injury from falls and immobility
- Pressure Ulcers
- Sepsis and Septic Shock
- Surgical Site Infections (SSI), to include measurement and improvement of SSI for multiple classes of surgeries
- Venous thromboembolism (VTE), including, at a minimum, all surgical settings

- Ventilator-Associated Events (VAE), to include Infection-related Ventilator-Associated Complication (IVAC) and Ventilator-Associated Condition (VAC)
- Readmissions

Exhibit 2 - The Community Health Outcome Improvement Coalition (CHOICe)

Membership and Governance

As previously mentioned, a Community Health Outcome Improvement Coalition (CHOICe) will be established in each geographic area of the state where an RCO is active. Each CHOICe advisory group will be established as a separate legal entity with its own charter and governing board.

A board of directors composed of nine to thirteen voting members is anticipated, most of whom will come from outside the RCO. Board membership will include at a minimum:

- One member from an independent PCMH practice
- One member will be the local public health district director or their designee (in regions with more than one health district, each will be represented)
- One member will be selected by the Department of Health and Welfare
- Two members will be selected by the RCO
- In counties with a federally recognized tribe, one member will be appointed by the tribe
- Remaining board members will be selected from the community at large. These members should have knowledge of the healthcare system and be representative of the community. Individuals representing the following areas could be considered: Medicaid beneficiaries, regional behavioral health board, behavioral health provider, local government entities, participant advocacy groups, regional state government leaders, social services or social supports, housing, community based non-profit or for profit organizations, community mental health centers, businesses leaders, community services organizations, community wellness programs, long-term care system, early learning, economic development, faith based organizations, transportation.

Administrative and logistical support will be provided by the local RCO who will have a contractual obligation with Idaho Medicaid for this function.

The CHOICe board of directors may establish non-voting advisory panels and work groups to broaden participation within the community.

Supplemental Information

The seven Regional Health Collaboratives (RCs) already formed under the State Healthcare Innovation Plan (SHIP) have a similar charge and could naturally develop to become CHOICe advisory groups. Alternatively, existing RCs may request a role within CHOICe to function in an advisory capacity.

All options for CHOICe advisory group functions, roles and formation will be dependent on the infrastructure the organization elects and its ability to establish and provide administrative and fiduciary support in collaboration with the RCO.

Advancing Population Health

CHOICe will play an important role in advancing population health within their region through the inclusion of constituents outside the traditional hospital and physician model but in partnership with the RCO and PCMH partners with which they working. Traditional models of healthcare reform focus primarily on controlling the costs of care and improving patient's outcomes and experience. They tend to focus on clinical preventive services and may not address "up-stream" or higher-level determinants of health that often drive spending. Through this reform initiative we hope to broaden the traditional approach through the integration of clinical services, public health and community based initiatives.

Knowing that a balanced portfolio of measures will include both clinical and community-wide measures CHOICe advisory groups may choose to be organized around the Centers for Disease Control and Prevention's (CDC) system for analyzing the measures of health at the patient level, clinic-community level and community-wide level. In their Community Channel activities CHOICe will be especially focused in the area of community-wide health as described below:

- **Traditional Clinical Approaches** - The focus is on an individual and has a patient construct. Typical clinical services done in a one-on-one patient interaction would be at this level.
- **Innovative Clinical Care** - The focus is a patient construct with a narrow population view such as a practice or an accountable care organization. The patient centered medical home is an innovative clinical mode that provides linkages which support patients in the community.
- **Community-Wide Health** - The focus is on a broad population, such as a regional geography, and has a community construct. Community-wide health initiatives typically have a policy focus.

Traditional Clinical Approaches	**Innovative Clinical Care Patient-Centered Medical Home**	**Community-Wide Health**
Focused on an individual; patient construct		Focused on broad population; community construct
Typical clinical services done in a one on one patient interaction	Linkages that support patients in the community and that provide services outside the clinical setting	Broader, mostly policy-focused aimed at supporting the broad community and the overall health of the population in the community
DIABETES Example		
Screening for pre-diabetes, diagnosis, treatment, medication, clinical guidance, A1C monitoring, eye exam, foot exam	Linkages and referrals to Diabetes Self-Management Education (DSME) classes, Registered Dietitian-Nutritionist referral, dental referral, CHW or CHEMS support for blood sugar monitoring and medication management	Community policy and practice to provide healthier communities; easier access to physical activity and proper nutrition; policies to reduce tobacco usage and trans fats in foods
OBESITY Example		
Diagnosis, medication, weight and height to calculate body mass index and monitor, blood pressure,	Linkages and referrals to Diabetes Self-Management Education (DSME) classes, Registered Dietician-Nutritionist referral, dental referral and cavity risk	Community policy and practice to provide healthier communities; easier access to physical activity and proper nutrition; mandatory changes

cholesterol screening, physician/patient counseling	assessment, CHW or CHEMS support for blood sugar monitoring and medication management	in school vending and physical education courses
TOBACCO Example		
Screening patients for smoking, ensuring smoking cessation referral, physician/patient counseling	Linkages that support patients in community or medical-health neighborhood, linking patient to cessation class or quit line	Practices and policies that support lower smoking rates statewide (clean indoor air policies, increasing the legal age of tobacco purchase, tobacco tax increase, etc.)