



Healthcare Transformation Council of Idaho

Meeting Agenda

Thursday, June 20, 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/475058890>
Dial in: +1 669 900 6833 Meeting ID: 475-058-890
 One tap mobile +16699006833,,475058890#

3:00 p.m.	Welcome and opening remarks; roll call; introductions; agenda review; review of minutes – <i>Dr. Ted Epperly & Dr. David Pate, Co-Chairs</i> - ACTION ITEM
3:10 p.m.	Review of Initiative Discussion from May Meeting – – <i>Dr. Ted Epperly & Dr. David Pate, Co-Chairs</i>
3:30 p.m.	Defining Value Based Payments – <i>Dir. Dave Jeppesen</i>
3:45 p.m.	Payer Presentations on VBP – <i>Various Payers</i>
4:15 p.m.	Workgroup Chartering – <i>Casey Moyer</i> - ACTION ITEM
4:45 p.m.	Medicaid Expansion Update – <i>Matt Wimmer & Lisa Hettinger</i>
5:00 p.m.	Adjourn

HTCI
 HEALTHCARE TRANSFORMATION
 COUNCIL OF IDAHO

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.

HEALTHCARE TRANSFORMATION
COUNCIL OF IDAHO



May 22, 2019 4:00 pm

Location: 450 W. State St., 7th Floor,
Conference Room 7A

Meeting Minutes:

Member Attendees: Dr. Andrew Baron (Phone), Matt Bell, Kathy Brashear (Phone), Cynthia York (proxy for Denise Chuckovich), Dr. Keith Davis (Phone), Dr. Scott Dunn (Phone), Dr. Ted Epperly, Dr. Mike Hajjar, Lisa Hettinger, Drew Hobby, Yvonne Ketchum-Ward, Dr. David Pate, Susie Pouliot, Patt Richesin, Neva Santos, Larry Tisdale, Dr. Karl Watts (Phone), Nikki Zogg.

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

Guests: Linda Rowe, Dr. Rhonda Robinson-Beale, Janet Reis, Roger Plothow, Chris Thomas, Cynthia York, Luke Kilcup, Jennifer Bly, Conner Sheldon

Status: Draft 06/07/2019

Summary of Motions/Decisions:

Motion:	Outcome:
Neva Santos moved to accept the minutes. Matt Bell seconded the Motion.	Passed

Patt Richesin moved to invite Christina Thomas to join the HTCI to fill the position Critical Access Hospital Member Position. Drew Hobby seconded the Motion. Abstention: Larry Tisdale	Passed
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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 “All of us are smarter than any of us.”

Idaho Healthcare Summit Update- *Dr. Ted Epperly*

- ◆ Ted Epperly spoke briefly about the success of the summit and invited Roger Plohow to share his thoughts and reflects on the Healthcare Summit.

CAH Membership Update- *Larry Tisdale*

- ◆ Mr. Tisdale spoke to the qualifications and backgrounds of Christina Thomas and Darin Dransfield.
 - Darin Dransfield has a background in Physical Therapy from North Idaho and has previously worked with Bear Lake. He currently worked as the CEO at the Franklin County Medical Center.
 - Christina Thomas was present at the meeting and spoke on her own behalf. Christina Thomas has a background as a Registered Nurse and Administrator. She has worked in rural communities in Montana and Wyoming. Currently she worked as the CEO at Caribou Memorial Hospital.
- ◆ The members had a brief conversation about the candidates and in the end voted and accepted Christina Thomas to be the new representative of Critical Access Hospitals as a member of the HTCI.

HTCI Report to the Legislature- *Casey Moyer*

- ◆ On May 8, 2019 OHPI with support from the HTCI co-chairs, submitted a one-page report to Legislature.
- ◆ The report to JFAC members sought to communicate the progress HTCI is making on establishing its goals and workplan. There is a full report due in October (intent language) which will require more detail.

Blue Cross Foundation Initiative Update- *Dr. Rhonda Robinson-Beale*

- ◆ Dr. Robinson Beale provided information to members on the initiatives and work the Foundation has or is working on to see where they may be able to align.
- ◆ The foundation is growing capacity in the following areas:
 - Engagement – research and convening
 - Partnership – Technical assistance and capacity building
 - Transformation Solutions – think tanks & facilitation
- ◆ The foundation is currently using these capacities to target rural health addressing the following pillars:
 - Community healthcare
 - Practice/Financial Redesign
 - Access to Quality Care
 - Workforce

Initiative Discussion and Selection- *Dr. Ted Epperly, Dr. David Pate, and Casey Moyer*

- ◆ Dr. Epperly opened this discussion speaking to the need for create realistic and measurable initiatives. He informed the members OHPI is looking for additional funding opportunities to further pursue initiatives.
- ◆ Dr. Epperly then moved into a greater discussion of initiatives and the need to work towards their goal of 50% VBP by 2023. There was an extensive discussion with a list of items the members need to come together on. They all agreed the following areas for future discussion:

- Definition of Value Based Payments. This must be realistic and be measurable.
 - How do we measure provider claims?
 - How to we make it so rural clinics can participate?
 - New claims data on self-funded payors.
 - The need for a payor provider workgroup.
 - Obtaining information from payors on what has been successful for VBP.
- ◆ They ended this discussion with agreeing to reach out to Kelly McGrath and Norm Varin to see if they would be interested in restarting a Multi-Payor Workgroup.

Meeting Adjourned: 6:06 pm

DRAFT



Healthcare Transformation Council of Idaho

Action Items

June 20, 2019 3:00PM

■ Action Item 1 – May HTCI Meeting Minutes

HTCI members will be asked to adopt the minutes from the May 22, 2019, HTCI meeting:

Motion: I, _____ move to accept the minutes of the May 22, 2019, meeting of the Healthcare Transformation Council of Idaho as presented.

Second: _____

■ Action Item 2 –HTCI Membership

HTCI members will be asked to formally support the chartering of a payer/provider workgroup to address the discussed initiative scope:

Motion: I, _____ move to create a payer/provider workgroup which shall follow the charge and outcomes agreed upon by HTCI.

Second: _____

HTCI
HEALTHCARE TRANSFORMATION
COUNCIL OF IDAHO

Idaho

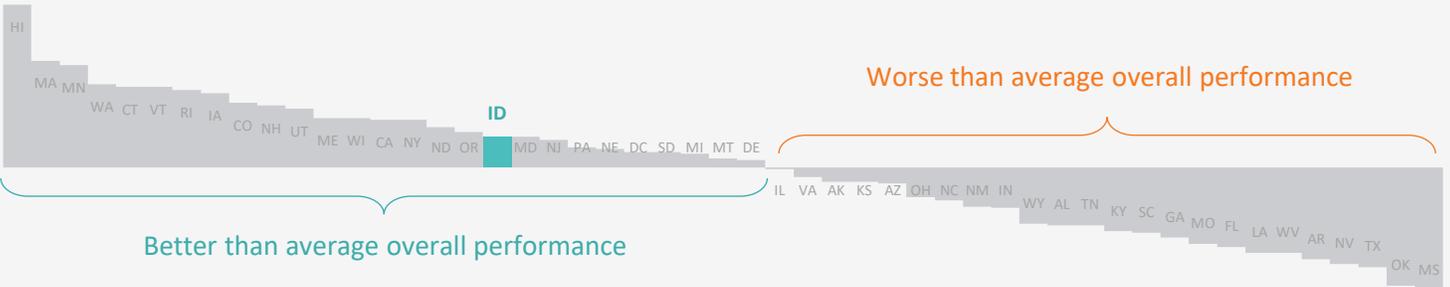
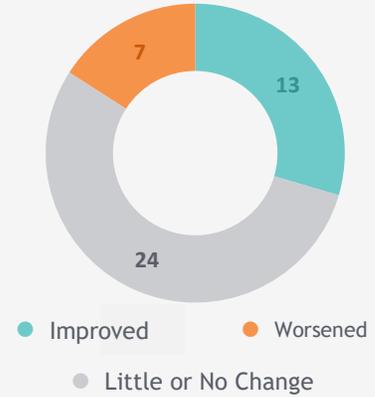


The Commonwealth Fund

Ranking Highlights^a

	National Rank		Rank Among Rocky Mountain States	
	2019	Change from baseline	2019	Change from baseline
Overall	18 of 51	+2	3 of 5	0
Access & Affordability	35	+1	4	0
Prevention & Treatment	33	+1	4	+1
Avoidable Use & Cost	3	+1	2	0
Healthy Lives	17	+1	3	0
Health Care Disparities	8	+6	1	+3

How Health Care in Idaho Has Changed^b



Top-Ranked Indicators

- Home health patients with a hospital admission
- Hospitals with lower-than-average patient experience ratings
- Central line-associated blood stream infection (CLABSI)

Bottom-Ranked Indicators

- Adults without all recommended vaccines
- Suicide deaths
- Adults without all recommended cancer screenings

Most Improved Indicators

- Children without all recommended vaccines
- High out-of-pocket medical spending
- Home health patients without improved mobility

Indicators That Worsened the Most

- Adults without a dental visit
- Hospital 30-day mortality
- Preventable hospitalizations ages 18–64

Estimated Impact of State Improvement^c

Top state in the U.S.	Top state in the Rocky Mountain region	Idaho could expect the following gains if performance in the state improved to the top level at these national and regional benchmarks:
138,952	64,841	more adults and children, beyond those who already gained coverage through the ACA, would be insured
77,315	38,657	fewer adults would skip needed care because of its cost
123,225	61,612	more adults would receive age- and gender-appropriate cancer screenings
3,599	654	more children (ages 19–35 months) would receive all recommended vaccines
168	69	fewer premature deaths (before age 75) would occur from causes that are potentially treatable or preventable with timely and appropriate care
27,381	25,530	fewer employer-insured adults and elderly Medicare beneficiaries would seek care in emergency departments for nonemergent or primary-care-treatable conditions

Table 1. State Health System Performance Indicator Data by Dimension

Dimension and indicator	Data year	State rate	U.S. average	Best state rate	State ranking	Data year	State rate	U.S. average	Change over time ^b
Access & Affordability	2019 Scorecard					Baseline			
Adults ages 19–64 uninsured	2017	16	12	4	42	2013	23	20	Improved
Children ages 0–18 uninsured	2017	5	5	1	26	2013	9	8	Improved
Adults age 18 and older without a usual source of care	2017	25	23	12	36	2013	28	24	Improved
Adults age 18 and older who went without care because of cost in past year	2017	14	14	8	31	2013	16	16	Improved
Individuals under age 65 with high out-of-pocket medical costs relative to their annual household income	2016-17	12	10	5	40	2013-14	17	11	Improved
Employee insurance costs as a share of median income	2017	5.9	6.9	4.8	14	2013	5.7	6.5	No Change
Adults age 18 and older without a dental visit in past year	2016	16	16	10	31	2012	13	15	Worsened
Prevention & Treatment	2019 Scorecard					Baseline			
Adults without all age- and gender-appropriate cancer screenings	2016	40	32	24	48	2012	39	31	No Change
Adults without age-appropriate flu and pneumonia vaccines	2017	66	62	54	47	2013	68	64	No Change
Diabetic adults without an annual hemoglobin A1c test	2016	12.8	12	5.6	32	2015	16.4	16.9	Improved
Elderly patients who received a high-risk prescription drug	2015	11	11	5	27	--	--	--	--
Children without a medical home	2017	55	51	39	42	2016	50	51	Worsened
Children without age-appropriate medical and dental preventive care visits in the past year	2017	32	32	18	27	2016	33	32	No Change
Children who did not receive needed mental health care	2017	13	22	4	22	2016	13	18	No Change
Children ages 19–35 months who did not receive all recommended vaccines	2016	26	29	15	17	2012	37	32	Improved
Hospital 30-day mortality	2014-17	14.5	13.9	12.8	42	2010-13	13.6	13.2	Worsened
Central line-associated bloodstream infections (CLABSI), Standardized Infection Ratio	2016	0.39	0.89	0.36	2	2015	0.64	0.99	Improved
Hospitals with lower-than-average patient experience ratings	2017	9	45	9	1	--	--	--	--
Home health patients without improved mobility	2017	23	25	20	10	2013	37	39	Improved
Nursing home residents with an antipsychotic medication	2017	18	15	7	40	2013	20	21	Improved
Adults with any mental illness reporting unmet need	2014-16	25	21	16	46	2009-11	23	21	Worsened
Adults with any mental illness who did not receive treatment	2014-16	56	56	42	27	2009-11	54	59	No Change

Table 1. State Health System Performance Indicator Data by Dimension (continued)

Dimension and indicator	Data year	State rate	U.S. average	Best state rate	State ranking	Data year	State rate	U.S. average	Change over time ^b
Avoidable Hospital Use & Cost						2019 Scorecard		Baseline	
Hospital admissions for pediatric asthma, per 100,000 children ages 2–17	2015	--	87.2	21.7	--	2012	--	142.9	--
Potentially avoidable emergency department visits									
Ages 18–64, per 1,000 employer-insured enrollees	2016	137.9	142.2	115.9	21	2015	133.5	159.0	No Change
Age 65 and older, per 1,000 Medicare beneficiaries	2015	172.9	196.9	138.3	9	2012	162.1	187.8	No Change
Admissions for ambulatory care–sensitive conditions									
Ages 18–64, per 1,000 employer-insured enrollees	2016	6.4	5.3	5.3	14	2015	3.6	4.6	Worsened
Ages 65–74, per 1,000 Medicare beneficiaries	2017	25	43.9	21.7	3	2013	27.7	47.7	No Change
30-day hospital readmissions									
Ages 18–64, per 1,000 employer-insured enrollees	2016	3.1	3.1	2.4	17	2015	2.5	2.9	Worsened
Age 65 and older, per 1,000 Medicare beneficiaries	2017	23.2	41	19.7	3	2013	24.8	43.5	No Change
Skilled nursing facility patients with a hospital readmission	2016	13	19	11	2	2012	14	20	No Change
Long-stay nursing home residents hospitalized within a six-month period	2016	11	15	5	8	2012	11	17	No Change
Home health patients also enrolled in Medicare with a hospital admission	2017	14	16	14	1	2013	14	16	No Change
Adults with inappropriate lower back imaging	2016	69.1	68.9	57.7	29	2015	77.6	71.1	Improved
Employer-sponsored insurance spending per enrollee	2016	\$5,282	\$4,882	\$3,255	40	2013	\$4,906	\$4,697	No Change
Medicare spending per beneficiary	2017	\$8,020	\$9,534	\$6,195	9	2013	\$7,526	\$9,081	No Change
Healthy Lives						2019 Scorecard		Baseline	
Mortality amenable to health care, deaths per 100,000 population	2014-15	64.9	84.3	54.7	10	2010-11	65.8	85.3	No Change
Breast cancer deaths per 100,000 female population	2017	21.6	19.9	15.6	41	2013	22.1	20.8	No Change
Colorectal cancer deaths per 100,000 population	2017	12.7	12.9	9.3	23	2013	13.4	14.6	No Change
Suicide deaths per 100,000 population	2017	23.2	14	6.6	47	2013	19.2	12.6	Worsened
Alcohol-related deaths per 100,000 population	2017	11.6	9.6	5.5	35	2013	11.9	8.2	No Change
Drug poisoning deaths per 100,000 population	2017	14.4	21.7	8.1	14	2013	13.4	13.8	No Change
Infant mortality, deaths per 1,000 live births	2016	5.8	5.9	3.5	19	2012	5.4	6	No Change
Adults who report fair or poor health	2017	14	17	9	12	2013	13	16	No Change
Adults who smoke	2017	14	16	9	5	2013	17	18	Improved
Adults who are obese	2017	30	31	23	18	2013	30	29	No Change
Children who are overweight or obese	2017	23	31	21	3	2016	26	31	Improved
Adults who have lost six or more teeth	2016	8	10	6	12	2012	9	10	No Change

Table 2. State Disparity Indicator Data

Dimension and indicator	Data year	2019 Scorecard			State ranking	Baseline			Change over time ^f
		Low-income rate ^d	Disparity ^e			Data year	Low-income rate ^d	Disparity ^e	
Disparity		2019 Scorecard				Baseline			
Adults ages 19–64 uninsured	2017	27	-20	34	2013	37	-30	Improved	
Children ages 0–18 uninsured	2017	4	--	--	2013	9	--	--	
Adults age 18 and older without a usual source of care	2017	34	-13	39	2013	31	-11	Worsened	
Adults age 18 and older who went without care because of cost in past year	2017	24	-17	32	2013	30	-25	Improved	
Individuals under age 65 with high out-of-pocket medical costs relative to their annual household income	2016-17	32	-29	45	2013-14	32	-29	No Change	
Adults age 18 and older without a dental visit in past year	2016	25	-15	39	2012	18	-12	Worsened	
Adults without all age- and gender-appropriate cancer screenings	2016	39	-5	2	2012	48	-18	Improved	
Adults without age-appropriate flu and pneumonia vaccines	2017	67	-2	2	2013	76	-13	Improved	
Children without a medical home	2017	63	-35	49	2016	55	-13	Worsened	
Children without age-appropriate medical and dental preventive care visits in the past year	2017	34	-10	16	2016	36	-3	No Change	
Children ages 19–35 months who did not receive all recommended vaccines	2016	24	-3	7	2012	38	-6	Improved	
Hospital admissions for pediatric asthma, per 100,000 children ages 2–17	2015	--	--	--	2012	--	--	--	
Potentially avoidable emergency department visits, Medicare beneficiaries age 65 and older, per 1,000 beneficiaries	2014	293.7	-134.9	4	2012	298.9	-152.7	Improved	
Hospital admissions for ambulatory care–sensitive conditions, Medicare beneficiaries age 65 and older, per 1,000 beneficiaries	2015	61.2	-36.6	7	2012	65.9	-33	No Change	
30-day hospital readmissions among, Medicare beneficiaries age 65 and older, per 1,000 beneficiaries	2015	27.6	-13.3	3	2012	35.9	-19.9	Improved	
Adults who report fair or poor health	2017	24	-17	4	2013	21	-15	Worsened	
Adults who smoke	2017	22	-12	12	2013	24	-16	Improved	
Adults who are obese	2017	35	-5	2	2013	37	-11	Improved	
Adults who have lost six or more teeth	2016	14	-12	19	2012	13	-9	Worsened	

Notes

(a) The 2019 Scorecard rankings generally reflect 2017 data. The 2019 Scorecard added or revised several performance measures since the May 2018 Scorecard report; rankings are not comparable between reports. Rank change from the baseline period represents states' rank difference from the baseline data year (generally 2012 or 2013). Positive values represent an improvement in rank; negative values are a worsening in rank.

(b) Trend data available for 45 of 47 total Scorecard indicators. Improved/worsened denotes a change of at least one half (0.5) standard deviation larger than the indicator's distribution among all states over the two time points. No change denotes no change in rate or a change of less than one-half standard deviation.

(c) Estimated impact if this state's performance improved to the rate of two benchmark levels — a national benchmark set at the level of the best-performing state and a regional benchmark set at the level of the top-performing state in region (www.bea.gov: Great Lakes, Mid-Atlantic, New England, Plains, Rocky Mountains, Southeast, Southwest, West). Benchmark states have an estimated impact of zero (0). Equivalent estimated impact based on national and regional benchmarks indicate that the best observed rate in the region was equal to the best observed rate nationally.

(d) Rates are for states' low income population, generally those whose household income is under 200% FPL.

(e) Disparity is the difference between the states' low-income and higher-income (400%+ FPL) populations.

(f) Improvement indicates that the low-income rate improved and the disparity between low- and higher-income populations narrowed; worsening indicates the low-income rate worsened and the disparity between low- and higher-income populations widened.



Defining Value Based Payments:

History, Context and Next Steps

Review of SHIP Reporting



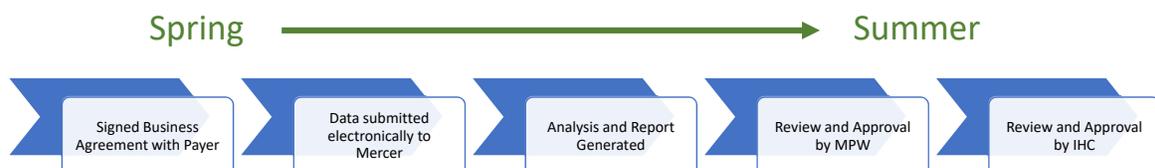
- The Statewide Healthcare Innovation Plan (SHIP) promoted the transformation of healthcare payments from volume based to payments focused on outcomes coinciding with the implementation of the Patient Centered Medical Home (PCMH)
- HCP-LAN Framework was adopted and used as the spectrum of payment reporting used for the SHIP
- Financial Analysis (payer supplied data) was completed in for calendar years 2015-2017 in alignment with the grant reporting guidelines
- Gaps in data were (self-funded, non-reporting payers) filled using models based on KFF.org, NAIC, and proprietary Mercer models.

 CATEGORY 1 FEE FOR SERVICE - NO LINK TO QUALITY & VALUE	 CATEGORY 2 FEE FOR SERVICE - LINK TO QUALITY & VALUE	 CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	 CATEGORY 4 POPULATION - BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	A APMs with Shared Savings (e.g., shared savings with upside risk only)	A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		C Integrated Finance & Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

Data Collection and Reporting



- Mercer established Business Agreements with each payer.
- Annual Calendar Year collection templates were distributed to and sent back by each participating payer*
- Analysis was completed by Mercer and draft reports were presented to MPW
 - Limitations, footnotes and discussion caveats included in the reports were reviewed and adjusted
- Report were reviewed and approved by the Idaho Healthcare Coalition at Monthly Meetings
- Submission were sent to CMMI



* Self Funded Plans were not included by payers, not all payers participated.

Percentage of Payments Results



CALENDAR YEAR	MEDICAID			COMMERCIAL & MEDICARE ADV.			MEDICARE			TOTAL			NET State Change
	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%	← Decreased 5%
Category 2: FFS with quality and value	0%	1%	1%	19%	20%	18%	37%	37%	39%	16%	16%	17%	← Increased 1%
Category 3: Methodologies built on FFS architecture.	0%	0%	0%	7%	9%	12%	20%	18%	16%	7%	8%	8%	→ Current 29% Increased 1%
Category 4: Population-based payment.	0%	0%	0%	3%	4%	9%	0%	0%	0%	2%	2%	4%	← Increased 2%

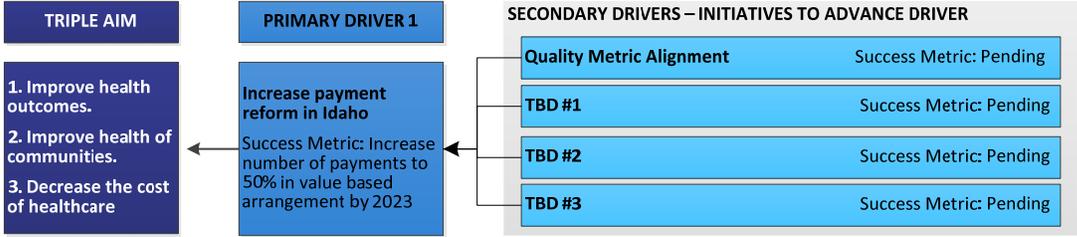
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Established a Target



Primary driver established at April HTCI Meeting:

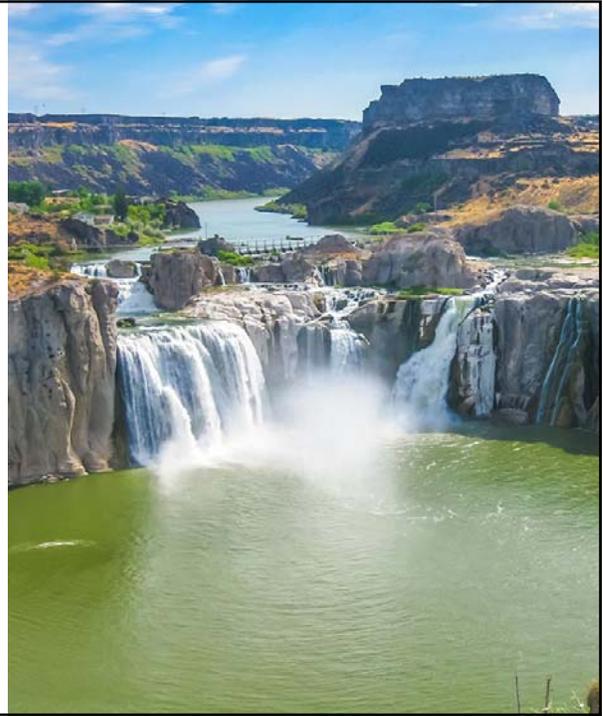
- Increasing payment reform in Idaho by increasing the number of VBP from 29% (baseline 2018) to 50% by 2023.



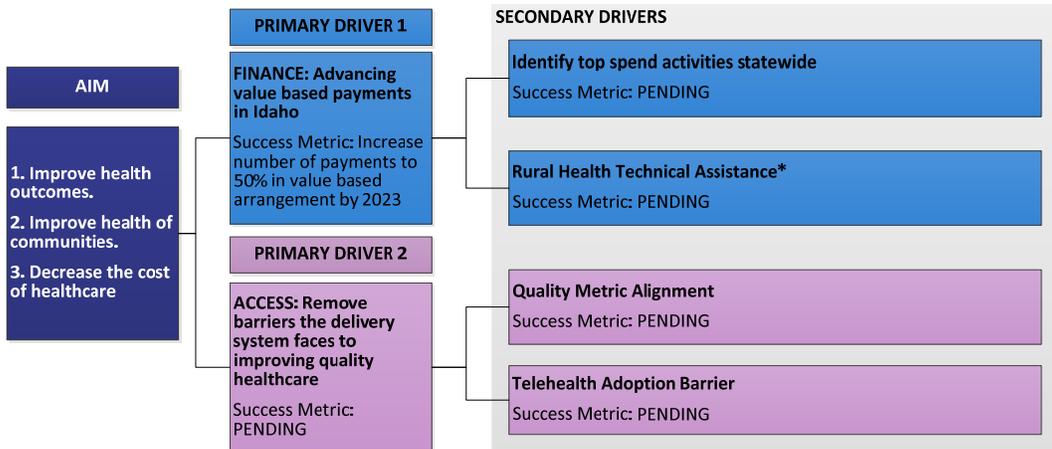
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Drivers and Initiatives:

Realistic, measurable and aspirational



Updated Driver Discussion



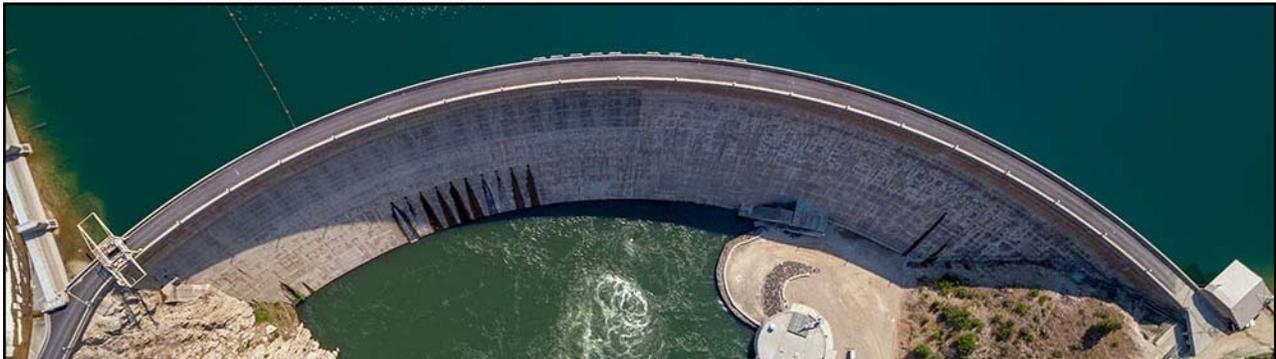
Initiatives



1. **Top 10 Spends Statewide**
 1. Identification of the top cost procedures each payer currently faces
 2. Conduct alignment analysis and determine how coordination could effectuate improvement
2. **Rural Health Technical Assistance***
 1. Workgroup to align with existing efforts
3. **Evaluate Telehealth Adoption and Use Barriers (in coordination with HQPC)**
 1. Subcommittee or Workgroup format, leverage former telehealth council members
 2. Baseline Data: SHIP Telehealth grantees & SHIP clinics
 3. Potential Deliverable: Updated Payment Matrix
4. **Quality Metrics Alignment**
 1. Multi-payer Workgroup
 2. Potential Deliverable: Single Core Metrics Set

* OHPI has identified a potential funding source and submitted a grant application

9



Chartering:

Establishing a Workgroup, Charge and Membership

Workgroup Charter



1. Charge:
 1. What is the purpose of the groups existence? ←
2. Functions:
 1. What is the role they provide to support HTCI? ←
3. Outcomes:
 1. What are the milestones expected from the Workgroup (short and long term)
4. Membership:
 1. Methodology, composition and recruitment mechanism
 2. Participation expectations



Next Steps:

MOTION TO CHARTER PAYER PROVIDER PATIENT WORKGROUP

- Charge
- Outcomes

