Healthcare Transformation Council of Idaho

Meeting Agenda

Thursday, April 18, 2019 3:00PM – 5:00PM (MT)

PTC Building (Health and Welfare Central Office)
450 West State Street – 7th Floor
Conference Room 7A
Boise, ID 83720

Registration URL: https://zoom.us/j/808766781
Dial in: +1 669 900 6833 Meeting ID: 808 766 781
One tap mobile +16699006833,,808766781#

3:00 p.m.	Welcome and opening remarks; roll call; introductions; agenda review; review of minutes – *Dr. Ted Epperly & Dr. David Pate, Co-Chairs* - ACTION ITEM
3:10 p.m.	Update on Medicaid Expansion – *Lisa Hettinger, Deputy Director & Matt Wimmer, Medicaid Administrator*
3:30 p.m.	Recap of March HTCI meeting & Member follow-ups – *Dr. Ted Epperly & Dr. David Pate*
3:40 p.m.	Initiative Discussion and Scoring Tool version 3.0 – *Dr. Ted Epperly & Dr. David Pate*
4:00 p.m.	Value Based Payment – Initiative #1 – Discussion and Action – *Dr. Ted Epperly & Dr. David Pate* – ACTION ITEM
4:50 p.m.	Additional business • Membership Update – ACTION ITEM • Idaho Healthcare Summit May 21-22, 2019 • Workgroup forming • Propose for HTCI Meeting on May 23rd
5:00 p.m.	Adjourn

CHARGE:

Promote the advancement of person-centered healthcare delivery system transformation efforts in Idaho to improve the health of Idahoans and align payment to achieve improved health, improved healthcare delivery, and lower costs.

FUNCTIONS:

- Promote and support transformation by identifying opportunities for innovation that will help shape the future of healthcare.
- Serve as a trusted source and a credible voice to strategically drive improvements in the healthcare delivery system.
- Serve as a convener of a broad-based set of stakeholders.
- Identify delivery system barriers that are preventing healthcare transformation and prioritize and recommend solutions.
- Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation.
- Recommend and promote strategies to reduce overall health care costs.
- Utilize accurate and timely data to identify strategies and drive decision making for healthcare transformation.
- Promote improved population health through policies and best practices that improve access, quality, and the health of all Idahoans.
- Promote whole person integrated care, health equity, and recognize the impact of social determinants of health.
- Support the efforts in Idaho to provide a healthcare workforce that is sufficient in numbers and training to meet the demand.
- Promote efficiencies in the collection, measuring, and reporting of quality metrics.

HTCI
HEALTHCARE TRANSFORMATION
COUNCIL OF IDAHO

HTCI
HEALTHCARE TRANSFORMATION COUNCIL OF IDAHO

March 21, 2019 3:00 pm

Location: 450 W. State St., 10th Floor, Conference Room 10A

Meeting Minutes:

Member Attendees: Matt Bell, Kathy Brashear, Denise Chuckovich, Dr. Keith Davis, Dr. Ted Epperly, Lisa Hettinger, Drew Hobby, Randall Hudspeth, Yvonne Ketchum-Ward, Molly Steckel (proxy for Susie Pouliot) Patt Richesin, Neva Santos, Dr. Karl Watts, Matt Wimmer, Nikole Zogg, Dr. Andrew Baron (phone)

OHPI Staff: Casey Moyer, Ann Watkins, Kym Schreiber, Meagan Graves

Guest Speakers: Governor Brad Little, Director Dave Jeppesen

Status: Draft 3/22/2019

Summary of Motions/Decisions:

Motion:	**Outcome:**
February HTCI Meeting Minutes Kathy Brashear moved to accept the minutes as amended Neva Santos second the Motion.	Passed

Agenda Topics:

Welcome and Opening Remarks; Roll Call; Introductions; Review of Minutes; Action Items, and Agenda Review- *Dr. Ted Epperly, Co-Chair of the HTCI*

- Dr. Epperly welcomed everyone to the meeting and took roll call.
- Dr Epperly opened the meeting sharing a quote "Innovation is not the result of chance, it is the result of action. It is not a thing to wait for, it is a thing to do."

Update on Medicaid Expansion- *Lisa Hettinger, Deputy Director IDHW, & Matt Wimmer, Medicaid Administrator IDHW*

- Ms. Hettinger and Mr. Wimmer updated the HTCI members on the current progress of Medicaid expansion efforts. Medicaid has been working with Behavioral Health for primary care resources. The department is not going to wait to start their work, they are moving forward with their plans of delivering a promise to care for the lives of Idaho.

Future Considerations of Healthcare Transformation- *Governor Brad Little & IDHW Director Dave Jeppesen*

Governor Little:

- Governor opened by sharing his experience with healthcare as a farmer managing cattle. In that role he didn't pay that much attention to human healthcare but understands the parallels now. Fee for service care is expensive and not an effective way to pay for healthcare.
- Governor Little referenced his speech for the State of the State and his Inauguration and his priority of making Idaho comfortable for Idahoans to live and retire.
- The four pillars of his Administration are
    1. Economic Viability
    2. Education
    3. Quality of Life
        a. Quality of life includes providing affordable and accessible healthcare, and what we do about mental health and substance abuse. He would like to see transparency in billing, healthcare, and how we pay for outcomes
    4. Building Confidence in Government
- Currently his office is looking at the people left out and the people who are priced out and how to get them coverage. His focus is to have affordable state-based healthcare plans, he has a plan to launch more plans with better coverage and pricing.
- He is interested in comprehensive affordable healthcare which covers all of the state and addresses all of Idaho's healthcare issues. He will be relying on the HTCI for input on the best options to achieve these goals.

Q&A for Governor Little:

- Yvonne Ketchum-Ward: The statehouse is looking at expanding care for mental health and substance abuse. What are your views on those issues?
    - Governor Little will be signing an executive order after the legislative session which addresses mental health, opioid use, heroin use, fentanyl use, and mental health treatment. Since Idaho is late to the game they will need help from the HTCI on where to put their dollars. The overarching goal is to reduce cost for individuals, reduce recidivism, reduce the drag on corrections, increase public safety, increase safety in schools, and create early intervention in schools.
- Matt Bell: Asked the Governors view on Bill 277.
    - The intent of the affordable care act (ACA) was not for us to cover everything off the ball as long as we are covering people because it is the right thing to do.
- Patt Richesin: Coverage need to be managed well and interlocking operations to be able to support, maintain the affordability, and sustainability so we don't find ourselves back here in 7 years. How do you propose we respond to your needs for the preparation necessary to keep them aligned?

    - We are going to set an example for everyone else and try to change everyone from paying the same fees to offering discounts for certain behaviors. We must start with Medicaid, then the state market place, then small and large businesses, and Individuals to create a personal responsibility and get the plans smaller.
- Randy Hudspeth: Do you have any ideas about new faculty for all areas of healthcare?
    - Sara Stover answered: During nursing day at the Capitol Building we were made aware of the challenges and we are prepared to meet with a nursing member after the legislative sessions. The colleges have identified there is a lack of instructors and lack of ability to obtain good instructors needed to fill the teaching positions. There is also a nursing shortage at the state hospitals and Sara will be reaching out to Patt Richesin for assistance as she has a lot of success with her hospital.
    - Brad Little: There are three growing areas- Government, Education, and Healthcare. The key is to reach students when they are in high school by reaching out to superintendents, principal's and career counselors to help incentivize work in healthcare. The career counselors would be able to get them enrolled in the right pre-requisites and enrolled in dual-credit courses.
- Dr. Ted Epperly closed the conversation with Governor Little by stating "What I heard from you, your interest is closing gaps between coverage and no coverage, those left out, rural and urban costs that exist in the state, interlocking connection between coverage, delivery, cost and outcomes. We promise to do our very best to take a complex issue and to distil it down to really make a difference and to align your activities."

Director Dave Jeppesen:

- "What I want and what I view going along with what the Governor said is how do we provide affordable and accessible healthcare to people. How do we do that? I want to leave a legacy for kids to stay here and come home."
- "There are two types of bad guys, villains and monsters. To overcome a villain, you need a hero. You can't overcome a monster with one person you need a whole village. When we think about healthcare transformation it is not a villain hero story it is not going to be a single entity or single person it is going to take the whole village." It will take the whole village to transform healthcare and solve healthcare problems.
- There was great progress made under the SHIP grant, 2/3 of all participants are part of PCMH clinics. We moved the needle from 25% to 29% for value-based payments. The grant was mostly used to build the infrastructure.
- Director Jeppesen offered a challenge for the HTCI to work on moving the needle from 29% to 50% value-based payments before the end of Governor Little's first term in 2023.
- Director Jeppesen highlighted feedback from Legislation; who are looking for the HTCI to have more of a public/private partnership evidenced in the funding model. There is a need for the council to seek out grant opportunities, funds from foundations, and businesses to demonstrate this. He believes if we are able to show there is private funding they will be more likely to agree to provide more funding next year during session.

Initiative Discussion and Scoring Tool- *Dr. Ted Epperly, Co-Chair*

- Dr. Epperly talked about the layout and scoring criteria of the scoring tool. The current areas of scoring criteria are: Data Driven, Leveraging Experience, Geographic Equity, Urban vs. Rural, Cost Impact, and Resource Intensity.

- Dr. Epperly opened the discussion for feedback from all the HTCI members.
    - Patt Richesin: we need to weigh initiatives with Director Jeppesen's value-based payment (VBP) challenge, create an inventory of items used and push those forward, and a way to measure the outcomes.
    - Dr. Karl Watts: Operational impact (feasibility), is this doable? (i.e. telehealth vs. quality, high value vs. a way to collect.). and tangible outcomes.
    - Dr. Keith Davis: Geographical equity, we need to align VBP, make it clear and move hard on set goals.
    - Molly Steckel: Will the 50% VBP goal become a guiding principle or an example?
    - Drew Hobby: Per member impact and 50% VBP goal.
    - Denise Chuckovich: Realistic goals that align with the shoe string budget.
    - Kathy Brashear: We need to create a definition for VBP with all payers.
    - Yvonne Ketchum-Ward: Cost Impact, doesn't believe we should make an initiative if there is no way to fund it.
    - Matt Wimmer: Impact it makes on the lives of Idahoans.
    - Matt Bell: Communicate value gained by investment and show the bend in the cost curve.
    - Randall Hudspeth: Work that is standard, and evidence based.
    - Nikki Zogg: Social Determinants of Health, adverse childhood exposure, early childhood chronic diseases, mental health, and substance abuse.

Additional Business and Next Steps- *Dr. Ted Epperly, Co-Chair*

- Dr. Epperly covered the next steps:
    - Work on defining value-based payments
    - Present SHIP dashboard
- Casey Moyer will be reaching out to the members for a profile picture and profile information.
- Dr. Epperly ended the meeting with the same quote he opened the meeting with.

Meeting Adjourned: 5:07 pm

Healthcare Transformation Council of Idaho

Action Items

April 18, 2019 3:00PM

- Action Item 1 – March HTCI Meeting Minutes

  HTCI members will be asked to adopt the minutes from the March 21, 2019 HTCI meeting:

  Motion: I, _____ move to accept the minutes of the March 21, 2019 meeting of the Healthcare Transformation Council of Idaho as presented.

  Second: _____

- Action Item 2 – Initiative Selection

  HTCI members will be asked to adopt value based payment initiative as HTCIs first initiative:

  Motion: I, _____ move HTCI adopt Value Based Payment Initiative as the first initiative to undertake as discussed.

  Second: _____

- Action Item 3 –HTCI Membership

  HTCI members will be asked to recommend a replacement candidate for the Critical Access Hospital slot:

  Motion: I, _____ move to recommend _____ be invited to join the Healthcare Transformation Council of Idaho to fill the Critical Access Hospital position on the membership matrix.

  Second: _____

SHIP Project Management Dashboard

Prepared for the Idaho Healthcare Coalition

Award Year 4, Quarter 4 + Annual

November 1, 2018 – January 31, 2019

FINAL PROJECT DASHBOARD

The SHIP Project Management Dashboard is an interim tool prepared for the Idaho Healthcare Coalition on a quarterly/annual basis to monitor the SHIP success measures.

- The final quarter of the project resulted in the many metrics targets increasing. This resulted in several metrics decreasing the percent accomplished despite increasing the numerator count.
- Goal 7 Update: To collect payer data for tracking the State's progress in shifting to value-based payments, an Idaho alternative payment model framework was developed by the Multi-Payer Workgroup; the model follows the Health Care Payment Learning and Action Network model and reflects the different payment methodologies in the Idaho marketplace.

SHIP Success Measures

Goal 1	86%	100%	100%		100%		99%↓	96%↓	53%↑		86%↑
	QT = 270	QT = 165	QT = 165	CMMI	AT = 1650	CMMI	AT = 165	AT = 165	QT = 165	CMMI	QT = 825k
Goal 2	100%		86%↓		73%↑		48%↓				
	QT = 165		QT = 825k		AT = 165		QT = 21				
Goal 3	100%		100%				86%↓				
	AT = 7		AT = 165		RETIRED		QT = 825k				
Goal 4	96%↓	100%↑	63%↓	86%↑	100%	100%	100%↑				
	QT = 50	SAT = 13	AT = 35	SAT = 125	AT = 2	AT = 12	AT = 20				
Goal 5	0%		0%								
	AT = 110		AT = 110		RETIRED						
Goal 6	100%		100%		29%						
	AT = 4		AT = 825k		AT = 80%						
Goal 7	98%↑				510%↑						
	AT = <100%				AT = 197%						

- SHIP success measure is not reported
- SHIP success measure is on target (≥90% of target)
- SHIP success measure is slightly off target (between 75% and 89% of target)
- SHIP success measure is not on target (<75% of target)

QT = Quarterly Target (Q1=Apr 30, Q2=July 31, Q3=Oct 31, Q4=Jan 31)
SAT = Semiannual Target (Q2=July 31, Q4=Jan 31)
AT = Annual Target (Jan 31)
ND = No Data
CMMI = Federally defined and reported metric

Please refer to the SHIP Operational Plan and goal charters for details regarding quarterly, semiannual, and annual targets.

State Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

SHIP Success Measures by Goal

Goal 1 Measurements: PCMH Transformation		
1	Q	Cumulative # (%) of primary care clinics that submit an interest survey to participate in a SHIP cohort. Model Test Target: 270.
2	Q	Cumulative # (%) of primary care clinics selected for a SHIP cohort that have completed a PCMH readiness assessment and a Transformation Plan. Model Test Target: 165.
3	Q	Cumulative # (%) of targeted primary care clinics selected for a SHIP cohort. Model Test Target: 165.
4	Q	CMMI Metric: Cumulative # (%) of primary care clinics selected for a SHIP cohort, of the total primary care clinics in Idaho.
5	A	Cumulative # (%) of targeted providers participating in primary care clinics selected for a SHIP cohort. Model Test Target: 1,650.
6	A	CMMI Metric: Cumulative # (%) of providers in primary care clinics selected for a SHIP cohort, of the total number of primary care providers in Idaho.
7	A	Cumulative # (%) of primary care clinics selected for a SHIP cohort receiving an initial transformation reimbursement payment and achieving technical support benchmarks for retaining the payment. Model Test Target: 165.
8	A	Cumulative # (%) of primary care clinics selected for a SHIP cohort that achieve their transformation goals as specified in their Transformation Plan. Model Test Target: 165.
9	Q	Cumulative # (%) of primary care clinics selected for a SHIP cohort that achieve national PCMH recognition/ accreditation. Model Test Target: 165.
10	Q	CMMI Metric: Cumulative # (%) of Idahoans who enroll in a primary care clinic selected for a SHIP cohort (of total state population).
11	Q	Cumulative # (%) of Idahoans who enroll in a primary care clinic selected for a SHIP cohort (of target population). Model Test Target: 825,000.
Goal 2 Measurements: Electronic Health Records (EHRs)		
1	Q	Cumulative # (%) of primary care practices selected for a SHIP cohort with EHR systems that support HIE connectivity. Model Test Target: 165.
2	Q	Cumulative # (%) of Idahoans who enroll in a primary care practice selected for a SHIP cohort that have an EHR that is connected to HIE. Model Test Target: 825,000.
3	A	Cumulative # (%) of primary care practices selected for a SHIP cohort with an active connection to the HIE and sharing/receiving HIE transactions for care coordination. Model Test Target: 165.
4	Q	Cumulative # (%) of hospitals connected to the HIE and sharing data for care coordination. Model Test Target: 21.
Goal 3 Measurements: Regional Collaboratives (RCs)		
1	A	Cumulative # of RCs established and providing regional quality improvement guidance and working with PHDs to integrate the Medical-Health Neighborhood. Model Test Target: 7.
2	A	Cumulative # of primary care practices selected for a SHIP cohort that receive assistance through regional SHIP PHD team. Model Test Target: 165.
3	R	Cumulative # of primary care practices selected for a SHIP cohort who have established protocols for referrals and follow-up communications with service providers in their Medical-Health Neighborhood. Model Test Target: 165.
4	Q	Cumulative # of patients enrolled in a primary care practice selected for a SHIP cohort whose health needs are coordinated across their local Medical-Health Neighborhood, as needed. Model Test Target: 825,000.
Goal 4 Measurements: Virtual PCMHs		
1	Q	Cumulative # (%) of Virtual PCMHs established in rural communities following assessment of need. Model Test Target: 50.
2	SA	Cumulative # (%) of regional CHEMS programs established. Model Test Target: 13.
3	A	Cumulative # (%) of CHEMS program personnel trained for Virtual PCMH coordination. Model Test Target: 35.
4	SA	Cumulative # (%) of new community health workers trained for Virtual PCMH coordination. Model Test Target: 125.
5	A	Cumulative # (%) of conferences held for CHW and CHEMS Virtual PCMH staff. Model Test Target: 2.
6	A	Cumulative # of SHIP clinics and CHEMS agencies that use telehealth tools to provide specialty and behavioral services to rural patients. Model Test Target: 12.
7	A	Cumulative # of SHIP participating clinics that participate in Project ECHO. Model Test Target: 20.
Goal 5 Measurements: Data Analytics		
1	A	Cumulative # (%) of primary care practices selected for a SHIP cohort with access to the analytics system and dashboard reporting. Model Test Target: 110.
2	A	Cumulative # (%) of primary care practices selected for a SHIP cohort that are meeting the clinical quality reporting requirements for their cohort. Model Test Target: 110.
3	R	Cumulative # (%) of RCs provided a report of PCMH clinic CQM performance data. Model Test Target: 7.
Goal 6 Measurements: Alternative Payment Reimbursement Models		
1	A	Count of payers representing at least 80% of the beneficiary population that adopt new reimbursement models. Model Test Target: 4.
2	A	Count of beneficiaries attributed to all providers for purposes of alternative reimbursement payments from SHIP participating payers. Model Test Target: 825,000.
3	A	Percentage of payments made in non-fee-for-service arrangements compared to the total payments made by SHIP participating payers. Model Test Target: 80%.
Goal 7 Measurements: Lower Costs		
1	A	Total population-based PMPM index, defined as the total cost of care divided by the population risk score. Model Test Target: <100%.
2	A	Annual financial analysis indicates cost savings and positive ROI. Model Test Target: 197%.

MERCER
MAKE TOMORROW, TODAY

PAYER FINANCIAL AND ENROLLMENT METRICS FOR GOAL 6 THROUGH AWARD YEAR 3 (AY3)

September 6, 2018

INTRODUCTION

In calendar year (CY) 2017, Idaho's Statewide Healthcare Innovation Plan (SHIP) continued promoting the transformation of healthcare payments from volume-based payments to payments focused on outcomes coinciding with the implementation of the Patient-Centered Medical Home (PCMH) model of care. To support testing of Idaho's SHIP, Idaho received a four-year federal State Innovation Model (SIM) Test grant. As part of the grant's requirements, the State of Idaho (State) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits, LLC to analyze financial metrics for the State population's health in an effort to measure the progress in moving from fee-for-service (FFS) to value-based payments.

STRATEGIES AND METHODS FOR VALUE-BASED PAYMENTS

The State's multi-payer approach shifting from FFS payments to value-based payment strategies is expected to achieve a long-term, sustainable impact on the State's healthcare system. In AY3, payers continued to move away from FFS and towards value-based payment through several methods, including:

- Pay-for-Performance (P4P)
- Enhanced P4P
- Shared Savings
- Shared Risk
- Full Risk
- Quality Bonuses
- Population-Based Payments
- Episode-Based Payments

In addition to the Patient-Centered Medical Home (PCMH) model of care, payers are testing alternative models including accountable care organizations (ACOs) with many of the State's acute care hospitals.

Payers also support total-cost-of-care programs with shared savings payments for improving and managing patients with chronic conditions to reduce avoidable emergency room visits.

The multi-payer approach includes:

- Understanding each payer's need to design and implement payment models that they believe fit their organization's goals and are most effective for their beneficiaries and provider partners.
- Recognizing that system wide transformation to value-based purchasing will only occur across Idaho payers if payers are participating as leaders of the change rather than responding to mandates.
- Acknowledging that payment transformation may not occur quickly in the State but, through partnership with payers, new reimbursement models will emerge that have a positive impact on the system statewide. Implementation of new reimbursement models representing at least 80% of the beneficiary population is the goal for the State and is underway.

To collect payer data for tracking the State's progress in shifting to value-based payments, an Idaho alternative payment model framework was developed by the Multi-Payer Workgroup. The model follows the Health Care Payment Learning and Action Network model and reflects the different payment methodologies in the Idaho marketplace.

BASELINE FOR IMPROVEMENT COMPARED TO AWARD YEAR 3

The overarching aim of the State's integrated multi-payer PCMH model is to improve quality outcomes and beneficiary experience, which is expected to lower the cost of healthcare. Transforming from a FFS reimbursement model to payment models that incentivize quality outcomes and improved beneficiary experience is a key goal to achieve this aim. Evidence of the transformation from paying for volume to paying for value will be shown by comparing the enrollment and payment metrics from commercial, Medicare and Medicaid payers throughout the State for each award year.

Data Requests

To measure progress, the baseline of CY 2015 data was compared to CY 2016 and CY 2017 data. Payers were asked for both years to provide percentages of beneficiaries and percentages of payments in the following categories:

- Category 1: FFS — no link to quality and value. Example is FFS payments.
- Category 2: FFS — link to quality and value. Examples include a) foundational payments for infrastructure and operations, b) pay for reporting, c) rewards for performance, and d) rewards and penalties for performance.
- Category 3: Value methodologies built on FFS architecture. Examples include a) methodologies with upside gainsharing and b) methodologies with upside gainsharing/downside risk.

SHIP IS SUPPORTED BY FUNDING OPPORTUNITY NUMBER CMS-1G1-14-001 FROM THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES.

- Category 4: Population-based payment. Examples include a) condition-specific population-based payments and b) comprehensive population-based payments.

To assist in compilation, the data request also asked for total dollars paid for medical services in both years. The data request forms did not change from year to year.

Mercer's Client Confidentiality Agreement was signed by commercial payers and Mercer to ensure their data was protected and kept private. The agreement covers all four award years. It was agreed that the data would be aggregated across payers so no individual payer data would be discernable.

Data Compilation

Upon receiving data from five of the State's largest payers, including Medicare and Medicaid, Mercer collected comparison data from public documentation, including KFF.org and statutory filings in the National Association of Insurance Commissioners format. Data was weighted for both enrollment and payment information by payers to combine the data and protect the privacy of commercial respondents.

TABLE 1: PERCENTAGE OF BENEFICIARIES PER CATEGORY FOR CY 2015, CY 2016 AND CY 2017

	MEDICAID			COMMERCIAL & MEDICARE ADV.			MEDICARE			TOTAL		
CALENDAR YEAR	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
Category 1: FFS without quality	100%	13%	13%	21%	22%	23%	8%	7%	6%	42%	15%	15%
Category 2: FFS with quality and value	0%	87%	87%	73%	71%	59%	72%	75%	78%	51%	77%	73%
Category 3: Methodologies built on FFS architecture	0%	0%	0%	4%	4%	13%	20%	18%	16%	6%	8%	11%
Category 4: Population-based payment	0%	0%	0%	2%	2%	4%	0%	0%	0%	1%	1%	2%

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TABLE 2: PERCENTAGE OF PAYMENTS (PAID OR ACCRUED) PER CATEGORY FOR CY 2015, CY 2016 AND CY 2017

	MEDICAID			COMMERCIAL & MEDICARE ADV.			MEDICARE			TOTAL		
CALENDAR YEAR	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
Category 1: FFS without quality	100%	99%	99%	71%	67%	61%	43%	45%	45%	76%	75%	71%
Category 2: FFS with quality and value	0%	1%	1%	19%	20%	18%	37%	37%	39%	16%	16%	17%
Category 3: Methodologies built on FFS architecture.	0%	0%	0%	7%	9%	12%	20%	18%	16%	7%	8%	8%
Category 4: Population-based payment.	0%	0%	0%	3%	4%	9%	0%	0%	0%	2%	2%	4%

Analysis

In CY 2017, all payer types remained consistent in their assignment of beneficiaries to value-based payment arrangements with incentives for providers based on quality and value. Gain-sharing, risk-sharing and population-based payments were completing their second year in the Medicare and commercial settings and additional assignments were relatively consistent for new membership. While membership attribution remains strong, payments were still primarily FFS. However, the CY 2017 data improved slightly with gains in categories 2, 3 and 4 compared to CY 2016 and CY 2015, driven by commercial and Medicare.

Anecdotal evidence suggests that payers and providers are limited in their ability to accept quality-based payments due to system limitation and increased risk due to the lack of beneficiaries assigned to each provider or were waiting to see the outcomes of initial assignments. Some payers required minimum levels of beneficiaries, such as 1,000 beneficiaries, before quality or risk-based payment arrangements replaced FFS.

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Medicaid continued the Health Connections PCMH program in CY 2017, although the design phase of the program was extended. The program includes four tiers with PMPM payments ranging from $2.50 to $10.00. While Medicaid members were attributed to primary care clinics, payments remained primarily FFS in CY 2017. At the request of providers, however, beginning July 1, 2019, Idaho Medicaid will expand Healthy Connections program to include shared savings for primary care practices and ACOs through direct contracts and through participation with regional care organizations. Medicaid is implementing several programs that cover a broad range of healthcare transformation activities and population-based care management initiatives. All Medicaid beneficiaries will be attributed to primary care, either through beneficiary choice or, if no choice is made, prior claims history or proximity to providers. In designing its payment program options, Idaho Medicaid is proposing a financial risk structure consistent with the Advanced APM standard of “more than nominal financial risk”, allowing participating clinicians to pursue the APM with Medicare, as allowed under the Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015. Medicaid expects to make the first shared savings payment in CY 2020.

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Statewide Initiatives to Advance the Use of Data and Evidence: A Working Inventory

Agency/Organization	Category	Initiative Type	Primary Office Location	Initiative Purpose	Location Type	Statewide or Program Area(s)	Start Year	End Year (if applicable)	Link to legislation (if applicable)	Initiative Website
DHW/OHPI/IHC/IMHC	Technical Assistance and Training	PCMH transformation	166 primary care clinics in Idaho	Training and Technical Assistance for PCMH	PCP's	Statewide	2016	2019		http://www.ship.idaho.gov/PCMH/tabid/3068/Default.aspx
DHW/OHPI/IHC	HIT Interoperability	Connections to IHDE	155 primary care clinics in Idaho	EHR integration and interoperability and connection to HIE	PCP's	Statewide	2016	2019		https://www.idahohde.org
DHW/OHPI/IHC/IMHC	Training and Technical Assistance	Peer Mentorship	166 primary care clinics in Idaho	To promote sharing of best practices and lessons learned	Online/Webinars	Statewide	2017	2019		http://www.ship.idaho.gov/PCMH/tabid/3068/Default.aspx
DHW/OHPI + PHDs 1-7	Regional Infrastructure Support	infrastructure development to support PCMH clinics undergoing PCMH transformation	Seven public health districts	Regional collaborative infrastsructure development, PCMH support, development of Hedical Health Neighborhood	Regional	Seven Regions	2015	2019		local public health district websites
DHW/Bureau of Rural Health/ISU	Workforce Development	CHW curriculum and delivery by ISU	Online hybrid model delivery	Develop and deliver Idaho curriculum for CHWS including developing Health Specific Modules in English and Spanish	Online	Statewide	2016	2018		http://www.ship.idaho.gov/WorkGroups/CommunityHealthWorkers/tabid/3054/Default.asp
DHW/Bureau of Rural Health/ISU	Workforce Development	CEMT curriculum development and delivery by ISU	Online hybrid model delivery	Develop and deliver curriculum for community EMTs in Idaho	Online	Statewide	2018	2019		http://www.ship.idaho.gov/WorkGroups/CommunityHealthEMS/tabid/3050/Default.aspx
DHW/Bureau of Rural Health/EMS Bureau	Workforce Development	Develop infrastrucutre supports for CHEMS agencies	9 CHEMS agencies and 4 EMTs agencies	Develop infrastructure capacity for the CHEMS to develop and deliver paramedic programs	EMS agencies	Statewide	2017	2019		various EMS operations statewide and http://www.ship.idaho.gov/WorkGroups/CommunityHealthEMS/tabid/3050/Default.aspx
DHW/Bureau of Rural Health/U of I WWAMI	Workforce Development	Develop online learning hubs using clinic/spoke model	U of I Water Center in Boise	Develop content geared to primary care practices on the topics of Opioid and Susbstance abuse/Behavioral Health Integration and MAT	Live online delivery modules	Statewide	2017	2019		https://www.uidaho.edu/academics/wwami/echo
DHW/Bureau of Rural Health	Telehealth Integration	Issue grants to promote telehealth adoption in Idaho at the PCP level	12 grants were awarded to 8 PCPS and 1 CEHMS agency in Idaho	To develop capacity and capability to integrate telehealth services delivery into the PCP workflow and practice	PCPS and CEHMS agency	Statewide	2017	2018	House Concurrent Resolution 46	http://www.ship.idaho.gov/WorkGroups/TelehealthCouncil/tabid/3059/Default.aspx and https://telehealthcouncil.idaho.gov/default.aspx
DHW/OHPI/DGW	HIT Interoperability	Clinical Quality Measures data aggregation for analytic reporting	Beta testing locations were thru out the state	To develop analytical reporting at the state and regional level for clinical quality measures reporting	Online	Statewide	2017	2019		http://www.ship.idaho.gov/WorkGroups/DataGovernanceWorkgroup/tabid/3906/Default.aspx
DHW/OHPI/IHC/	Payment Reform	Evolve from FFS to VBP arrangements	166 PCPS, 4 commercial payers, Medicaid and Medicare	To work with PCPS and payers to migrate from FFS to VBP arrangements	In person and online	Statewide	2015	2019		http://www.ship.idaho.gov/WorkGroups/MultiPayerWorkgroup/tabid/3046/Default.aspx
DHW/OHPI/IHC/	Sustainability to further Healthcare Transformation	Determine return on investment of the $39.6 m SIM Grant	166 PCPS, 4 commercial payers, Medicaid and Medicare	To demonstrate outcomes and value of the investment of federal dollars in Idaho to achieve outcomes	Calendar Year Financial Analysis Report	Statewide	2016	2019		http://www.ship.idaho.gov/
DHW/DPH/IHC/PHW	Regional Infrastructure Support	Expand population health practices thru out Idaho	Public health districtis, primary care practices, DHW, and community based organizations	Share best practices for population health	In person and on line	Statewide	2016	2019		http://www.ship.idaho.gov/WorkGroups/PopulationHealthWorkgroup/tabid/3049/Default.aspx
DHW/DBH/IHC/BHI	Behavioral Health Integration in Primary Care	Educate and promote integration of behavioral health at the primary care level	PCPS and behavioral health providers throughout Idaho	To educate, share best practices and devleop mechanisms to promote behavioral health integration into the primary care practices	Idaho Integrated Behavioral Health Network (IIBHN) formation	Statewide	2015	2019		http://www.ship.idaho.gov/WorkGroups/BehavioralHealthIntegrationWorkgroup/tabid/3043/Default.aspx
DHW/OHPI/U of I and BSU	Evaluation	Conduct state level evaluation of SIM Grant	Boise	Qualitiative evaluation with rapid cycle improvement components for the Idaho Statewide Healthcare Innovation Plan (SHIP) Initiative	1173 Patient interviews 127 clinic interviews onsite or by phone, interviews of RC members, CHEws, CHEMS, Project ECHO	Statewide	2016	2018		http://www.ship.idaho.gov/Portals/93/Documents/SET/FINAL%20State%20Level%20Evaluation%20Report%20%20for%20Idaho%20SIM%20SHIP%20Grant%2012.26.2018_compressed.pdf?ver=2019-04-02-114619-397
DHW/OHPI/BSU CEH	Sustainability	Learning Resource Site for PCPS	BSU Community and Environmental Health (BSU CEH)	To provide resoureces, artifacts from SHIP and deliver curriculum to healthcare professionals	BSU CEH	Statewide	2018	2019		https://idahohealthconnect.org/about-ihc/

Initiative Prioritization & Scoring Tool

DRAFT - version 3.0

April 17, 2019

	Charge Alignment	Data Driven	Evidence Based	Leveraging Experience	Geographic Equity	Cost Impact	Cost Containment	Implementation Resources	Operational Feasibility	Sustainability
Prompt	Does this improve the health of Idahoans? Is the vision clear? Does the issue or opportunity align with the Council's strategic intent?	Is it measurable? Can baseline data accessed or gathered? Is data be aggregated electronicly?	Does research or data indicate improved outcomes and quality of life? Does research/data incorporate clinical expertise, best available research, and client/patient perspectives?	Does it build off existing efforts? What is the impact on other interventions & initiatives? What is the alignment with other organizational structures?	Does it serve all community types (urban, suburban, rural, frontier)? Is there alignment with community, regional, state priorities? What are the consumer & community perceptions of need?	What is the impact to the overall cost of healthcare for Idahoans? What is the cost to providers? What is the cost to consumers?	Does this bend the cost curve?	What level of resource is needed to implement the initiative? Is expert assistance available? How will this be staffed? Will training or workforce development needed?	Is there alignment with community, regional, state priorities? Does this fit with family and community values, culture and history?	What are the financial supports, technology supports, and administrative supports required to sustain the program or practice with integrity?
Scoring	Does Not Align = 1 Minimally Aligns = 2 Somewhat Aligns = 3 Aligns = 4 Strongly Aligns = 5	No Data Available= 1 Minimal Data Available = 2 Some Data Available = 3 Data Available = 4 Strong Data Available = 5	No Evidence = 1 Minimal Evidence = 2 Some Evidence = 3 Evidence = 4 High Evidence= 5	No Experience = 1 Minimal Experience = 2 Some Experience = 3 Experience = 4 Strong Experience = 5	Does Not Meet Need = 1 Minimally Meets Need = 2 Somewhat Meets Need = 3 Meets Need = 4 Strongly Meets Need = 5	No Impact = 1 Low Impact/ High Cost = 2 High Impact/ High Cost = 3 Low Impact/ Low Cost = 4 High Impact/Low Cost = 5	Unknown = 1 Minimal Reduction = 2 Some Reeduction = 3 Reduction = 4 High Reduction = 5	No Resources Available= 1 Minimal Resources Available = 2 Some Resources Available = 3 Resources Available = 4 Strong Resources Available = 5	Is Not Feasible = 1 Minimally Feasible = 2 Somewhat Feasible = 3 Feasible = 4 Strongly Feasible = 5	Not Sustainable = 1 Minimally Sustainable = 2 Somewhat Sustainable = 3 Sustainable = 4 Strongly Sustainable = 5