



# Idaho Healthcare Coalition

## Meeting Agenda

Wednesday, August 10, 2016, 1:30PM – 4:30PM

JRW Building (Hall of Mirrors)  
1<sup>st</sup> Floor East Conference Room  
700 W State Street, Boise, Idaho

Call-In Number: 1-877-820-7831; Participation Code: 302163

Attendee URL: <https://rap.dhw.idaho.gov/meeting/61598423/827ccb0eea8a706c4c34a16891f84e7b>

Attendee Smartphone

URL: [pulsesecure://?method=meeting&action=join&host=rap.dhw.idaho.gov&meetingid=61598423&signin=rap.dhw.idaho.gov%2Fmeeting%2F&stoken=827ccb0eea8a706c4c34a16891f84e7b](https://pulsesecure://?method=meeting&action=join&host=rap.dhw.idaho.gov&meetingid=61598423&signin=rap.dhw.idaho.gov%2Fmeeting%2F&stoken=827ccb0eea8a706c4c34a16891f84e7b)

Password: 12345

1:30 p.m.	Opening remarks, roll call, introduce any new members, guests, any new DHW staff, agenda review, and approval of 07/13/2016 meeting notes – <i>Dr. Ted Epperly, Chair</i>
1:40 p.m.	IHDE/HIT update - <i>Burke Jensen, IDHW and Scott Carrell, IHDE</i>
2:00 p.m.	RC discussion— putting first things first – main goal PCMH with a bidirectional connection to the MHN – <i>Dr. Epperly, Chair and Elke Shaw-Tulloch, IDHW Division of Public Health</i>
2:30 p.m.	Mercer update – <i>Katie Falls, Mercer</i>
2:45 p.m.	Communications discussion and update – <i>Katie Falls, Mercer and Elke Shaw-Tulloch, IDHW Division of Public Health</i>
3:00 p.m.	Break
3:15 p.m.	MACRA presentation – <i>JP Sharp, JD, MPH, Medicare Access and CHIP Reauthorization Act Lead, Center for Medicare &amp; Medicaid Innovation</i>
3:45 p.m.	SHIP Operations and Advisory Group Reports/ Updates – Please see written report (SHIP Operations and IHC Workgroup Reports – July 2016): <ul style="list-style-type: none"> <li>• Presentations, Staffing, Contracts, and RFPs status – <i>Cynthia York, DHW</i></li> <li>• Regional Collaboratives Update – <i>Miro Barac, DHW</i></li> <li>• Telehealth, Community EMS, Community Health Workers – <i>Miro Barac, DHW</i></li> <li>• HIT Workgroup – <i>Burke Jensen, DHW</i></li> <li>• Multi-Payer Workgroup – <i>Dr. David Peterman, Primary Health and Josh Bishop, PacificSource, Workgroup Chairs</i></li> <li>• Quality Measures Workgroup – <i>Dr. Andrew Baron, Terry Reilly Clinics, Workgroup Chair</i></li> <li>• Behavioral Health/Primary Care Integration Workgroup – <i>Ross Edmunds, Behavioral Health Division, Workgroup Co-Chair</i></li> <li>• Population Health Workgroup – <i>Elke Shaw-Tulloch, Health Division, Workgroup Chair</i></li> <li>• IMHC Workgroup – <i>Dr. Scott Dunn, IMHC Workgroup Chair</i></li> </ul>
4:00 p.m.	Additional business & next steps – <i>Dr. Ted Epperly, Chair</i>
4:30 p.m.	<b>Adjourn</b>



# Idaho Healthcare Coalition

## Action Items August 10, 2016

- Action Item 1 – Minutes

IHC members will be asked to adopt the minutes from the last IHC meeting:

Motion: I, \_\_\_\_\_ move to accept the minutes of the July 13 2016, Idaho Healthcare Coalition (IHC) meeting as prepared.

Second: \_\_\_\_\_

Motion Carried.

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- Action Item 2 – Recommendation for Appointment to IHC

IHC members will be asked to provide a recommendation to the Governor for appointment to the IHC.

Motion: I, \_\_\_\_\_ move that the Idaho Healthcare Coalition recommend the governor appoint Dr. James Lederer to the IHC.

Second: \_\_\_\_\_

Motion Carried.

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# Idaho Healthcare Coalition

## Meeting Minutes:

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**SUBJECT:** IHC July Minutes

**DATE:** July 13, 2016

**ATTENDEES:** Josh Bishop, Dr. Andrew Baron, Pam Catt-Oliason, Russell Duke, Dr. Ted Epperly, Lisa Hettinger, Deena LaJoie, Dr. David Pate, Susie Pouliot, Neva Santos, Dr. Kevin Rich, Neva Santos, Elke Shaw-Tulloch, Mary Sheridan, Jennifer Wheeler, Matt Wimmer, Cynthia York, Nikole Zogg

**Teleconference:** Scott Carrell, Dr. Mike Dixon, Dr. Scott Dunn, Katherine Hansen, Janica Hardin, Carol Moehrle, Daniel Ordyna, Geri Rackow, Dr. Boyd Southwick, Dr. Bill Woodhouse

**Members Absent:** Director Richard Armstrong, Melissa Christian, Jeff Crouch, Ross Edmunds, Lee Heider, Dr. Glenn Jefferson, Yvonne Ketchum, Rene LeBlanc, Maggie Mann, Nicole McKay, Casey Meza, Tammy Perkins, Dr. David Peterman, Dr. Robert Polk, Dr. David Schmitz, Larry Tisdale, Karen Vauk, Lora Whalen, Janet Willis, Dr. Fred Wood

**Guests:** Jesse Arnoldson, Rachel Blanton, Wayne Denny, Gina Pannell, Janet Reis, SeAnne Saffii-Waite, Stewart Wilder, Dr. Tom Young, and Shenghan Xu

**IDHW Staff:** Burke Jensen, Taylor Kaserman, Casey Moyer, Kym Schreiber, Ann Watkins,

**Mercer:** Katie Falls

**STATUS:** Draft (07/14/2016)

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# Summary of Motions/Decisions:

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**Motion:**

Neva Santos moved to accept the minutes of the May 18, 2016 and June 8 2016 Idaho Healthcare Coalition (IHC) meeting as prepared.

Dr. Andrew Baron seconded the motion.

Dr. David Pate moved that the Idaho Healthcare Coalition recommend the Governor appoint Kathy Brashear to the IHC.

Neva Santos seconded the motion.

Dr. Kevin Rich moved that the Idaho Healthcare Coalition recommend the Governor appoint Pam Catt-Oliason to the IHC.

Josh Bishop seconded the motion.

Dr. Scott Dunn moved that the Idaho Healthcare Coalition accept Matt Wimmer as co-chair to the Idaho Medical Home Collaborative Workgroup and recommend the Governor appoint him to the IHC.

Dr. Kevin Rich seconded the motion.

Dr. David Pate moved that the Idaho Healthcare Coalition adopt the SHIP cohort two recruitment plan and interest survey as presented by Dr. Scott Dunn and Kym Schreiber to the IHC.

Russell Duke seconded the motion.

**Outcome:**

Motion carried

Motion carried.

Motion carried.

Motion carried.

Motion carried.

# Agenda Topics:

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**Opening remarks, Introductions, Agenda review, Approve minutes –**

- ◆ Dr. Epperly presented a recent article published in the Idaho Statesman entitled *8 myths about covering the uninsured in Idaho* published in the Idaho Statesman. IHC members Dr. Baron and Yvonne Ketchum are quoted in this article and there will be a follow up article by the Idaho Statesman.
- ◆ Dr. Epperly provided a quote for the meeting “If you don’t try to create the future you want, you must endure the future you get.” by John C. Maxwell.
- ◆ Dr. Epperly called roll. At the time of roll call there was not a quorum present. The approval of motions was deferred until a quorum was established mid-way through the meeting.

**Mental Health Diagnosis and Suicide Prevention Screening – Stewart Wilder, Dr. Tom Young**

- ◆ Dr. Epperly discussed the present and immediate need for better mental health care in Idaho in helping eliminate the number of Idahoans committing suicide. He introduced presenters Dr. Tom Young a board certified physician who has worked in many areas of the medical field throughout his career, he is the President and Co-founder of nView Health, an organization dedicated to improving the diagnoses of mental illness by primary care doctors. Stewart Wilder is an owner of the Interim HealthCare franchise and President of the Live Wilder foundation which is dedicated to achieve zero suicide in youth. Both Dr. Young and Mr. Wilder have been impacted by suicide.
- ◆ Dr. Young presented on nView Health, a new company that provides clients with a new way of diagnosing mental

illness. Right now the first step in addressing mental illness which is diagnosis is not being handled properly. Currently 1 in 5 people will experience a diagnosable mental illness this year. When untreated can lead to severe impacts on patients, families, health systems, payers, employers and the community.

- ◆ The estimated economic impact of these untreated mental diagnoses is 465 billion dollars annually. Most chronic illnesses become twice as expensive to treat with missed, under-diagnosed or untreated mental health comorbidity. Treating patients with 360° care costs less than when patients end up in the hospital with these illnesses.
- ◆ Patient Centered Medical Homes (as a response to these problems) need a standard depression screening method. Current statistics show that 45% of people who commit suicide visited their primary care doctor within a month of their death. After attempting suicide 67% of people seek medical attention which leads to higher medical costs.
- ◆ Primary care doctors have the potential to help prevent suicides and help connect patients to the mental health care they need. Studies show that two thirds of mental health diagnoses come from primary care doctors; however there is a high misdiagnosis rate among these patients. The Mini-International Neuropsychiatric Interview (M.I.N.I.) is the most widely used neuropsychiatric diagnostic assessment tool in the world according to the World Health Organization, with a diagnosis rate of 89% from the National Institute of Health. Consistency in diagnosing mental illness is an important step in addressing the issues with mental health in the country and within Idaho.
- ◆ Stewart Wilder presented the Live Wilder foundation he started that is focused on ending youth suicide. Their goal is to advance to zero suicide deaths in youth through education and treatment. Mr. Wilder has helped to establish the Idaho Suicide Prevention Coalition which is a government funded program for suicide prevention.
- ◆ Dr. Tom Young took questions on their presentation. Dr. Pate inquired what percent of Idaho's medical homes have a mental health doctor imbedded in the medical neighborhood; only 5 to 10% of the medical homes have this service.
- ◆ Dr. Epperly helped conclude the presentation by thanking both Dr. Young and Mr. Wilder for their presentations and the work they have done towards ending suicide deaths.

#### **Mercer Project Management Update and Communications Materials – *Katie Falls, Mercer:***

- ◆ Katie Falls presented on the communications toolkit summary for the IHC. The toolkit was developed to help IHC market the PCMH model to other providers, patients, and various people in the healthcare community. The summary provided to the audience shows what materials have been created, their purpose and their intended target audience.
- ◆ Ms. Falls reviewed the three new communication materials created by the Mercer team. The first is the PCMH window sticker PCMH practices could display as a visual to show patients who participate in the Medical-Health Neighborhood and is available to help with various needs of the patient. IHC members had several suggestions on how to improve the stickers' graphic. Suggestions made were to make the PCMH icon bigger, remove or change the type of car displayed as transportation, to change exercise to physical activity and add it into one icon for public health, and to simplify the graphic. Ms. Falls and the SHIP team will take these suggestions and work on redesigning the graphic presenting several options at the next IHC meeting.
- ◆ As a companion piece to the Medical Health Neighborhood sticker, Ms. Falls presented the PCMH/Medical-Health Neighborhood mini poster that is meant to complement the window sticker for use by SHIP primary care clinics.
- ◆ Ms. Falls also presented on the contents of the provider Medical Health Neighborhood fact sheet. IHC members discussed the fact sheet and discussed the potential need for an MOU to be a part of the medical neighborhood toolkit. This MOU may be developed as a regionally based tool.
- ◆ IHC members also identified a gap in the medical home community fact sheet. The discussion ended with Katie receiving feedback on the content of that fact sheet. A future deliverable e.g. the patient fact sheet will be developed soon for IHC review.
- ◆ Ms. Falls provided a brief update on the Mercer dashboard. The dashboard was supposed to be presented today; however it was delayed because there are goal success measures that are being adjusted. Once these measures have been finalized, they will be incorporated in the dashboard and it will be presented to the IHC. These updates may also trigger revisions to the Workgroup charters.

#### **Regional Collaboratives Update – *Dr. Boyd Southwick, Eastern Idaho Public Health District (Region 7) and Dr. Kevin***

*Rich, Central District Health Department (Region 4):*

- ◆ Dr. Southwick provided a brief presentation on the activities of Region 7 RC. Out of the eight clinics in their region, six are not NCQA recognized. In an effort to remedy this; care coordinator positions have been established. The region is also focusing on identifying diabetes resources as well as utilizing NCQA standards that apply to diabetes.
- ◆ In the near future, Region 7 will be looking at tobacco cessation and how to encourage their clinics to continue quality control monitoring for this activity.
- ◆ Dr. Kevin Rich presented on the Region 4 RC activities. This RC has strong membership participation from all but one of the 15 cohort one clinics. The Regional Collaborative has started work on educating their clinics and other partners about plans for the RC4 medical health neighborhood.
- ◆ With over half of their clinics being NCQA recognized; they have sent out surveys to help identify gaps in areas that may require more focus within their district.

**Cohort 2 Recruitment Proposal – Dr. Scott Dunn, IMHC Chair and Kym Schreiber SHIP Operations**

- ◆ Kym Schreiber discussed the lessons learned from cohort one's application and selection processes. There was only a two week turn around last year for the interest application; for Cohort 2 clinic recruitment, there will be a longer window for completing the interest survey. Also the number of interest survey questions has been shortened and no longer mirrors the questions included in the final application. The title of *interest application* has been changed to *interest survey* to further distinguish between this introductory process and the final application process.
- ◆ Dr. Dunn discussed an expanded recruitment strategy that includes other avenues for clinic outreach. Several organizations within Idaho's healthcare system will be enlisted to encourage primary care clinics to fill out an interest survey. The interest survey along with an introduction letter from Dr. Epperly will be available electronically on the SHIP website and a physical copy will also be sent out to clinics if needed. The interest survey requests that clinics provide key pieces of information to aid in the distribution of the final application.
- ◆ Ms. Schreiber presented the Cohort 2 recruitment timeline and highlighted changes from the prior year. October 28<sup>th</sup>, 2016 will be the deadline for submission of final applications. The IMHC workgroup will meet August 24<sup>th</sup> to discuss the Cohort 2 final application process and identify if any changes are needed.

**SHIP Operations and Advisory Group Reports/Updates – Cynthia York, Administrator, OHPI:**

- ◆ Josh Bishop, Co-Chair of the Multi-Payer Workgroup presented on the financial analysis provided by Mercer and certified by an actuary. This report and analysis is based upon the sets of data provided by all Idaho payers. The analysis includes 2015 findings and conservatively estimates 90 million dollars in savings with conservative interventions.
- ◆ Mary Sheridan provided highlights on ongoing activities with the CHEMS and CHW groups with the start of the first training course for Community Health Workers on August 22, 2016.

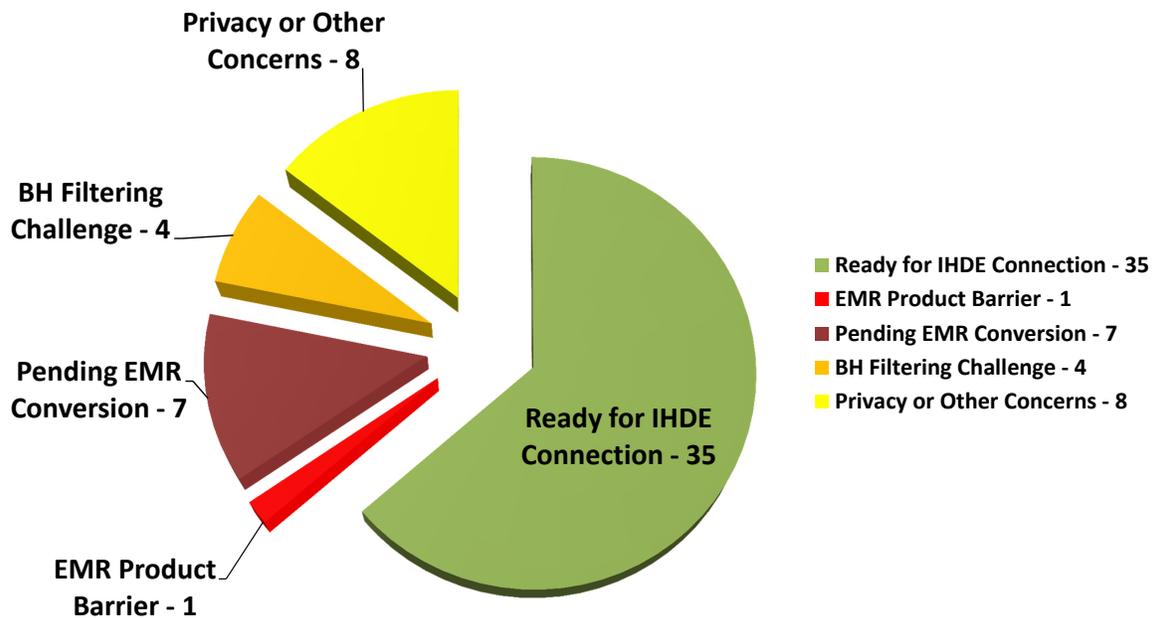
**Closing remarks and Next Steps – Dr. Ted Epperly:**

- ◆ The next IHC meeting is August 10, 2016, and will be located in the JRW Building East side conference room on the first floor.

There being no further business Dr. Epperly adjourned the meeting at **4:22pm**

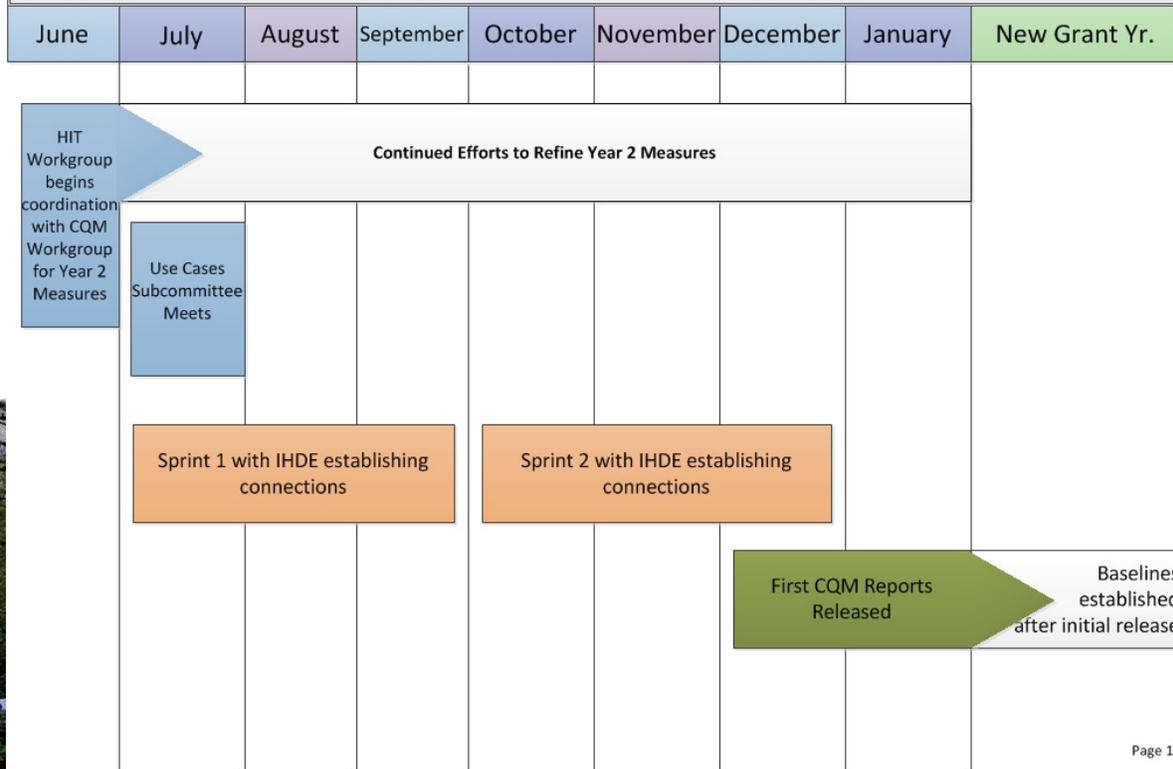


## Clinic IHDE Readiness Assessment Results



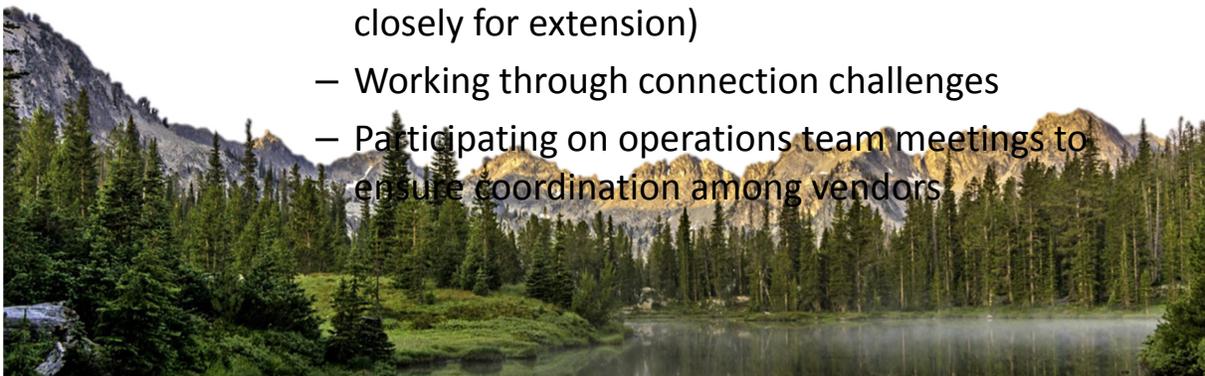
# Anticipated Health IT Timelines

(IHDE Connections and CQM Reporting timelines tied to the end of the grant year – Jan. 31st)



## Idaho Health Data Exchange

- Began / Completed readiness assessment calls for clinic organizations
- Next Steps
  - Building clinic connections for first sprint (July-September original timeframe; monitoring closely for extension)
  - Working through connection challenges
  - Participating on operations team meetings to ensure coordination among vendors





## HIT Workgroup Activities

- HIT Workgroup
  - Recommended lessons learned to be applied to Cohort 2 application process
- Data Element Mapping Subcommittee
  - Provided recommendations to redefine first 4 measures
  - Evaluated Year 2 measures to develop recommendations for CQM Workgroup
  - Refined patient attribution methodology
- Use Cases Subcommittee
  - Defined how specific users will use the data analytics tool from HealthTech



## HealthTech Solutions

- Established hosting services within a dedicated Virtual Private Cloud
- Developed four environments for the analytics system: Production, Training, Development, and Test
- Next Steps
  - Currently developing the measure calculation engine for first 4 measures based on sample patient CCD files and measure spec sheets





Statewide **Healthcare  
Innovation** Plan

# Questions

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# QUALITY PAYMENT PROGRAM



## **KEY TOPICS:**

- 1) The Quality Payment Program**
- 2) The Merit-based Incentive Payment System (MIPS)**
- 3) Incentives for Participation in Advanced Alternative Payment Models (Advanced APMs)**
- 4) What are the next steps?**

# Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**



**The Merit-based  
Incentive  
Payment System  
(MIPS)**

**or**

**Advanced  
Alternative  
Payment Models  
(APMs)**

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

## When and where do I submit comments?

- The proposed rule includes proposed changes not reviewed in this presentation. We will not consider feedback during the call as formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on June 27, 2016. When commenting refer to file code CMS-5517-P.
- Instructions for submitting comments can be found in the proposed rule; FAX transmissions will not be accepted. You must officially submit your comments through one of the following ways:
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier
- For additional information, please go to:  
<http://go.cms.gov/QualityPaymentProgram>

# MIPS: First Step to a Fresh Start

- ✓ **MIPS is a new program**
  - **Streamlines 3 currently independent programs to work as one and to ease clinician burden.**
  - **Adds a fourth component to promote ongoing improvement and innovation to clinical activities.**



**Quality**



**Resource use**



**Clinical practice  
improvement  
activities**



**Advancing care  
information**

- ✓ **MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.**

# Who Will Participate in MIPS?

Affected clinicians are called “**MIPS eligible clinicians**” and will participate in MIPS. The types of **Medicare Part B** eligible clinicians affected by MIPS may expand in future years.

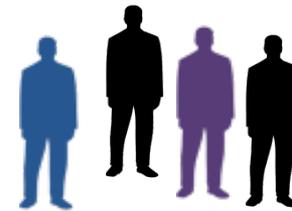
Years 1 and 2



Physicians, PAs, NPs, Clinical nurse specialists, Certified registered nurse anesthetists

Years 3+

Secretary may broaden Eligible Clinicians group to include others such as



Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

**Note: Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery, doctor of dental medicine, doctor of podiatric medicine, or doctor of optometry, and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.**

# Who will NOT Participate in MIPS?

There are 3 groups of clinicians who will NOT be subject to MIPS:



**FIRST** year of Medicare Part B participation



Below **low patient volume** threshold



Certain participants in **ADVANCED** Alternative Payment Models

↓  
Medicare billing charges less than or equal to \$10,000 and provides care for 100 or fewer Medicare patients in one year

Note: MIPS **does not** apply to hospitals or facilities

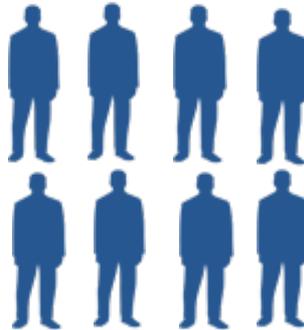
**Note: Most clinicians will be subject to MIPS.**

**Subject to MIPS**

**Not in APM**



**In non-Advanced APM**



**In Advanced APM, but not a QP**



**QP in Advanced APM**



Some people may be in Advanced APMs but not have enough payments or patients through the Advanced APM to be a QP.

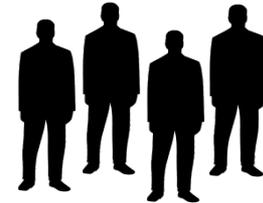
# PROPOSED RULE

## MIPS: Eligible Clinicians

Eligible Clinicians can participate in MIPS as an:



Or



**Individual**

**Group**

A group, as defined by taxpayer identification number (TIN), would be assessed as a group practice across all four MIPS performance categories.

Note: "Virtual groups" will not be implemented in Year 1 of MIPS.

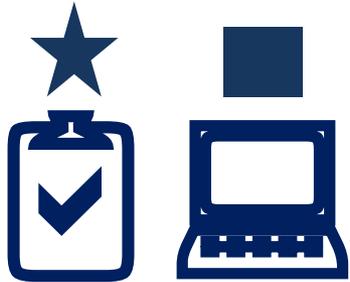
# PROPOSED RULE

## MIPS: Performance Category Scoring

Summary of MIPS Performance Categories		
Performance Category	Maximum Possible Points per Performance Category	Percentage of Overall MIPS Score (Performance Year 1 - 2017)
 <p><b>Quality:</b> Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high-value measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.</p>	80 to 90 points depending on group size	50 percent
 <p><b>Advancing Care Information:</b> Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.</p>	100 points	25 percent
 <p><b>Clinical Practice Improvement Activities:</b> Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn “full credit” in this category, and those participating in Advanced APMs will earn at least half credit.</p>	60 points	15 percent
 <p><b>Cost:</b> CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.</p>	Average score of all cost measures that can be attributed	10 percent

# PROPOSED RULE

## MIPS Performance Period



**MIPS Performance  
Period  
(Begins 2017)**

- ✓ All MIPS performance categories are aligned to a performance period of one full calendar year.
- ✓ Goes into effect in first year  
(2017 performance period, 2019 payment year).

2017	2018	2019	2020	2021	2022	2023	2024	2025
								
<b>Performance Period</b>		<b>Payment Year</b>						

## PROPOSED RULE

# MIPS: Payment Adjustment

- ✓ A MIPS eligible clinician's payment adjustment percentage is based on the relationship between their CPS and the MIPS performance threshold.
- ✓ A CPS below the performance threshold will yield a negative payment adjustment; a CPS above the performance threshold will yield a neutral or positive payment adjustment.
- ✓ A CPS less than or equal to 25% of the threshold will yield the maximum negative adjustment of -4%.



Quality



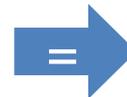
Resource  
use



Clinical  
practice  
improvement  
activities



Advancing  
care  
information



MIPS  
Composite  
Performance  
Score (CPS)



## PROPOSED RULE

# MIPS: Payment Adjustment

- ✓ A CPS that falls at or above the threshold will yield payment adjustment of 0 to +12%, based on the degree to which the CPS exceeds the threshold and the overall CPS distribution.
- ✓ An additional bonus (not to exceed 10%) will be applied to payments to eligible clinicians with exceptional performance where CPS is equal to or greater than an “additional performance threshold,” defined as the 25th quartile of possible values above the CPS performance threshold.



Quality



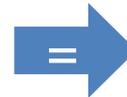
Resource  
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Clinical  
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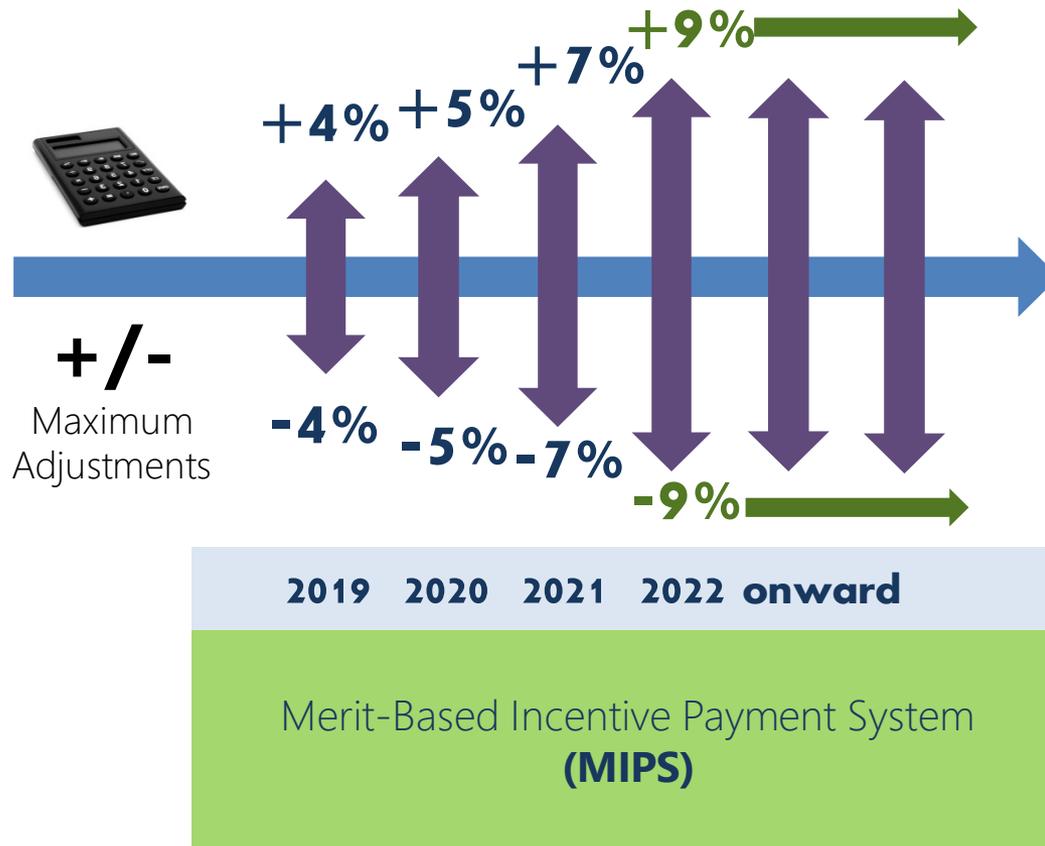
Advancing  
care  
information



MIPS  
Composite  
Performance  
Score (CPS) 

# How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score, clinicians will receive +/- or neutral adjustments up to the percentages below.



The potential maximum adjustment % will increase each year from 2019 to 2022

# **INCENTIVES FOR ADVANCED APM PARTICIPATION**

# What is an Alternative Payment Model (APM)?

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value**.

As defined by  
MACRA,  
**APMs**  
include:

- ✓ **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- ✓ **MSSP** (Medicare Shared Savings Program)
- ✓ **Demonstration** under the Health Care Quality Demonstration Program
- ✓ **Demonstration** required by federal law

## Advanced APMs meet certain criteria.



As defined by MACRA, Advanced APMs **must meet the following criteria:**

- ✓ The APM requires participants to use **certified EHR technology**.
- ✓ The APM **bases payment on quality** measures comparable to those in the MIPS quality performance category.
- ✓ The APM either: **(1)** requires APM Entities to bear more than nominal **financial risk** for monetary losses; **OR (2)** is a **Medical Home Model expanded** under CMMI authority.

# PROPOSED RULE

## Medical Home Models

### Medical Home Models:

- ✓ Have a **unique financial risk criterion** for becoming an Advanced APM.
- ✓ Enable participants (who are not excluded from MIPS) to receive the **maximum score in the MIPS CPIA category.**



A **Medical Home Model** is an **APM** that has the following features:

- ✓ Participants include **primary care practices** or multispecialty practices that include primary care physicians and practitioners and offer primary care services.
- ✓ **Empanelment of each patient** to a primary clinician; and
- ✓ **At least four** of the following:
  - Planned coordination of chronic and preventive care.
  - Patient access and continuity of care.
  - Risk-stratified care management.
  - Coordination of care across the medical neighborhood.
  - Patient and caregiver engagement.
  - Shared decision-making.
  - Payment arrangements in addition to, or substituting for, fee-for-service payments.

# PROPOSED RULE

## Advanced APM Criterion 1:

### Requires use of CEHRT



Certified  
EHR use

**Example:** An Advanced APM has a provision in its participation agreement that at least 50% of an APM Entity's eligible clinicians must use CEHRT.



- ✓ An Advanced APM must **require at least 50% of the eligible clinicians in each APM Entity to use CEHRT** to document and communicate clinical care. The threshold will **increase to 75%** after the first year.
- ✓ For the **Shared Savings Program only**, the APM may apply a **penalty or reward** to APM entities based on the degree of CEHRT use among its eligible clinicians.

## PROPOSED RULE

# Advanced APM Criterion 2: Requires MIPS-Comparable Quality Measures



Quality  
Measures

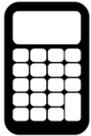
- ✓ An Advanced APM must **base payment on quality measures** comparable to those under the proposed annual list of MIPS quality performance measures;
- ✓ **No minimum** number of measures or domain requirements, **except** that an Advanced APM must have at least one **outcome measure** unless there is not an appropriate outcome measure available under MIPS.

- ✓ **Comparable** means any actual MIPS measures or other measures that are **evidence-based, reliable, and valid**. For example:
  - Quality measures that are endorsed by a consensus-based entity; or
  - Quality measures submitted in response to the MIPS Call for Quality Measures; or
  - **Any other quality measures that CMS determines to have an evidence-based focus to be reliable and valid.**

## PROPOSED RULE

# Advanced APM Criterion 3:

Requires APM Entities to Bear More than Nominal Financial Risk



Financial  
Risk

An Advanced APM must meet **two standards**:

### Financial Risk Standard

APM Entities must  
bear risk for  
monetary losses.

&

### Nominal Amount Standard

The risk APM Entities  
bear must be of a  
certain magnitude.

- ✓ The Advanced APM financial risk criterion is **completely met** if the APM is a **Medical Home Model** that is **expanded under CMS Innovation Center Authority**
- ✓ Medical Home Models that **have not been expanded** will have **different financial risk and nominal amount standards** than those for other APMs.

# Proposed Rule Advanced APMs

**Based on the proposed criteria, which current APMs will be Advanced APMs in 2017?**

- ✓ **Shared Savings Program** (Tracks 2 and 3)
- ✓ **Next Generation ACO Model**
- ✓ **Comprehensive ESRD Care (CEC)** (large dialysis organization arrangement)
- ✓ **Comprehensive Primary Care Plus (CPC+)**
- ✓ **Oncology Care Model (OCM)** (two-sided risk track available in 2018)

# How do I become a **Qualifying APM Participant (QP)**?



You must have a **certain %** of your patients or payments through an **Advanced APM**.

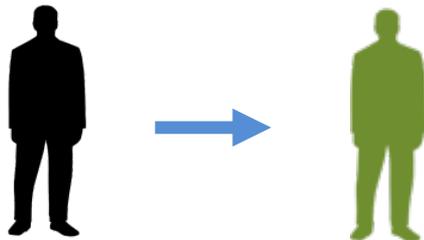


Bonus applies in 2019-2024; then QPs receive higher fee schedule updates starting in 2026

## PROPOSED RULE

# How do Eligible Clinicians become QPs?

### Eligible Clinicians to QP in 4 STEPS



Eligible Clinicians

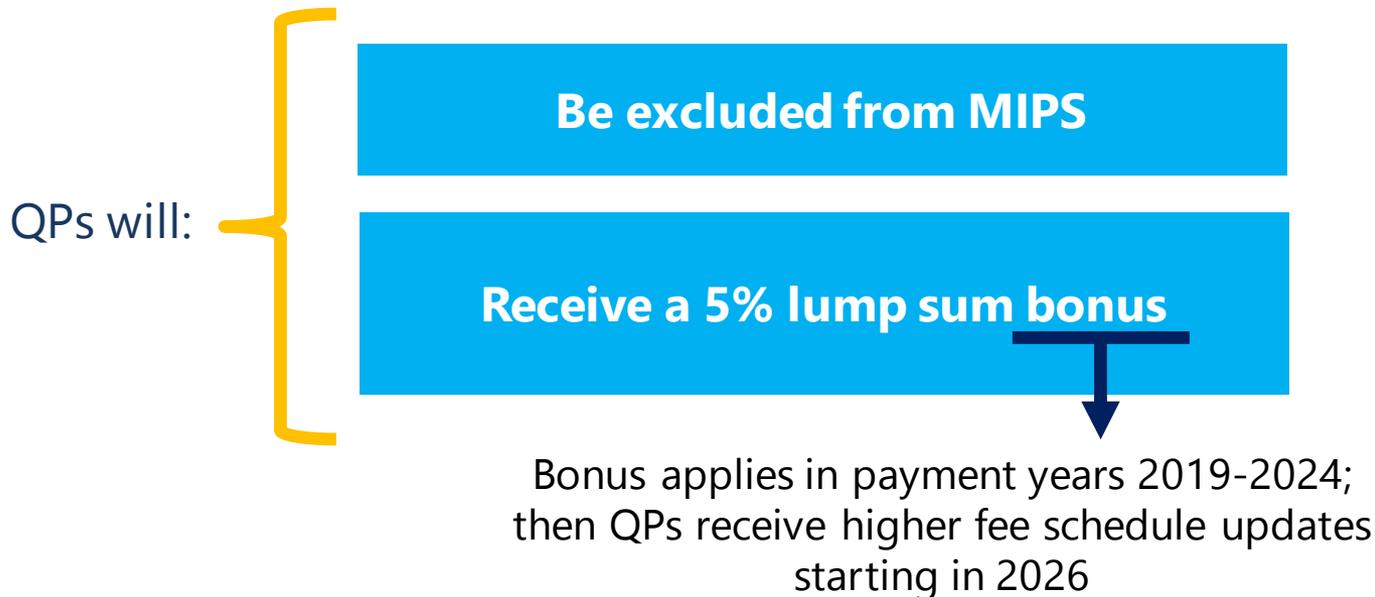
QP

1. QP determinations are made at the **Advanced APM Entity level**.
2. CMS calculates a **“Threshold Score”** for each Advanced APM Entity.
3. The Threshold Score for each method is compared to the corresponding **QP threshold**.
4. All the eligible clinicians in the Advanced APM Entity **become QPs** for the payment year.

- ✓ The period of assessment (QP Performance Period) for each payment year will be **the full calendar year that is two years prior to the payment year** (e.g., 2017 performance for 2019 payment).
- ✓ Aligns with the MIPS performance period.

## PROPOSED RULE

# APM Incentive Payment



- ✓ The “APM Incentive Payment” will be based on the estimated aggregate payments for professional services furnished the year prior to the payment year.
- ✓ E.g., the 2019 APM Incentive Payment will be based on 2018 services.

# PROPOSED RULE

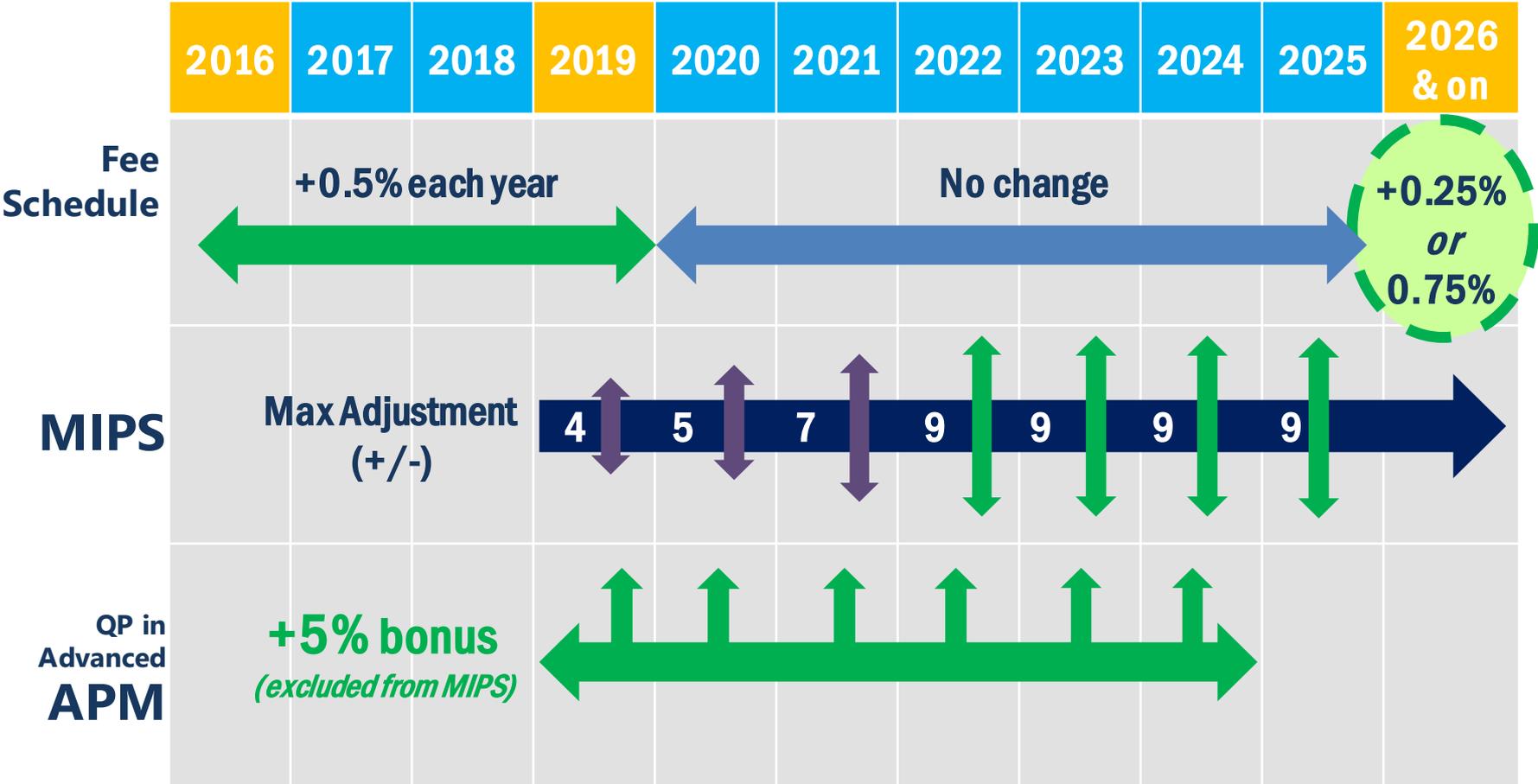
## QP Determination and APM Incentive Payment Timeline

2017	2018	2019
<b>QP Performance Period</b>	<b>Incentive Payment Base Period</b>	<b>Payment Year</b>
QP status based on Advanced APM participation here.	Add up payments for a QP's services here.	+ 5% lump sum payment made here. (and excluded from MIPS adjustments)

2018	2019	2020
<b>QP Performance Period</b>	<b>Incentive Payment Base Period</b>	<b>Payment Year</b>

Repeat the cycle each year...

# Putting it all together:



Find additional information about the Quality Payment Program, including fact sheets, upcoming webinars and more at:

<http://go.cms.gov/QualityPaymentProgram>

## Disclaimer

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# SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition August 10, 2016

## **SHIP OPERATIONS:**

### **SHIP Contracting/Request for Proposal (RFP) Status:**

- **Report Items:**
  - Viann, Electronics LLC was awarded the contract as the population health data vendor.
  - A contract for the Telehealth Training and Technical Assistance contract has been awarded and is awaiting release of funds from CMMI.
  - CMMI approved release of funds for the Contracts for the Public Health Districts 1-7.
  - CHEMS agency contracts are under development.

### **SHIP Administrative Reporting:**

- **Report Items:**
  - Mercer and SHIP project management staff continue to work on refinements to the Master Project Management Plan (MPMP) as well as data collection protocols related to Goals 1 – 6.
  - A State Evaluator Workgroup (SEW) kickoff meeting will be held on Monday, August 15, 2016 from 8:30 a.m. – 10:00 a.m. MST.
  - Multiple requests for release and approval for use of pre-implementation carryover funds were submitted to CMMI.
  - Project Management staff met with CMMI Project Officer to discuss our Risk Log and provided updates all components of SHIP.
  - Office of Healthcare Policy Initiatives submitted a Facts, Trends & Figures Report for SFY2016 and a Performance Measures Report on SHIP milestones.
  - Our CMMI Project Officer confirmed that the Quarterly Progress Report for Q1 Year 2 has been accepted.

### **Regional Collaboratives (RC):**

- **Report Items:**
  - D1: The full membership meeting of the Regional Collaborative was held on July 27, 2016. The agenda included: Regional EMS update & discussion, CHW update & discussion, IHDE regional update & discussion, Clinic progress update, PCMH regional meeting/training review, Medical Health Neighborhood discussion.
  - D2: No Regional Collaborative meeting in July due to vacations.
  - D3: Regional Collaborative met on 8/2. Agenda included review of workgroup activities, presentation from Central Oregon Health Council, discussion on challenges in coordination between R3 & R4, instructions for Regional Health Improvement Plan. Other activities include behavioral health integration meeting on 7/25, PCMH workgroup meeting on 6/10 and senior workgroup meeting on 6/21
  - D4: CHC met on 7/5/16; executive committee meeting took place on 7/27/16. Other activities include: ER to PCP communication, discussion about Medical Health Neighborhood Survey Results for Diabetes, discussion about the need to develop supports available to the cohort as a group of clinics, versus supports for individual clinics. Executive leadership sees value in community care team models, potential focus around clinical-community linkages.

- D5: No meetings in June and July. In July each member was sent an email containing information about the cohort two interest survey to aid in their discussions with interested clinics. District 5 Resource List project, version 1, is scheduled to go live in August. The list will be uploaded to the PHD 5 and SCHC websites, an annual hard copy will be available as well. This list will be reviewed and updated on a regular basis as new resources continue to be identified or if current information changes.
- D6: Meetings: SHC Executive Committee: June 29, 2016; SHC Clinic Committee: May 19, 2016; SHC Medical Health Neighborhood: June 30, 2016. Activities include: Development of the Strategic Plan based on Southeastern Healthcare Collaborative Charter that will be reviewed by Executive Committee for edits and approval, meetings with Pocatello Free Clinic (regional resource guide) and Food Bank (screening and education during mobile food pantry waiting lines); exploring options for referral tracking and management across the Medical Health Neighborhood; SHIP presentation to representatives from eight clinics at Portneuf Quality Alliance meeting on July 25, 2016. Focus was on SHIP introduction, engagement, and cohort 2 clinic selection.
- D7: Eastern Health Collaborative Meet on July 14th, 2016. Topics discussed: tobacco baseline measure and tobacco cessation resources. How does helping to achieve PCMH help with clients and tobacco resources. EHC Executive Committee met on July 6th, 2016 (1st Wednesday of Every Month). Discussion held surrounding regional collaborative baseline data from clinics. Also discussed was IHDE and clinics and potential for further participation in HIE from other health care services. Website tool for medical-health neighborhood facilitation was discussed. Dr. Southwick will present at upcoming IHC Meeting. Success Measure 5: PCMHs that receive community health needs assessment reports – this is a new measure in goal 3.
- Idaho Department of Health and Welfare Division of Public Health is working closely with the Public Health Districts SHIP programs on identifying sources and approaches for community needs assessments that will be provided to RCs and SHIP clinics.
- Public Health District SHIP staff is formulating RC strategic plans, scheduled to be presented to the IHC in October.
- PHD sub grants were approved by CMMI and executed on July 1<sup>st</sup>, 2016.
- **Next Steps:**
  - D1: Regional Collaborative is not meeting in August – next meeting 9/28/16. Survey the clinics to find out which members of the Medical Health Neighborhood they are currently working with and develop a strategy for communication.
  - D2: Next meeting scheduled for August 11th. Topics on agenda include: behavioral health integration, community health worker training, IHDE timelines, next year clinical quality measures and strategic planning.
  - D3: The Southwest Health Collaborative will finalize target areas for the Regional Health Improvement Plan (RHIP). This document is intended to guide the SWHC beyond the SIM funding as a mechanism for convening and aligning work among our partners in the community. As a result, we see this work as supporting sustainability activities and as a tool for supporting collaboration across the MHN. All target areas identified in the RHIP will have a clinical and prevention arm. Current workgroup activities involve leveraging existing resources for PCMH transformation support.
  - D4: Medical-Health Neighborhood meeting scheduled August 4th at Central District Health Department with invites to cohort 1 clinics to learn about local resources for strengthening diabetes care. Request for clinic progress/goals/challenges to be presented in September to CHC by the PHD QI staff. Strategic plan development and review by Executive Committee. Narrowing of efforts; the need for more measurable projects with potential scalability.

- D5: Next RC meeting scheduled for August 19. Topics of discussion will include final approval of the SCHC Charter, a demonstration of the Brilljent portal, review of the Medical Health Neighborhood, Strategic Plan review, an update on clinics' transformation efforts, and any SHIP project updates. The executive committee members will be informed to save the date for October 26 and the tentative executive meeting in Boise with all districts. We are also eager to receive feedback from our members on the functionality of the resource list. The SCHC Strategic Plan will continue to be discussed and reviewed on an ongoing basis as the SHIP project progresses into cohort years two and three. The expansion of the Medical Neighborhood will also be a topic of discussion as more information develops and IHC's vision of these groups is defined.
- D6: Next meetings: SHC Executive Committee: August 31, 2016; SHC Clinic Committee: September 1, 2016; SHC Medical Health Neighborhood: October, TBD. Projected activities include: complete, edit, approve Strategic Plan by 8-31-2016; meeting with Pocatello Free Clinic, Food Bank, and other Medical Health Neighborhood partners; contact primary care clinics for cohort 2 recruitment; set up follow up meetings for CHEMS with Bingham Memorial, Health West.
- D7: Executive team will continue to work on strategic plan. Continue to facilitate communication between healthcare services for possible solutions for referral management and HIE connection. Contact primary care clinics for cohort 2 recruitment. Continue to finalize plan for increased utilization of medical-health neighborhood by PCMH clinics..

## **ADVISORY GROUP REPORTS:**



### **Telehealth SHIP Subcommittee:**

- **Report Items:**
  - The Telehealth request for quotation to provide technical assistance and training services to support program development closed July 21, 2016.
  - IDHW is establishing a contract with the successful vendor and a timeline for service implementation will begin upon contract signature. The Telehealth contactor will provide an educational series of six webinars to support successful Telehealth program development and implementation in the PCMH.
- **Next Steps:**
  - IDHW will establish a contract with the successful Telehealth vendor and schedule a kick-off planning meeting to develop the timeline for project implementation. The timeline will be communicated to IHC, workgroups, and PCMHs to support participation in the learning series.
  - SHIP staff are developing a grant application that will provide an opportunity for SHIP PCMH cohort 1 clinics to apply for funding to develop and implement a Telehealth program. The target release for the grant application is late September 2016.



### **Community Health Workers:**

- **Report Items:**
  - State of Massachusetts CHW program staff will be in Boise to train Idaho CHW program instructors on August 8-10.
  - Currently, six student applications have been received and approved.
  - We receive many questions about reimbursement for CHW services and how PCMHs can support their work.

- The CHW student application is found on the SHIP website:  
<http://ship.idaho.gov/WorkGroups/CommunityHealthWorkers/tabid/3054/Default.aspx>.
- We are seeking IHC support to distribute the training opportunity below to stakeholders:
  - The Idaho Department of Health and Welfare (IDHW), through the Idaho Statewide Healthcare Innovation Plan (SHIP), is implementing a Community Health Worker (CHW) training program in collaboration with Idaho State University. The training is delivered live online Tuesday evenings from 6:30-9:30 PM MST for 16 weeks beginning **August 23**. There is no cost to participate in the training for students accepted into the program.
  - **The application and registration period is open and space is available!**
  - For more information and the course application:
    1. To learn more about CHW training, visit:  
<http://www2.isu.edu/idiem/chw.shtml>
    2. For CHW course information, additional details, and contact information:  
<http://cetrain.isu.edu/enrollment/course/community-health-worker/>
    3. Students must apply and receive a registration code from IDHW to participate in the CHW course at no cost. Please visit the SHIP CHW website for the participation application:  
<http://ship.idaho.gov/WorkGroups/CommunityHealthWorkers/tabid/3054/Default.aspx>. A complete application includes two parts, an application completed by the student and one by the employer or community sponsoring organization.
    4. After receiving email with registration instructions and a registration code from IDHW, register for the course at ISU: <http://cetrain.isu.edu/chw>.
- **Next Steps:**
  - Continue the CHW student recruitment and application review process.
  - Meet with Massachusetts program staff and Idaho CHW course instructors at ISU during the training session.
  - We will appreciate IHC and workgroup feedback about talking points and ideas to address stakeholder questions about how PCMHs can fund and support CHW work.

## **WORKGROUP REPORTS:**



### **Community Health EMS:**

- **Report Items:**
  - The second CHEMS workgroup was held July 27, 2016. Members could participate in person or call in. Agenda items included: recruitment, outreach, mentoring, tiered funding, success measures review and update, BSU project, and BLS/ILS sub workgroup.
  - The meeting included 30 participants with representation from the following: EMS agencies, Community Paramedic programs, Boise State University, Idaho State University, Public Health Districts, Medicaid, Pacific Source, and IDHW.
  - Meeting materials can be found at: <http://ship.idaho.gov/WorkGroups/CommunityHealthEMS/tabid/3050/Default.aspx>
  - Ada County Paramedics gave an outreach presentation to Medicaid Health Connections on July 11, 2016 and can provide administrative and mentoring training for agencies interested in CHEMS.

- Meeting with Meg Hall, Medicaid Healthy Connections, regarding Tier 3 funding/reimbursement on July 25, 2016.
- Currently recruiting students for the second ISU cohort, January 2017. Expressed interest from Boundary Ambulance, Clearwater County Ambulance, Elmore Ambulance Service, Emergency Response Ambulance, Magic Valley Paramedics, Payette County Paramedics, Donnelly Rural Fire Protection, Lewiston Fire Department, and Shoshone County EMS.
- CMMI has approved the SHIP CHEMS tiered concept and cost reimbursement contract which will allow agencies to receive funding upon the completion of certain deliverables.
- Updated Success Measures were reviewed and approved.
- BSU project will drill into the sustainability and value of CHEMS.
- **Next Steps:**
  - Next meeting is scheduled for August 24, 2016.
  - Follow up with agencies/students currently enrolled in the ISU Community Paramedic Certificate program for possible interest/recruitment for 2nd cohort.
  - Medicaid Healthy Connections tiered payment has been instituted to encourage the Patient Centered Medical Home (PCMH) model of care in the State of Idaho. To be considered for a Tier Three Healthy Connections Care Management, a provider must demonstrate enhanced care coordination by integrating CHEMS into their PCMH model.
  - Creation of BLS/ILS sub workgroup.



### **Idaho Medical Home Collaborative:**

- **Report Item:**
  - The group did not meet in July. Next meeting will occur August 24, 2016, to review PCMH selection criteria and the final application for Cohort 2.
- **Next Steps:**
  - The IMHC will meet again August 24<sup>th</sup> 2016 from 12:30pm to 2:30pm MTS via teleconference.



### **Health Information Technology:**

- **Report Item:**
  - The HIT Workgroup met on July 21, 2016.
    - Discussed HIT recommendations for Cohort 2 Application.
    - Discussed the SHIP patient attribution methodology.
    - Discussed updates from Idaho Health Data Exchange (IHDE) and HealthTech Solutions, our analytics partner
    - Discussed process for reviewing and updating the workgroup membership.
  - The Health IT consultants that facilitated the Use Cases Subcommittee meetings on July 11 and 12, 2016 are working to finalize the initial draft of the use case report.
  - The Data Element Mapping Subcommittee met on July 14 and July 28
    - Continued the dialogue surrounding recommendations for Year 2 measures
    - Refined the patient attribution methodology
- **Next Steps:**
  - The next HIT Workgroup meeting is scheduled for August 18, 2016.
  - The Workgroup leadership will conduct the committee membership review.

- The Data Element Mapping Subcommittee is scheduled to meet on August 11, 2016 and will further refine the patient attribution methodology.

## **MPW** Multi-Payer:

- **Report Item:**
  - The SHIP Administrator, IDHW Deputy Director, and IHC Chair met with Pacific Source, Select Health, Blue Cross of Idaho and Regence Blue Shield to discuss a value based payment framework for Idaho to gain clarity into the different payment methodologies and agree on the method for data collection of payer metrics for CMMI requested data.
  - The SHIP Administrator met with the newly appointed Self-funded representative to the Multi-Payer workgroup and provided a SHIP overview.
- **Next Steps:**
  - The SHIP Administrator is working with Mercer to draft a request for payment metrics to send to payers.
  - SHIP Administrator is working with the MPW co-chairs to develop an agenda for the next MPW meeting to potentially be held in September.
  - A MACRA/MIPs presentation will be provided to the IHC at the August 10th meeting.

## **CQM** Clinical/Quality Measures Quality Measures Workgroup:

- **Report Item:**
  - The CQM Workgroup did not meet this past month.
- **Next Steps:**
  - The CQM Workgroup plans to meet again later in August or September once the Data Element Mapping Subcommittee has refined its recommendations.

## **BHI** Behavioral Health:

- **Report Item:**
  - The workgroup met Tuesday August 9<sup>th</sup> 2016. Agenda topics covered at the meeting where:
    - Clinical Quality Measures discussion with SHIP HIT Project Manager Burke Jensen and Operations Manager Casey Moyer.
    - Lessons Learned from the NASHP Training for the Public Health District SHIP Managers and the Regional Collaboratives with Rachel Blanton, Gina Pannell, and other SHIP managers.
    - Idaho Integrated Behavioral Health Network (IIBHN) with Dr. Gerrish, Jennifer Yturiondobeitia, and Gina Westcott.
- **Next Steps:**
  - Next meeting is scheduled for Tuesday, October 4<sup>th</sup>, 2016 9:00am-11:00am at 1720 Westgate Drive, Suite A, Room 131.

## **PHW** Population Health:

- **Report Item:**
  - The PHW met August 3 from 3:00 – 4:30.

- Received an update on a project of a subgroup of the PHW to inventory work being done in healthcare clinics across the state. The work in clinics has a focus on quality improvement initiatives. Programs doing this work with clinics include, at this point, SHIP, public health grants focused on diabetes, heart disease and stroke and colorectal cancer and two initiatives of Qualis focused on Medicaid and heart disease. This inventory and interactive map will be placed on the SHIP website when completed.
- Discussed the availability of immunization data to be used as a clinical/population-based measure for SHIP and the RCs. This data could be used as clinic-specific baseline data and even be used to compare non-SHIP clinics to SHIP clinics and analyzed at the regional level.
- Discussed the update of Get Healthy Idaho: Measuring and Improving Population Health. This document which is the SHIP grant population health improvement plan will be updated and finalized by January 2017. The Division of Public Health is taking the lead and will be seeking input and updating data over the next few months.
- Progress is being made on the development of a website to display population health data.
- **Next Steps:**
  - The next meeting of the PHW is September 7.