



Idaho Healthcare Coalition

Action Items

July 13, 2016

- Action Item 1 – Minutes

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

Motion: I, _____ move to accept the minutes of the May 18, 2016 and June 08 2016, Idaho Healthcare Coalition (IHC) meeting as prepared.

Second: _____

Motion Carried.

- Action Item 2 – Recommendation for Appointment to IHC (**JUNE MEETING**)

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 Kathy Brashear to the IHC.

Second: _____

Motion Carried.

- Action Item 3 – 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 Pam Catt-Oliason to the IHC.

Second: _____

Motion Carried.

■ Action Item 4 – Idaho Medical Home Collaborative Workgroup Chair (**JUNE MEETING**)

IHC members will be asked to accept Matt Wimmer as the new co-chair of the Idaho Medical Home Collaborative Workgroup as presented and provide a recommendation to the governor for appointment to the IHC.

Motion: I, _____ move 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.

Second: _____

Motion Carried.

■ Action Item 5 – Communication Plan Materials

IHC members will be asked to adopt the SHIP Communications Plan materials as presented by Mercer.

Motion: I, _____ move that the Idaho Healthcare Coalition adopt the SHIP Communications Plan materials as presented by Mercer.

Second: _____

Motion Carried.

■ Action Item 6 – Cohort Two Recruitment Plan and Interest Survey

IHC members will be asked to adopt the SHIP cohort two recruitment plan and interest survey as presented by Dr. Scott Dunn and Kym Schreiber to the IHC.

Motion: I, _____ move 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.

Second: _____

Motion Carried.



Idaho Healthcare Coalition

Meeting Minutes:

SUBJECT:	IHC June Minutes	DATE:	June 8 th , 2016
ATTENDEES:	Director Richard Armstrong, Katherine Hansen, Janica Hardin, Lisa Hettinger, Deena LaJoie, Dr. Robert Polk, Susie Pouliot, Neva Santos, Elke Shaw-Tulloch, Mary Sheridan, Larry Tisdale, Jennifer Wheeler, Cynthia York	LOCATION:	700 W State Street, 1 st Floor East Conference Room
Teleconference:	Josh Bishop, Scott Carrell, Dr. Keith Davis, Dr. Mike Dixon, Dr. Scott Dunn, Casey Meza, Dr. David Peterman, Dr. Dave Schmitz		
Members Absent:	Dr. Andrew Baron, Melissa Christian, Russell Duke, Ross Edmunds, Dr. Ted Epperly, Senator Lee Heider, Dr. Glenn Jefferson, Yvonne Ketchum, Rene LeBlanc, Nicole McKay, Daniel Ordyna, Dr. David Pate, Tammy Perkins, Geri Rackow, Dr. Kevin Rich, Dr. Boyd Southwick, Karen Vauk, Lora Whalen, Anne Wilde, Janet Willis, Dr. Fred Wood, Dr. Bill Woodhouse, Nikole Zogg		
IDHW Staff	Casey Moyer, Ann Watkins, Kym Schreiber, Miro Barac, Burke Jensen, Kate Creswell, Taylor Kaserman, Alexa Wilson		
Guest Attendees	Kathy Brashear, Katie Falls, Rachel Blanton, Diane Kelly, Tracy McCulloch, Dr. Janet Reis, Linda Rowe, Dr. SeAnne Safaii- Waite, Kayla Sprenger, Norm Varin, Matt Wimmer, Dr. Shenghan Xu,		
STATUS:	Draft (06/14/2016)		

Summary of Motions/Decisions:

Quorum was not met during the meeting and all motions were deferred to a later date.

Agenda Topics:

Opening remarks, Introductions, Agenda review, Approve minutes –

- ◆ Lisa Hettinger welcomed everyone and thanked them for coming. Ms. Hettinger started the meeting with a quote “The only way to make sense out of change is to plunge into it, move with it, and join the dance.” by Alan Watts, and proceeded with calling role.
- ◆ Ms. Hettinger introduced and welcomed Kathy Brashear Senior VP Chief Resource Officer for Alliance Title Team. Ms. Brashear has thirty years of experience in human resources; she will be taking the place of Anne Wilde on the coalition. Ms. Hettinger also introduced Matt Wimmer as the new Administrator for the Division of Medicaid within the Department of Health and Welfare. Mr. Wimmer provided information on his background and work experience.
- ◆ Ms. Hettinger solicited changes or corrections that needed to be added to the May 18th meeting minutes, no changes were noted.

Oral Health Integration – Jeff Hummel, MD, MPH, Jennifer Wheeler, Idaho Oral Health Alliance

- ◆ Ms. Wheeler introduced Dr. Hummel with Qualis Health. Dr. Hummel has worked for Qualis Health since 2006 as Medical Director for Healthcare Informatics. His special interest is integrating information technology into clinical workflows for quality improvement. He is currently involved in several national and regional projects designed to integrate oral health into primary care in a medical home setting.
- ◆ Highlights from his presentation include:
 - Many of dental problems are preventable diseases that can be easily treated or prevented by meeting a person’s dental health needs, especially in children.
 - Tooth decay is one of the greatest impacts on children and can affect their health in many ways.
 - Children age 3-4 with infections may end up in the operating room and under anesthesia; this may result in issues with learning later on in life. These children are also at high risk for diabetes later in life.
 - 25% of children suffer from tooth decay.
 - In the adult population 30-40% of adults suffer from periodontal disease.
 - Currently oral health professionals are looking for an upstream solution to these oral health issues which affect large portions of the population.
- ◆ Dental professionals should enlist the help of primary care teams or a physician because this at-risk demographic group is likely to be seen by a primary care doctor rather than a dentist.
- ◆ The Oral Health Alliance is working toward a partnership with primary care physicians to focus on preventative efforts, which is in line with the SHIP’s triple aim to improve health outcomes for all Idahoans, improve quality and patient experience of care and reduce health care costs
- ◆ Dr. Hummel concluded his presentation and responded to questions.

Regional Collaboratives Update – Dr. Scott Dunn, Panhandle Health District and Dr. Kelly McGrath, North Central Health District

- ◆ Dr. Dunn from Regional Health Collaborative (RC) 1 updated the IHC on current regional events and activities. At their last meeting Mary Sheridan presented on CHEMS and the regional collaborative is coordinating with EMS agencies in region 1 to foster cooperation. The RC is also in the process of establishing a clinical information sharing platform. The RC has identified two quality initiative projects: 1) oral health fluoride varnish and 2) opioid prescribing. The RC has set up dates to do more focused training on the different areas of the NCQA process and how to capture each of the NCQA elements.

- ◆ Kayla Sprenger presented on behalf of Dr. McGrath on the current events and activities taking place in Regional Health Collaborative (RC) 2. The RC membership includes representatives from each Cohort 1 clinic. Membership also includes community members representing the patient perspective. The RC has met seven (7) times during each regional collaborative meeting and there is time set aside for each of the cohort one clinics to share best practices.

SHIP State Evaluator – *Dr. Shenghan Xu, Associate Professor of Operations Management College of Business and Economics, University of Idaho*

- ◆ Dr. Xu thanked the IHC for inviting her and her team to present and introduced herself and her team that will be working as the state evaluation team for SHIP. Dr. Xu reviewed the professional backgrounds of the nine member evaluation team, providing an insight to the expertise they are bringing to this project. Her presentation highlighted the following:
 - The differences between state led and federal led evaluations and the way they are conducted. The state evaluators' objective is focused on the goals established by the state. The state evaluation is focused on process measures, while the federal evaluation focuses more on outcome measures. Most data will be collected through surveys, focus groups, and meetings/interviews.
 - Staffing assignments for each of the project goals was discussed.
- ◆ A workgroup is being formed as a mechanism for review and feedback as well as directing comments to the IDHW team.

Communications Materials Update – *Katie Falls, Mercer*

- ◆ Katie Falls updated the IHC on the communication materials that Mercer has been preparing. The fact sheet will describe the benefits of the medical health neighborhood concept and ultimately it will be customized to reflect each Regional Collaborative.
- ◆ Casey Moyer provided additional context citing the presentation two months ago. A medical-health neighborhood poster was presented and received positive feedback which is now being used to develop two tool kit items for clinics and patients. Additional information will be presented at the next IHC meeting.
- ◆ Ms. Falls provided an update on other Mercer project deliverables that included, the master project management plan, IHC Dashboard and yearly operational plan. The Year 3 Operational Plan is due on December 1, 2016 to CMMI. Planning for this document is already underway.
- ◆ The IHC dashboard that includes Goals 1-7 success measures will be presented at the July 2016 IHC meeting.

HIT Update – *Burke Jensen, DHW HIT Project Manager*

- ◆ Burke Jensen provided a HIT update.
- ◆ There are two SHIP project goals related to enhancing health IT, – goals 2 and 5.
- ◆ In year one of the model test grant, the Cohort 1 (55 clinics) will report out on four metrics. The next year the Cohort 1 (55 clinics) will begin reporting an additional six (6) metrics. Cohort 2 will begin their first year reporting the first four metrics. In year three, Cohort 1 (55 clinics) will report all sixteen clinical quality metrics; Cohort 2 (55 clinics) will report ten clinical quality metrics; Cohort 3 (55 clinics) will report four clinical quality metrics.
- ◆ Mr. Jensen presented a timeline that outlines the goals of the HIT workgroup for the rest of this grant year. Key milestones include: 1) two work sprints in which IHDE will be connecting (bi-directional) to cohort one clinics and 2) release date of the CQM reports.
- ◆ Janica Hardin noted that this is an aggressive timeline for the 55 clinics. Ms. Hardin was asked a question on the process for establishing the baseline and who is responsible for conducting this dialogue with the clinics and their EMRs. SHIP is reviewing this to determine who will fill this gap; this may be a joint effort between HealthTech Solutions (HTS), and IDHW staff.
- ◆ The HIT workgroup has two subcommittees to assist and support the HIT workgroup:
 - Data Element Mapping subcommittee has provided recommendations on the different clinical quality metrics that align with national measures the analytic solution will produce for the clinic, county, region and state.
 - Use Cases subcommittee will convene in July to develop a gap analysis of the different clinics and the information that is needed.
- ◆ Idaho Health Data Exchange (IHDE) is conducting readiness assessments for all of the cohort 1 clinics. Thirty-five clinics are currently ready to connect to IHDE. The other twenty have various connection issues that are being

addressed. IHDE is also working on privacy agreements between them, the clinics, and HTS. The next steps for IHDE are to finalize the readiness assessments and begin building connections.

- ◆ An IT consultant with expertise in health data exchanges, particularly the Oklahoma health data exchange, has been contracted to assist and support Idaho and the HIT workgroup address best practices.
- ◆ Mr. Jensen concluded his presentation by opening the floor to questions.

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

- ◆ Cynthia York presented the workgroup summary report. She added that one of the biggest challenges within operations is working to achieve integration of the seven goals when coordinating fifteen vendor contracts.
- ◆ Kym Schreiber directed everyone's attention to the PCMH cards that were handed out at the meeting. They are wallet size cards and are a recruitment tool for clinic or primary care providers interested in PCMH transformation. These will help with recruitment of clinics for cohorts two and three. Anyone interested in receiving additional cards to assist in clinic recruitment may contact Kym.

Timeline and Next Steps –

- ◆ Lisa Hettinger reminded the IHC that implementations are never easy, and expressed appreciation for all of the stakeholders who continue to come together to ensure the SHIP goals are reached.
- ◆ Cynthia York provided an update on the funding carry over request for Year 1 Pre Implementation; CMMI has approved the request and Idaho's submission document has been identified as a best practice to share with other states.

There being no further business the Chair adjourned the meeting at **3:30pm**.

Introduction to the Mini-International Neuropsychiatric Interview (M.I.N.I.)



Nview Health Enables Physician Practices to Deliver Validated Diagnostic Behavioral Health Screens, Interviews, Outcome Tracking and Services to Patients in a Simple and Easy-to-Bill Platform.

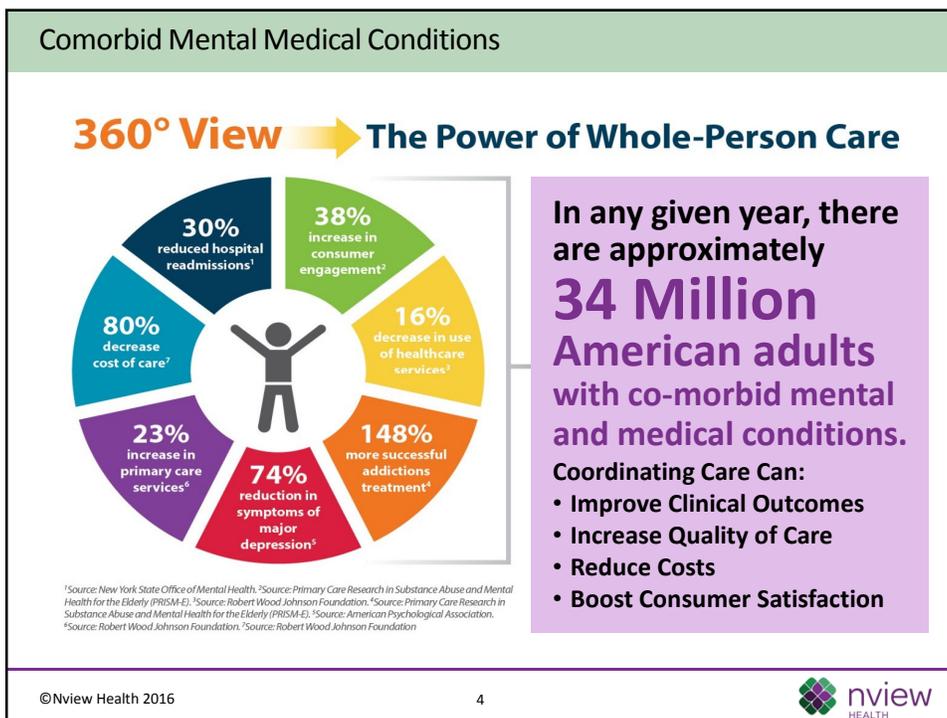
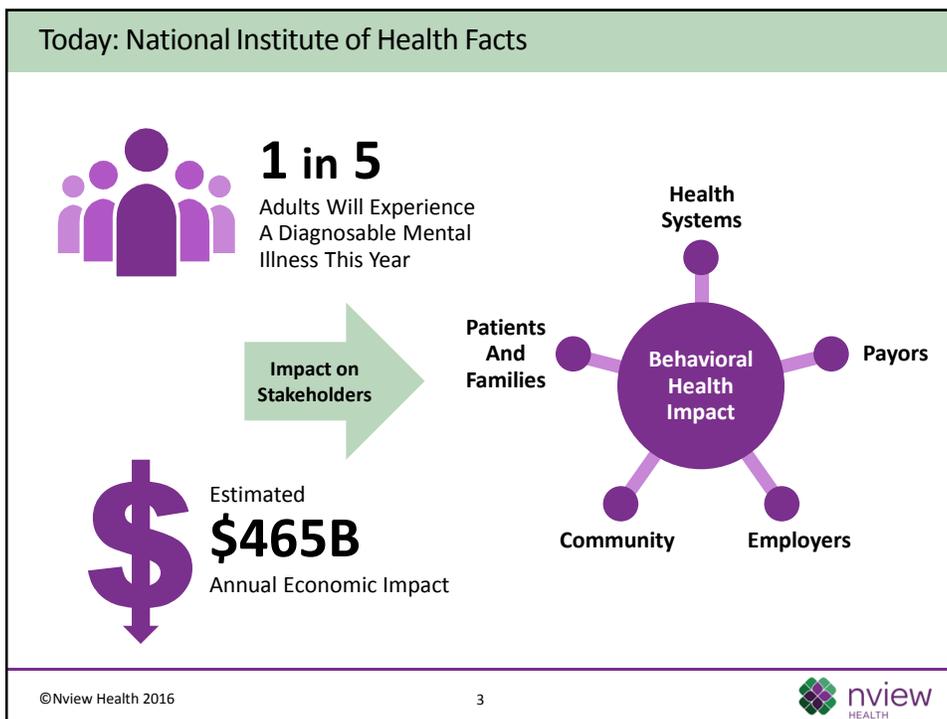


About Nview Health



Integrated Behavioral Health Solutions

- Privately Held Delaware Corporation
- Offices in Jacksonville, FL, and San Diego, CA
- Continuing to develop new technology and products



Economic Burden

The fact is most chronic illnesses are at least **twice as expensive to treat** with a missed, under-diagnosed or untreated mental health comorbidity.

COMORBID DEPRESSION

54% Increase in monthly health care expenditures for those with chronic conditions and comorbid depression.

Without Depression

With Depression

COMORBID ANXIETY

67% Increase in monthly health care expenditures for those with chronic conditions and comorbid anxiety.

Without Anxiety

With Anxiety

Annual Medical Cost (in thousands)

Disorder	With Treated Mental Illness	Without Treated Mental Illness
Heart Failure	\$2.56	\$6.74
Allergic Rhinitis	\$3.27	\$8.46
Asthma	\$3.73	\$10.56
Migraine	\$3.82	\$15.47
Back Pain	\$11.61	\$33.25
Diabetes	\$13.06	\$27.28
Hypertension	\$13.38	\$27.06
Ischemic Heart Disease	\$62.40	\$110.94

Costs per patient, based on claims data for 229,776 patients, 2004 – 2006 Source - OCI 2008

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Total Burden - It Effects All of Us

POOR HEALTH COSTS U.S. ECONOMY

\$576 BILLION

39% DUE TO LOST PRODUCTIVITY

The estimated costs are categorized into the following three major areas

In billions of dollars

\$232

\$227

\$117

- Wage Replacement (incidental absence due to illness, workers' comp, short-term disability, long-term disability)
- Medical and Pharmacy (employee group health and workers' comp medical treatments, employee group health pharmacy treatments)
- Lost Productivity (absence due to illness, reduced performance)

Source: 2015 Integrated Benefits Institute

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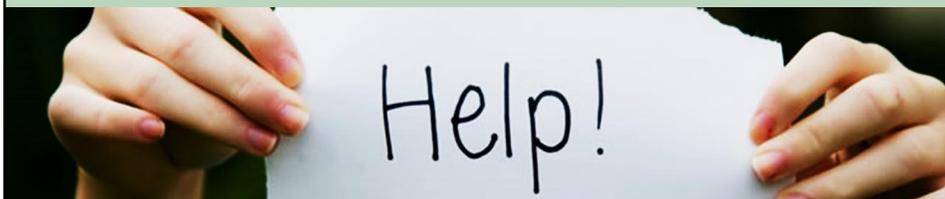
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Patient-Centered Medical Home

- 360° Care
- Connected Communications- Same Currency of information Exchange
- Data Driven Outcomes measures
- Reduction in Cost of Care
- Improved early diagnosis
- Family and support system integration



Suicide Impact on Primary Care



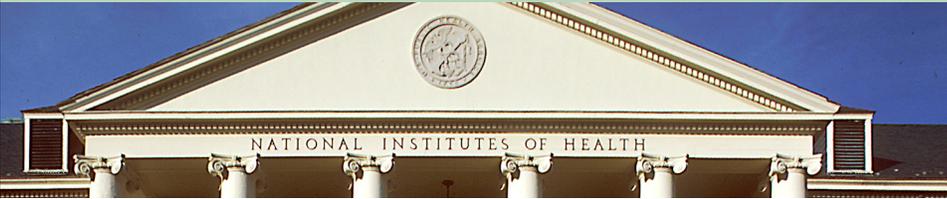
- Up to 45% of individuals who die by suicide have visited their primary care physician within a month of their death.
- Up to 67% of those who attempt suicide receive medical attention as a result of their attempt.
- Approximately 13 family practice patients attempt suicide annually; physicians are only aware of 1 – 2.



Primary care has enormous potential to help prevent suicides and connect people to needed specialty care.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC419387/>

Diagnostic Accuracy



Statistics from the National Institutes of Health show

Two-thirds of all mental health diagnoses and treatments come from the primary care doctor and pediatric primary care doctors.

Yet, the study shows, they struggle to get it right with misdiagnosis rates reaching:

- 97.8%** Social Anxiety Disorder
- 92.7%** Bipolar Disorder
- 85.8%** Panic Disorder
- 65.9%** Major Depressive Disorder
- 71.0%** Generalized Anxiety Disorder



NIH published diagnosis rate for the M.I.N.I. is 89%.

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History of Behavioral Health Platform - The M.I.N.I.

1990
Dr. Sheehan releases the M.I.N.I.

1996
The M.I.N.I. and it's measures are computerized.

2013
USHP commercialized the M.I.N.I. and measures

2016
Nview Health purchases copyrights and updates platform

The M.I.N.I. was created after the drug Paxil failed it's first clinical trial in the late 1980's.

It was determined the failure was not due to the drug, but rather the psychiatrist's personal bias during the trial candidate's screening process for inclusion/exclusion criteria.

Driven by the huge monetary loss, the pharmaceutical company turned to **Dr. David Sheehan, M.D., M.B.A.**, to develop a comprehensive assessment that:

- **Is Clinically Validated** and peer reviewed for accuracy and sensitivity.
- **Links Primary DSM Disorders with any Co-morbidities** using validated algorithms.
- **Takes Less than Fifteen Minutes to Complete.**
- **Has Both Clinician Driven & Self-Assessment Modalities.**
- **Has an Adjoining Suite of Validated Tools** that creates quantified treatment outcomes.

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Diagnostic Tool Comparison

Validated diagnostic neuropsychiatric interviews.



M.I.N.I. - Mini-International Neuropsychiatric Interview

- Most widely used neuropsychiatric diagnostic assessment tool in the world by the World Health Organization.
- Takes approximately 15 minutes to administer.
- Screens for 17 adult and 24 childhood DSM-5 disorders.

SCID – Structured Clinical Interview for DSM

- Takes approximately 90 minutes to administer.
- On-site scoring is NOT available.

PHQ-9 – Patient Health Questionnaire

- It is a public domain, self-administered screening.
- Not a diagnostic assessment.

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M.I.N.I. Behavioral Health Solutions Suite

M.I.N.I. SCREEN

Preliminary screen to ACA depression requirements and establish medical need for further behavioral health diagnosis.

- M.I.N.I. Screen (17 DSM Disorders)
- M.I.N.I. Kid Screen (24 DSM Disorders)

M.I.N.I. DIAGNOSTIC INTERVIEW

The M.I.N.I. DSM-5 and ICD-10:

- Created in 1990. Validated in 1996 (89% accuracy). Takes 5-15 minutes to complete.
- M.I.N.I. Kid last validated in 2010.
- Versions used by Dept. of Defense for American warfighters since 1990.
- Most utilized comprehensive diagnostic evaluation assessment in the world (NIH).
- Used or referenced in over 10,000 clinical studies.

M.I.N.I. OUTCOME TRACKER

The M.I.N.I Symptom Disorder Tracker measures clinically meaningful change (CMCM) outcomes over time.

- Sheehan Disability Scale (SDS)
- Sheehan-Suicidality Tracking Scale (S-STs)
- Sheehan-Homicidally Tracking Scale (S-HTs)

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M.I.N.I. & M.I.N.I. Kid - Screened DSM-5 Disorders

- Adjustment Disorders
- Attention Deficit Disorder (ADD)
- Agoraphobia
- Alcohol Use Disorder
- Anorexia Nervosa
- Antisocial Personality Disorder
- Attention Deficit/Hyperactivity Disorder (ADHD)
- Bulimia Nervosa
- Conduct Disorder
- Generalized Anxiety Disorder
- (Hypo) Manic Episode (bipolar)
- Major Depressive Episode
- Obsessive Compulsive Disorder
- Oppositional Defiant Disorder
- Panic Disorder
- Pervasive Developmental Disorder
- Posttraumatic Stress Disorder
- Psychotic Disorders
- Separation Anxiety Disorder
- Social Phobia (Social Anxiety Disorder)
- Specific Phobia
- Substance Use Disorder
- Suicidality
- TIC Disorders (Tourette's, etc.)



The M.I.N.I. In Your Practice – 3 Simple Steps



- 1 M.I.N.I. Screen in Waiting Room (3-5 min.)**
 - Front Desk staff completes patient sign-in process.
 - Patient is provided with verbal instructions and a tablet to complete M.I.N.I. Screen.
 - Staff receives results indicating if patient qualifies to take M.I.N.I. Interview.

Or: M.I.N.I. Screen in exam room (3-5 min.)

 - Nurse/MA completes initial assessment.
 - Patient is provided with verbal instructions and a tablet to complete M.I.N.I. Screen.
 - Staff receives results indicating if patient qualifies to take M.I.N.I. Interview.
- 2 M.I.N.I. Interview in exam room (10-20 min.)**
 - Nurse/MA provides patient with instructions and a tablet to complete M.I.N.I. Interview.
 - Results are immediately available for provider review during visit.
- 3 Referral**
 - Provider reviews results with patient as part of the visit.
 - Provider determines if they will treat patient or refer patient based on practice policy/comfort.
 - Tracker scales are initiated to monitor patient progress and treatment course.

Our Users

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Introduction to the M.I.N.I. 6.0

- Short, structured diagnostic interview developed in 1990 by psychiatrists and clinicians in the United States and Europe for DSM-5 and ICD-10 psychiatric disorders.
- Employed by mental health professionals and health organizations in more than 100 countries.
- Most widely used psychiatric structured diagnostic interview instrument in the world. With an administration time of approx. 15 minutes.
- The structured psychiatric interview of choice for psychiatric evaluation and outcome tracking in clinical psychopharmacology trials, epidemiological studies and clinical use.

Validation Process

- Validated against the much longer Structured Clinical Interview for DSM diagnoses (SCID-P) in English and French and against the Composite International Diagnostic Interview for ICD-10 (CIDI) in English, French and Arabic.
- Validated against expert opinion in a large sample in four European countries (France, United Kingdom, Italy and Spain).
- More time-efficient alternative to the SCID-P and CIDI according to NIMH Division of Clinical and Treatment Research.

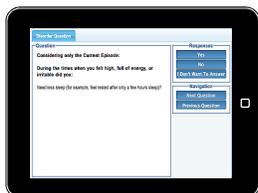
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Behavioral Health Solution Suite



M.I.N.I. Screen

- Screens for inclusion criteria for a disorder.
- If a patient answers “Yes” to a question on the screen, they will seamlessly be transitioned into the full interview of questions.
- Preliminary screen meets all ACA depression requirements and establishes medical need for further behavioral health diagnosis.
- The M.I.N.I. Screen takes 3-5 minutes to complete.



M.I.N.I. Diagnostic Interview

- M.I.N.I.: was created in 1990. It was validated in 1996 (89% accuracy).
- Covers 17 disorders for adults and 24 disorders for children.
- Most utilized comprehensive diagnostic evaluation assessment in the world (NIH).
- Has been used or referenced in over 10,000 clinical studies.
- Versions of the interview have been used by the Dept. of Defense for American warfighters since 1990.
- The M.I.N.I. Kid was last validated in 2010.
- Provides clinically validated information to providers on disorders.
- The interview takes 5-15 minutes to complete.

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Behavioral Health Solution Suite



M.I.N.I. Interview Summary

- Provides easy to read assessment results for Physician to review with the patient immediately following patient completion.
- Sent via encrypted PDF email file to designated provider.
- Options to print summary alone or detailed report.

Trackers

Symptom Disorder Tracker measures clinically meaningful change (CMCM) outcomes over time.

Sheehan M.I.N.I Tracker (SMT)

Evidenced based outcome tracking scale.

Sheehan Suicidality Tracking Scale (S-STs)

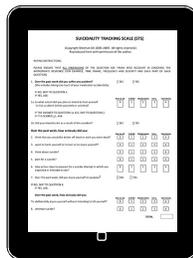
Patient self-report or clinician administered rating scale validated assessment.

Sheehan Homicidality Tracking Scale (S-HTS)

Validated assessment of emergent homicidal ideations and behaviors.

Sheehan Disability Scale (SDS)

- Agnostic to the disorder (mental health, COPD, bone fracture, etc.). Monitors patient’s symptoms, providing a validated, quantified treatment outcome.



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Cloud-Based Delivery Platform



Cloud-Based Delivery Platform

- HIPAA Compliant cloud-based solution, available on any web-enabled device.
- Allows screens, interviews, and outcome measure trackers to be administered in office or at home via end-to-end encrypted email.
- Automated notification for patients with suicidal ideation.
- Patient results are sent directly to your site using a variety of methods. That data can then be loaded into EMR's.
- Automates audit trails for compliance with quality measure requirements for Risk-Based Practices / ACOs.

Data Integration

Data from the Nview platform can be loaded into an EMR by:

- Dragging and dropping the password-protected PDF, either from your email, or from our platform into your EMR.
- Exporting the data from our platform as a tab-delineated File using the import feature available on most EMR's.
- Importing patient demographic and care team information from your existing EMR into our platform.

Application Program Interface (API) development will allow our platform and your EMR to access data on-demand.



Thank You.

Medical-Health Neighborhood

Communications Toolkit Summary

Tool	Target Audience	Key Communications Objective	Additional Information
 <p>Medical-Health Neighborhood Fact Sheet: Participant Edition</p>	Potential Medical-Health Neighborhood (MHN) participants within the community.	<ol style="list-style-type: none"> 1) Describes the MHN concept. 2) Introduces the Regional Health Collaborative (RC). 3) Provides a case example of a patient using a MHN. 4) Provides information on the local process to join the MHN. 	<p>This communication will be delivered by PHD staff, RC members, and existing MHN participants.</p> <p>Reading Level: 8th grade</p>
<p>PENDING</p> <p>Medical-Health Neighborhood Fact Sheet: Patient Edition</p>	Patient within a PCMH being introduced to the MHN concept.		<p>This communication may be provided to a patient in their new-client paperwork.</p> <p>Reading Level: 6th grade</p>
 <p>Medical-Health Neighborhood Poster</p>	Community members, patients and other individuals accessing services through a MHN participant.	<ol style="list-style-type: none"> 1) "This business is a part of the local Medical-Health Neighborhood." 2) Describes what a MHN means to a community member. 	<p>Standard 8 ½ x11" size in full color print. May be posted in a visible place in the business with a MHN sticker.</p> <p>Reading Level: 6th grade</p>
 <p>Medical-Health Neighborhood Sticker</p>	Community members, patients and other individuals accessing services through a MHN participant.	"This business is a part of the local Medical-Health Neighborhood."	<p>Sticker is full color, laminated and leverages the existing graphic designs of the other toolkit contents.</p> <p>Reading Level: N/A</p>

WHAT IS THE MEDICAL-HEALTH NEIGHBORHOOD ?

UNDERSTANDING YOUR ROLE IN THE NEIGHBORHOOD

The Medical-Health Neighborhood is a partnership between a Patient Centered Medical Home (PCMH) and other professionals in the community to work together as a team to provide the best of care for their patients and clients. These professionals are committed to understanding and responding to a person's TOTAL health needs in a coordinated and collaborative fashion. These organizations are actively working together to help people achieve and maintain their best health.

Physical, emotional, social, and cultural needs all impact a person's health. PCMHs, healthcare professionals and community organizations must work together to help our patients, clients, and community members achieve the best possible health. This is accomplished by forming close relationships, referral and follow-up communication pathways, collaborative community forums and MOUs between participating entities.

Coordinating specialty care and community services through the Medical-Health Neighborhood helps individuals and families benefit the most from health and social services by using our existing services and resources effectively. A Medical-Health Neighborhood is organized and defined at the community level by the Regional Health Collaborative (RC); a component of the Idaho Healthcare Coalition and the Statewide Healthcare Innovation Plan (or SHIP).



MEDICAL-HEALTH NEIGHBORHOOD PARTICIPANTS

The Medical-Health Neighborhood serving this community includes all types of medical and social support organizations.

This includes, but is not limited to:

- PCMHs
- Medical Specialists
- Behavioral health professionals
- Community Supports
- Hospital Services
- Housing
- Oral Health
- Pharmacy Services
- Laboratory Services
- Community Health EMS
- Transportation
- Health Plans
- Exercise and Fitness Services
- Food and Nutritional Supports

WHY A MEDICAL-HEALTH NEIGHBORHOOD MATTERS

A Medical-Health Neighborhood goes beyond just a referral network. It is a highly coordinated and organized element of a healthy community, (also referred to as population health). The fundamental premise of population health is changing behavior and moving toward better health outcomes for populations. The broader impact of the Medical-Health Neighborhood is to bridge the relationship between the individual, clinical, provider-level responses to the broader, population health community-wide response.

RC Information/Co-Branding Area



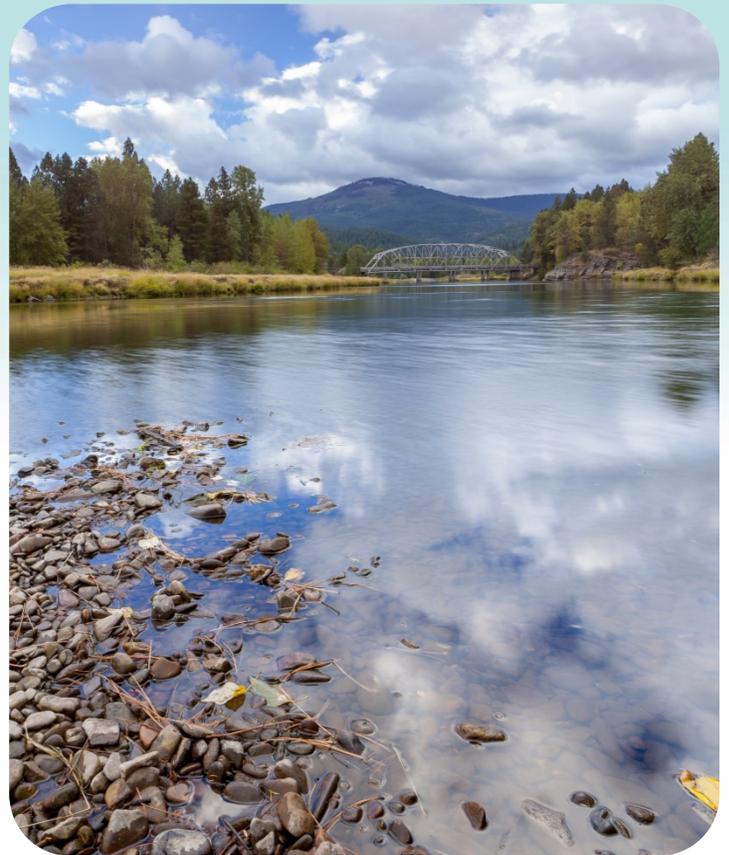
HOW DO I JOIN AND WHAT ARE THE STEPS TO BECOMING PART OF MY LOCAL MEDICAL-HEALTH NEIGHBORHOOD?

PHD/RC should create content for this section that addresses the following questions:

- 1) Who is the contact?
- 2) What are the steps? For example, is the relationship formalized and, if so, how?
- 3) Is the provider identified on a website as a member of the Medical-Health Neighborhood? In a database? Etc.? Are there specific local incentives to participate?
- 4) What is the Regional Health Collaborative's role and responsiveness?

RIVER IMAGE TO RIGHT MAY BE REMOVED FOR ADDITIONAL SPACE IF NEEDED.

Please use GARAMOND FONT 12PT



HOW DOES A MEDICAL-HEALTH NEIGHBORHOOD ACTUALLY WORK?



Mrs. Jones was recently seen by her physician who practiced at a PCMH. During the appointment her provider used a new screening tool which included several questions about food security (i.e. adequate access to food). Because of her relationship with her care team she told her physician that she struggles to make ends meet on her fixed income and often runs out of food before having money to purchase more.

Based on this feedback Mrs. Jones is introduced to Anna, a Community Health Worker (CHW) who recently joined the PCMH team. Anna and Mrs. Jones talk about potential resources including the local food bank. Mrs. Jones isn't sure about using the food bank since she doesn't believe in accepting things from others, but over time begins to develop trust with Anna who talks through her concerns. They agree to set a private appointment with the food bank manager to check it out.

Mrs. Jones meets Alan, the food bank manager and together they spend 30 minutes talking about how the food bank works, where the food comes from and how Mrs. Jones could volunteer to help out. A few days after the appointment, Alan calls Anna to fill her in on the meeting with Mrs. Jones and he shares what they agreed upon.

Now that Anna and the PCMH are aware of this new resource and connection, they will continue to provide care to Mrs. Jones and will verify that this linkage remains in place as long as needed. This close coordination between a food bank and a PCMH is one example of an enhanced referral pathway with feedback and how ongoing communication works in a Medical-Health Neighborhood.



I'M PART OF YOUR MEDICAL-HEALTH NEIGHBORHOOD



WHAT IS THE MEDICAL- HEALTH NEIGHBORHOOD?

The Medical-Health Neighborhood is a partnership between a Patient Centered Medical Home (PCMH) and other professionals in the community to work together as a team to provide the best of care for their patients and clients. These professionals are committed to understanding and responding to a person's TOTAL health needs in a coordinated and collaborative fashion. These organizations are actively working together to help people achieve and maintain their best health.

The Medical-Health Neighborhood serving this community includes all types of medical and social support organizations, such as: behavioral health specialists, hospital care, community supports, pharmacy services, nutrition services, oral healthcare, medical specialists, and those providing activities that help keep people healthy and prevent disease.

Local Partner:



More information is Available at:
WWW.SHIP.IDAHO.GOV



STATEWIDE HEALTHCARE INNOVATION PLAN (SHIP) Interest Survey 2016

Version 2.0 DRAFT (July 2016)

Thank you for your interest in the Idaho Statewide Healthcare innovation Plan (SHIP). Please complete the following contact information and brief survey questions to help us identify clinics interested in receiving further information regarding recruitment for Cohort 2 participation.

Clinic Demographic Information	
Clinic Name	
Clinic's Physical Address	
City	
State	
Zip Code	
Phone Number	
Fax Number	
Main Contact First Name	
Main Contact Last Name	
Main Contact Email Address	
Survey Questions	
How did your clinic hear about SHIP?	<input type="checkbox"/> On-line <i>[Drop-down; select one]</i> <input type="checkbox"/> Medicaid <input type="checkbox"/> Public Health District <input type="checkbox"/> Other:
Why is your clinic interested in participating with SHIP?	<i>[free text; 100 character max]</i>
What is your Practice type? (Check all that apply)	<input type="checkbox"/> Family Medicine <i>[check all that apply]</i> <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Multi-Specialty <input type="checkbox"/> Other:
Is your clinic familiar with the Patient-Centered Medical Home (PCMH) model of care?	<input type="checkbox"/> Very familiar (Clinic is Nationally recognized or accredited at a higher level or NCQA Level 3; PCMH transformation has been implemented within clinic) <input type="checkbox"/> Familiar (Clinic Nationally recognized or accredited at a mid-level or NCQA Level 1 or 2; clinic has begun implementation of PCMH transformation) <input type="checkbox"/> Somewhat familiar (Clinic is not currently recognized or accredited but Clinic administration has outlined steps to begin implementing PCMH transformation) <input type="checkbox"/> Limited familiarity (Clinic is not currently recognized or accredited but Clinic administration has begun discussion about implementing PCMH transformation) <input type="checkbox"/> Not familiar (Clinic is not currently recognized or accredited, and Clinic administration has not discussed implementing PCMH transformation) <i>[Drop-down; select one]</i>
Has your clinic identified a Physician/Provider Champion?	<input type="checkbox"/> Yes <i>[Drop-down; select one]</i> <input type="checkbox"/> No
Does your clinic use an Electronic Health Record (EHR)?	<input type="checkbox"/> Yes <i>[Drop-down; select one]</i> <input type="checkbox"/> No

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



PCMH Recruitment Plan

Cohort 2 – Grant Year 3

Version 6.0 DRAFT (July 2016)

Introduction

Idaho envisions a statewide healthcare system transformation that changes the standard of practice for healthcare in Idaho, delivering integrated, efficient, and effective primary care services through the patient-centered medical home (PCMH), which is integrated within the local Medical-Health Neighborhood, and supported and incentivized by value-based multi-payer payment methods. Through this transformation, Idaho will improve the quality and experience of care for all Idahoans, improve health outcomes, and control costs.

In December 2014, the Idaho Department of Health and Welfare (IDHW) received a State Innovation Model (SIM) grant from CMMI. This grant will fund a four (4) year model test that began on February 1, 2015, to implement SHIP. During the grant period, Idaho will demonstrate that the state's entire healthcare system can be transformed through effective care coordination between primary care providers practicing patient-centered care, and the broader medical neighborhoods of specialists, hospitals, behavioral health professionals, long-term care providers, and other ancillary care services.

Governance and Stakeholder

Work on the SHIP began in 2013 when Idaho stakeholders came together to study Idaho's current healthcare system and develop a plan for transformation. The six (6) month planning process involved hundreds of Idahoans from across the state working together to develop a new model of care. In early 2014, Governor Otter established the Idaho Healthcare Coalition (IHC) which has continued to build on earlier stakeholder work and momentum. IHC members include private and public payers, legislators, health system leaders, primary care providers, nurses, healthcare associations, and community representatives.

While all stakeholders have been instrumental to the progress made to date, the work of participating payers and healthcare providers deserves special recognition because of both their contribution to the pending changes and the impact of those changes on their work. Throughout discussions and deliberations with Idaho's healthcare providers, their dedication and resolve to improve the health of their patients, community, and overall State population has helped address challenges and barriers to healthcare transformation. Primary care doctors, nurse practitioners, hospitals, nurses, social workers, behavioral health professionals, and other specialists and ancillary providers together are the driving force of Idaho's innovation. Their willingness to contribute their expertise, share their experience, and volunteer their time to improving Idaho's health is a true testimony to the integrity and value of Idaho's healthcare workforce. It is also anticipated that this collaboration will help address barriers and challenges moving forward.



The Idaho Medical Home Collaborative (IMHC) makes recommendations to the IHC on topics related to the development, promotion, and implementation of PCMHs in Idaho. For the SIM Model Test, the IMHC will make recommendations to IDHW and the IHC related to expanding the PCMH model through the SIM initiative. (<http://ship.idaho.gov/WorkGroups/IdahoMedicalHomeCollaborative>)

The IMHC is comprised of subject matter experts who will use their expertise and experience with the PCMH model in Idaho to produce recommendations to guide the development, promotion and implementation of PCMHs statewide through the SIM Model Test.

While the IHC members are active in the SHIP PCMH application review, they cannot participate in the selection process of PCMH clinics. As non-compensated, appointed public officials, per the Ethics in Government Act, IHC members are not prohibited from having an interest in a contract made with SHIP so long as the provisions of the Bribery and Corruption Act are strictly adhered to, which includes: 1) not taking any part in the preparation of the contract and bid specifications and 2) not voting, or approving the contracts.

Target Audience for Recruitment

Many of Idaho's providers are ready to test the model and, at the same time, are working to recruit other providers. During the Medical Health Home Project, Medicaid had 364 primary care providers servicing 49 locations throughout the state. Many of these practices are currently Cohort 1 participants. An *Interest Application* was issued in August 2015 to determine additional primary care practices' interest in transformation to a PCMH model; this generated 134 responses. By the end of the SIM Model Test period, Idaho will have 165 practices around the State transformed from a traditional primary care practice to a well-integrated, coordinated PCMH model supported by value-based payment models.

Practices being targets include: all Primary Care Practices (PCPs) within the State of Idaho who are engaged in the PCMH model of care and those interested in PCMH. Limited specialty clinics providing primary care services as well as Behavioral Health service providers whom are offering primary care are also encouraged to apply for participation with SHIP.

PCPs should consider the following questions when thinking of becoming a PCMH clinic:

1. Are you interested in lowering malpractice costs, increasing quality of care and increasing reimbursements?
2. As a physician are you providing your patients with evidence-based medical care?
3. Are you tracking and monitoring your patients that have been identified with certain diagnoses?
4. Are you using an electronic health record that allows you and your staff to manage patients and track their care within and outside of the practice?
5. Do you provide your patients with on-going patient education that allows for a true partnership for care?
6. Are you setting goals to make your practice clinically and operationally sound?

Answering yes to most or all of these questions, may indicate that a clinic is ready to implement the Patient-Centered Medical Home model of care.

Methodology

For primary care providers, the communication goal is two-tiered based on the audience. For primary care providers who have already engaged in the SHIP model test, the goal is to increase understanding of SHIP and its implementation. For primary care providers who have not been engaged in the process, the goals are to increase understanding of the model and to recruit their participation and commitment to the model. The specific message to primary care providers will include: how the SHIP model test will benefit their practice and patients; additionally, resources and supports that will be available to help them as they transition to the PCMH model of care. Messages will also focus on the fact that Idaho is testing a model that has been chosen based on experience with the PCMHs in the State.

For Cohort 1, the *Interest Application* and *Final Application* incorporated topics to review the readiness of primary care clinics within the State of Idaho that reflect both geographic and population focused diversity, as well as clinics that demonstrate readiness to take on PCMH transformation work. The priority topics identified within the applications were:

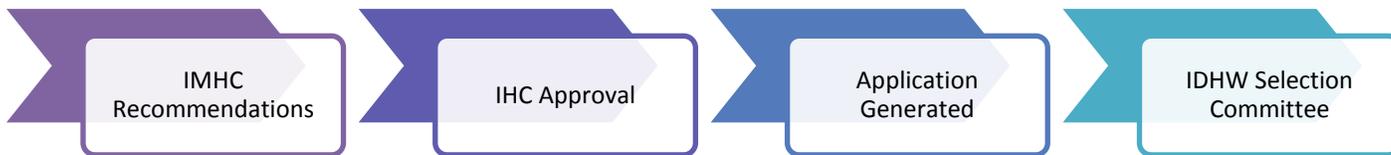
1. Clinic Profile: clinic demographic factors comprising of patient access to care, empanelment, and payer distribution.
2. Transformation Plan, History, and Experience: engaged leadership and effective transformation experience.
3. Health Information Technology (HIT) Capabilities: electronic health record (EHR) usage and access to appropriate data.
4. Primary Care/ Behavioral Health Integration: increasing patient wellness and support of integration of behavioral health within primary care settings.
5. Team Based Care: care coordination experience.
6. Population Health Management: utilization of evidence based practices and data for care management.
7. Quality Improvement (QI) Activities: identifying performance opportunities to improve clinical quality, efficiency, and patient experience.
8. Clinic Vision and Mission: identifying a physician champion and aligning clinic’s strategy with SHIP goals and the Triple Aim.

Cohort 1 Lessons Learned

SHIP Cohort 1 recruitment process yielded several opportunities for improvement and included:

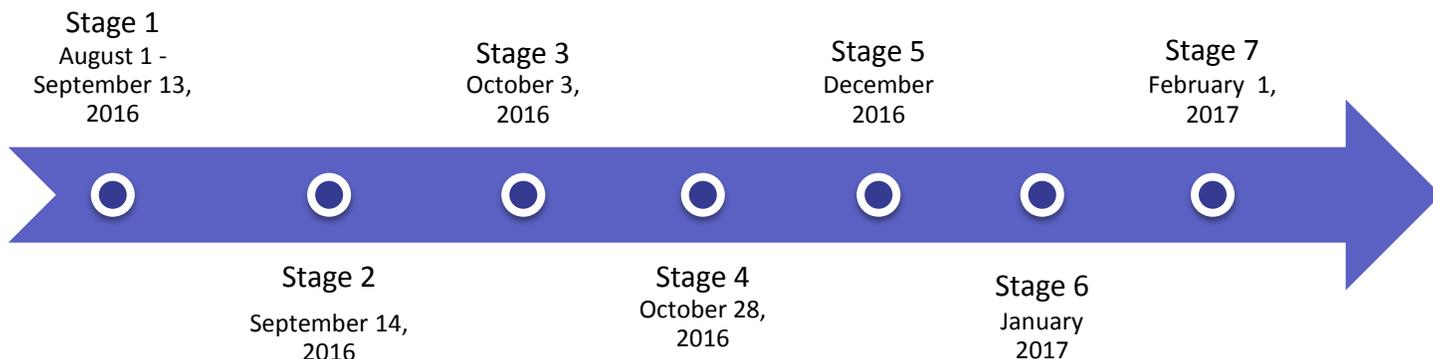
Cohort 1 Lessons Learned—Potential Improvements	Description and Impacts	Change to Methodology
<i>Completion times for Interest Application</i>	<ul style="list-style-type: none"> • <i>The Interest Application had a 2-week turnaround at a time of year when primary care practices are at their busiest.</i> • <i>The application should have allowed for more time to be completed, or a simpler method for completion should have been identified.</i> 	<i>Future Cohorts will have a larger window of time to complete a form showing their interest in participation with SHIP.</i>
<i>Questions asked and length of application</i>	<ul style="list-style-type: none"> • <i>The completion of the Interest Application was laborious for some applicants with limited understanding in the value of questions asked that were then repeated in the Final Application.</i> • <i>Applicants were frustrated with the duplicative work this created and additional time spent providing SHIP with information they had already obtained.</i> 	<i>Future Cohorts will submit a short form consisting of contact information, and answer a short survey of questions.</i>
<i>Confusion in naming of application</i>	<ul style="list-style-type: none"> • <i>Utilizing the term “application” led some to believe the Interest Application was the only application for SHIP Cohort 1.</i> • <i>Some clinics may not have completed a Final Application, as they had already completed an application.</i> 	<i>Proposing the “Interest Application” be renamed the “SHIP Interest Survey” to avoid confusion through the application process for future cohorts.</i>

Process for establishing Cohort 2 Selection Criteria



Selection criteria and the Final Application for SHIP Grant Year 3 – Cohort 2 clinics will be revised based on lessons learned during the Cohort 1 application processes and will incorporate feedback from the IMHC after their yet to be scheduled August meeting. The SHIP team will build a combined Final SHIP Application and Readiness Assessment into an online application after completing the final version with assistance from the IMHC. The IMHC will present the proposed selection criteria along with the draft of the Final Application to the IHC during their September 14, 2016, meeting.

Selection Criteria Process:



Stage 1: SHIP team will incorporate edits and changes recommended from the IMHC workgroup into the combined Final Application and Readiness Assessment and will begin building the online application into Key Survey.

Stage 2: SHIP team and IMHC will present the combined Final Application and Readiness Assessment to the IHC.

Stage 3: SHIP team will email notification to clinics that both have completed a SHIP *Interest Survey*, or were notified to complete the SHIP *Interest Survey*, that the combined Final SHIP Application and Readiness Assessment has been posted online.

Stage 4: Final SHIP Application submission deadline.

Stage 5: Final selection of clinics and notification for Cohort 2 will be made and presented to the IHC on December 14, 2016

Stage 6: Clinics will be enrolled into Cohort 2 of SHIP.

Stage 7: Start of the Idaho Model Test Grant Year 3.

SHIP assembled a group oral Health, Division of Medicaid, and the Office of Healthcare Policy Initiatives as well as a subject matter expert from the PCMH Contractor to participate in the Clinic Selection of Cohort One. The IMHC and the IHC provided the framework and support for PCMH transformation as part of the SHIP. The scoring of the final applications incorporated the adopted criteria from the IHC during their August 2015 meeting.

Selection Committee members participation with the selection process was confidential. Much like a “black out” period during a contract request for proposal (RFP), members were asked not to discuss the applications and the selection process with anyone outside of the Selection Committee until the final clinic selections were made and announced.

The process took approximately 8 hours of each member’s time. A Kick-off meeting was held via teleconference on November 23, 2015, reiterating expectations, detailing the instruction set, and reviewing the documents associated with the process. Prior to the meeting each committee member received:

- A copy of the relevant selection criteria from each application
- A scoring rubric with instructions
- A matrix to capture scores for each application

As part of the Selection Committee for Cohort One, members evaluated each application for its ability to ensure the clinic’s success in achieving and supporting each of the seven SHIP program goals. As guided by the IHC, selection criterion is based on key transformation standards and elements thought to increase the chance of successful PCMH creation and potential recognition. These criteria included:

- Clinic Leadership: A physician champion is an important element for successful PCMH transformation; practice commitment to transformation is evidenced in part by a strong champion support the change effort(s).
- Geographic Location: Geographic distribution is essential; each health district region of Idaho has a different patient mix and medical neighborhood needs. Further, the Public Health District staff will play an integral role in supporting practice transformation, providing technical assistance and building QA competence.
- EHR: Practices included in Year 1 of the project will be required to interface their electronic health record (EHR) with the Idaho Health Data Exchange (IHDE). Practices without an EHR will require additional time and support to implement an EHR product prior to connecting to the IHDE and exchanging data with the statewide exchange.
- Rural vs. Urban: Clinics residing in counties designated as rural are able to contribute to the virtual telehealth component of the SHIP and are an emphasized element of the SHIP model test application.
- Previous PCMH Experience: Previous participation in pilot projects and accreditation as a PMCH offers advantage to the project as these early adopters will serve as peer leaders for Year 2 and 3 selected clinics.

Outreach and Recruitment

As described in the Operational and Communications Plans, SHIP is engaging numerous stakeholders through multiple avenues. In addition to broad stakeholder outreach, there are project-specific outreach and recruitment activities as well. Outreach channels utilized during Cohort 1 recruitment and will continue for Cohort 2 recruitment includes:

SHIP Recruitment Outreach Channels	Responsible Party & Mechanisms Utilized
<i>Office of Healthcare Policy Initiatives</i>	<ul style="list-style-type: none"> • SHIP PCMH Project Manager – general customer service in email notifications, communications, and question responses, Healthcare events and management, informational webinars • SHIP Administrative staff – general customer service in email and telephonic responses • SHIP.idaho.gov website - general SHIP information, timelines, historical information, links to the Interest Survey and Final Application
<i>Public Health District staff (statewide)</i>	<ul style="list-style-type: none"> • PHD SHIP Managers – direct communications to clinics, local PCMH recruitment, Regional Collaborative meetings • PHD SHIP Quality Assurance Specialists - direct communications to clinics, local PCMH recruitment, SHIP presentations
<i>Medicaid Healthy Connections</i>	<ul style="list-style-type: none"> • Medicaid Quality Improvement Specialists – direct communications to clinics, statewide PCMH recruitment, Medicaid Tier Payment processes • Medicaid Health Resource Coordinators – direct communications to clinics, local Lunch & Learn events, general customer service communications

PCMH outreach to clinics for Cohort 1 began in August 2015 with the posting of the *Interest Application* to solicit information from a broad spectrum of interested clinics about transforming Idaho’s healthcare system. Official recruitment of clinics for Cohort 1 participation began in October 2015 with the release of the Final SHIP Application.

Clinics not accepted for Cohort 1 participation with SHIP were offered additional resources within the state to assist with developing quality assurance strategies and other PCMH initiatives they could apply for. Clinics not accepted into Cohort 2 will be provided similar updated resources and will be provided with information regarding other initiatives available within the state and region.

The IMHC will review the questions proposed for the *Interest Application* on June 29, 2016, as well as the proposal to change the name of the *Interest Application* to the *Interest Survey*. Outreach to clinics for Cohort 2 will begin in July of 2016. This will be followed by two SHIP interest webinars, which will be held in August and September 2016. These webinars will include the benefits and resources of participating in SHIP, what a clinic will receive via training and technical assistance from the PCMH contractor, and an outline of expectations within their cohort year. Clinics who have been nationally recognized through a PCMH accrediting organization (NCQA, URAC, Joint Commission, AAAHC), are strongly encouraged to apply for SHIP. Their experience can be utilized to mentor other clinics who may not be as experienced in transformation, and they will receive additional resources from the PCMH contractor to assist in establishing quality assurance activities or policies, and other advanced PCMH topics as identified as a need by the clinic.

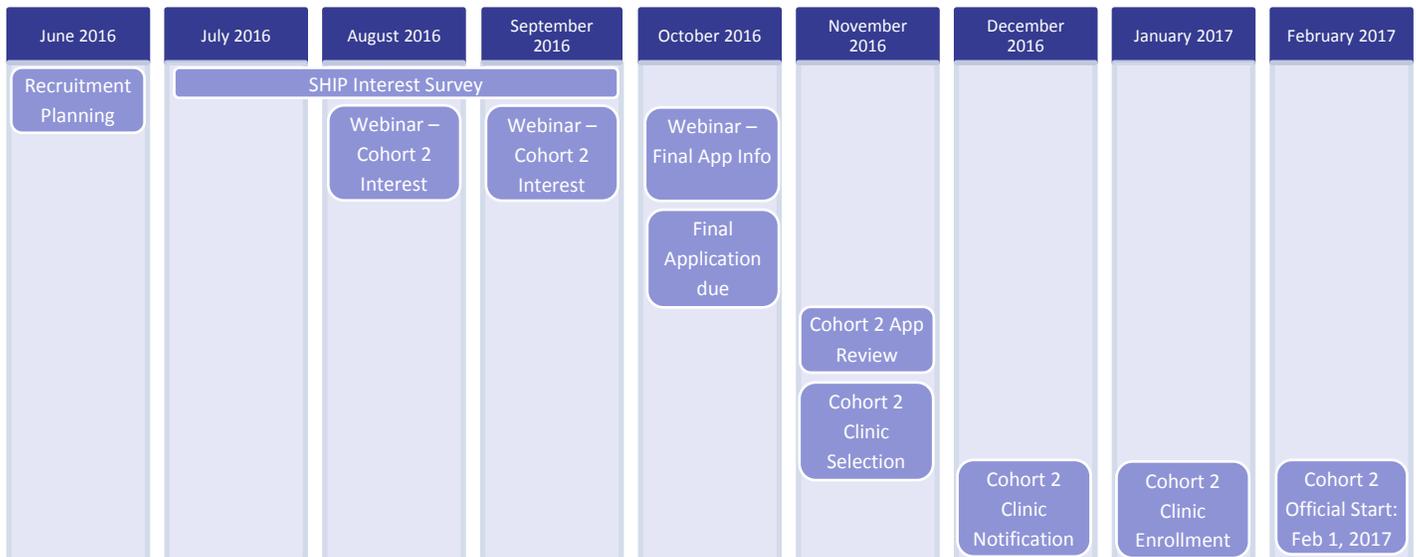
Official recruitment of clinics for Cohort 2 will begin in October 2016, followed by a final application informational webinar to be held in early October. The Final Application for Cohort 2 will be released in early October with a deadline at the end of October. Clinics will be notified of the selection results during the first week of December 2016, one week

prior to the public announcement at the IHC December 2016 meeting. The clinic enrollment process with the PCMH contractor will occur in January 2017 with Cohort 2 and the SIM Grant Model Test Year 3 to begin on February 1, 2017. See table 1 for further details.

Table 1.

	Cohort 1	Cohort 2
Date Span	2/1/16 – 1/31/17	2/1/17 – 1/31/18
No. PCPs targeted	500	450
Number of Clinics Selected	55	55
Final App Open	10/23/15	10/3/16
Final App Due	11/13/15	10/28/16
Selection Announcement to IHC	12/9/15	12/14/16

Timeline





SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition July 13, 2016

SHIP OPERATIONS:

SHIP Contracting/Request for Proposal (RFP) Status:

- **Report Items:**
 - A contract for the data analytics vendor for population health has been finalized and is awaiting release of funding from CMMI.
 - An RFQ is being amended for a Telehealth vendor to provide technical assistance and training related to the design of the SHIP Telehealth program.
 - Funding was approved for the Community Health Worker Curriculum design, pending a review of final submissions pertaining to three budget items.
 - Contracts are finalized for Public Health District Contracts Regions 1-7 for 7/1/2016-1/31/2017 and are awaiting release of funding from CMMI.
 - An amendment for the Brilljant, LLC contract has been finalized.

SHIP Administrative Reporting:

- **Report Items:**
 - Our CMMI Project Officer requested additional clarifications on risk measures which were included in the CMMI SHIP Quarterly Report submitted to CMMI in May, 2016. Those clarifications were submitted to CMMI this week. The next CMMI quarterly report will include goal metrics reporting.
 - Mercer and SHIP project management staff continue to work on refinements to the Master Project Management Plan (MPMP).
 - Mercer and SHIP staff are continuing to refine data collection protocols related to Goals 1 – 6 metric measurements to comply with CMMI reporting requirements.
 - The State Evaluator is meeting with DHW SHIP staff and attending workgroup and advisory group meetings to gather further information on each of the components of SHIP. Their evaluation plan will be provided to DHW in August, 2016. A State Evaluator Workgroup (SEW) is being formed and additional information will be reported on this workgroup in August.
 - OHPI budget planning for SFY2017 was finalized and submitted to Finance for their review and comments.
 - A budget revision was submitted to CMMI for CHEMS program and was approved by CMMI as submitted.
 - Submission of multiple requests to CMMI for release and approval for use of pre-implementation carryover funds.

Regional Collaboratives (RC):

- **Report Items:**
 - The Executive Leadership Teams from Regions 4 and 7 will be reporting their progress.
 - Success measures related to SHIP goal 3 have been revised to more closely align with the aim of the original intent. Success measures related to SHIP goal 3 have been revised to more closely align with the aim of the original intent.
 - Success Measure 1: Established/ operational RCs – reporting frequency has been changed from quarterly to yearly.

- Success Measure 2: PCMHs receiving assistance through the regional SHIP PHD program – the assistance is limited to SHIP clinics, reporting frequency has been changed from quarterly to yearly.
- Success Measure 3: PCMHs using protocols with Medical-Health Neighborhood providers - quarterly targets have been revise so that they increase gradually. No change requested to annual targets.
- Success Measure 4: Patients with coordinated health needs – This measure has been addressed in SHIP goal 1, and has been removed from goal 3.
- 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 subgrants were approved by CMMI and executed on July 1st, 2016.
- **Next Steps:**
 - Continue supporting establishment of functioning Regional Collaboratives.
 - Continue coordinating PHDs effort with other programs and entities.
 - Provide calendar of RC meetings across the State at the next IHC meeting.

ADVISORY GROUP REPORTS:



Telehealth SHIP Subcommittee:

- **Report Items:**
 - Responses to the Telehealth technical assistance and training curriculum Request for Quotation (RFQ) were over available budget. The RFQ scope was revised and resubmitted to IDHW Contracts and Procurement Services. The revised RFQ will be posted on Monday, July 11th.
 - A process and grant application for SHIP clinics to seek funding to implement Telehealth projects (procedure, documentation, scoring criteria and evaluation process) is underway.
 - On June 17th, the Idaho Telehealth Council Goal 2 Subcommittee met and received presentations by Meredith Guardino, Oregon Office of Rural Health, and Catherine Britain, Telehealth Alliance of Oregon. Participants received information about the Telehealth projects funded through Oregon's SIM grant. The presenters shared valuable insights into Telehealth implementation and lessons learned. Meredith and Catherine also spent additional time with IDHW staff for more detailed discussions about Telehealth projects funded through CMMI and ideas for developing the Idaho PCMH Telehealth application.
- **Next Steps:**
 - Develop the application process for the SHIP clinics telehealth projects.
 - Next meeting of the Idaho Telehealth Council scheduled for July 15th at 10AM. The Council meeting will include an overview summary of the subcommittee meeting and virtual PCMH brochure.



Community Health Workers:

- **Report Items:**

- IDHW staff developed an on-line application for CHW students to participate in SHIP CHW training program. The application consists of two parts: one completed by the student and the other completed by the PCMH, primary care clinic, or community organization that employs or partners with the CHW. Both parts must be submitted for the application to be complete.
- Applications will be reviewed by IDHW and approved by the following priority tiers:
 - Priority area 1: Applicants currently employed by Patient-Centered Medical Homes in SHIP Cohort #1.
 - Priority area 2: Applicants employed by Idaho Primary Care Clinics or Patient-Centered Medical Homes not currently part of SHIP Cohort #1.
 - Priority area 3: Applicants currently employed or volunteering as CHWs in other types of community organizations or settings.
- Applicants receiving approval to participate in the SHIP CHW program will register for the course at no cost.
- Data must be collected and reported quarterly by the CHW and employer to IDHW on the required measures for one year after course completion and may choose to report optional measures:
- Required Measures:
 - Total number of patients contacted by the Community Health Worker
 - Total number of unique patients served by the Community Health Worker
 - Total number of outreach or educational events provided by the Community Health Worker
- Optional Measures:
 - Number and percent of patients referred for additional services by the Community Health Worker
 - Number and percent of patients completing referrals by the Community Health Worker
 - Number and percent of patients assessed or screened by the Community Health Worker
 - No show rate (number of appointments kept/number of appointments scheduled in the clinic.)
- The training program, housed at Idaho State University, will begin August 22, 2016, and the first cohort will be limited to 25 students.
- Applications are found at:
<http://ship.idaho.gov/WorkGroups/CommunityHealthWorkers/tabid/3054/Default.aspx>
- ISU is currently interviewing instructors for the SHIP CHW course. Each course will be taught with pairs of instructors, including one CHW and one with public health/clinical experience. All instructors are required to attend in-person training by the State of Massachusetts staff next month. Idaho is adapting and adopting the State of Massachusetts CHW core curriculum.
- **Next Steps:**
 - ISU will complete the course instructor application and interview process and send the list of instructors to IDHW.
 - IDHW is developing and implementing strategies to distribute the CHW student application information.

WORKGROUP REPORTS:



Community Health EMS:

- **Report Items:**

- The CHEMS Workgroup kick-off meeting was conducted on June 22, 2016. Agenda items included an overview of project progress to date, review of metrics previously approved by IHC, and review of the charter. Meeting materials are found at: <http://ship.idaho.gov/WorkGroups/CommunityHealthEMS/tabid/3050/Default.aspx>.
- The meeting included 31 participants, with representation from EMS agencies, Community Paramedic programs, universities, Medicaid, Pacific Source, Public Health Districts, and IDHW.
- There are currently 5 EMS agencies statewide participating in the first Community Paramedic cohort and training at Idaho State University.
- The group identified the following priority activities: recruitment of the second Community Paramedic cohort, data collection and reporting process, and development of CHEMS for EMTs.
- IDHW staff, in partnership with Ada County Paramedics, conducted a technical assistance training program for EMS agency administrators from new CHEMS programs on June 22 from 8AM-1 PM. The agenda included presentations on key considerations for agencies, SHIP CHEMS metrics, and outreach opportunities and strategies.
- IDHW submitted a proposal to CMMI that will provide up to \$10,000 per CHEMS agency to support program development and implementation.
- **Next Steps:**
 - IDHW staff and Ada County Paramedics will provide a presentation to Medicaid Healthy Connections staff on July 11.
 - IDHW is creating a proposal to support the development of CHEMS program for Basic and Advanced EMTs.
 - The next workgroup meeting is scheduled for July 27, 2016. Discussion topics will include: CHEMS education for Basic and Advanced EMTs, development of recruitment strategies for cohort 2, and overview of the BSU CHEMS evaluation project.



Idaho Medical Home Collaborative:

- **Report Item:**
 - The IMHC convened on June 29th 2016. The workgroup discussed the upcoming recruitment of cohort two of SHIP.
 - The interest survey and final application for cohort two were discussed. The interest survey will be sent to Idaho primary care practice providers in late July. The final application and additional recruitment procedures for cohort two will be finalized at the next IMHC meeting.
 - Matt Wimmer provided additional information on the second phase of Healthy Connections. The Healthy Connections team is working to align clinical quality measures with SHIP and looking for input from providers on pros and cons for the different measures.
- **Next Steps:**
 - Following approval from the IHC the interest survey will be sent out to potential cohort two clinics in July.
 - The IMHC will meet again August 24th 2016 from 12:30pm to 2:30pm MTS via teleconference.

Health Information Technology:**• Report Item:**

- The HIT Workgroup met on June 16, 2016.
- Presented a document outlining the HIT scope for the SHIP project.
- Discussed the need to review the workgroup membership.
- Shared an anticipated Health IT timeline, the projected CQM reporting requirements for clinics, and the results of the Idaho Health Data Exchange (IHDE) readiness assessments.
- Presented an updated version of the CQM Lifecycle flow diagram.
- The Use Cases Subcommittee met on July 11 and 12, 2016 and identified and outlined several use cases for clinicians and state / regional users leveraging the data analytics solution.
- The Data Element Mapping Subcommittee co-chairs presented to the Clinical Quality Measures (CQM) Workgroup on June 29, 2016 and discussed Year 2 & 3 measures.

• Next Steps:

- The next HIT Workgroup meeting is scheduled for July 21, 2016.
- The Workgroup will need to provide input on the Cohort 2 application process.
- The Workgroup leadership will conduct the committee membership review.
- The Data Element Mapping Subcommittee is scheduled to meet on July 28, 2016 and will discuss Year 2 & 3 measures.
- The Data Element Mapping Subcommittee leadership will present recommendations at the August CQM Workgroup meeting.
- The data analytics dashboard use cases will be finalized following the Use Case Committee meetings held in early July.

Multi-Payer:**• Report Item:**

- SHIP Administrator is working with the MPW co-chairs to develop an agenda for the next MPW meeting to be held in August.
- Mercer provided the actuarially certified Financial Plan for Idaho's integrated multi-payer PCMH model to the SHIP Administrator on May 27, 2016. The Financial Plan was distributed to the Payers in June and will be made available to the IHC members at the July 13, 2016 meeting.

• Next Steps:

- A draft value based payment framework for Idaho to gain clarity into the different payment methodologies that exist in the Idaho marketplace for primary care and the creation of a common language for primary care providers and payers to communicate about contracting methodologies has been developed. The SHIP Administrator, Deputy Director and IHC Chair will meet with individual payers to discuss this proposed draft. Meetings are anticipated to take place in July and August.

Clinical/Quality Measures Quality Measures Workgroup:

- **Report Item:**

- The CQM Workgroup met on June 29, 2016 to consider recommendations from the HIT Workgroup
 - Discussed follow-up items from previous meeting, including the ability for HealthTech, our data analytics contractor, to provide analytic visualizations for components of composite measures (tobacco screening and cessation counseling) as well as the ability to sort the reports by age, gender, race, ethnicity, etc.
 - Discussed the minimal impact of the proposed MACRA/MIPS Rule for our Year 1 measures.
 - Discussed the CMS versions of three of the measures in the SHIP CQM catalog – Adult Depression Screening, Childhood Immunization Status and Non-Malignant Opioid Use.
 - Discussed the remaining measures for years 2 and 3.
 - Recommended substituting the Elective Delivery and Low Birth Weight Rate measures for alternative measures.

- **Next Steps:**

- The CQM Workgroup plans to meet again in August.
- Consider the Behavioral Health Integration (BHI) Workgroup recommendations for alternatives to the Adherence to Antipsychotic Medications measure.
- Consider whether to align with the CMS or the National Immunization Survey (NIS) immunization measure.
- Consider additional HIT Workgroup recommendations for alternatives to non-malignant opioid measure.
- Consider the HIT Workgroup recommendations for substitute measures for the Elective Delivery and Low Birth Weight Rate measures.
- Discuss the remaining years 2 and 3 measures to learn about potential alignment with national HEDIS measures and learn about any potential alternatives.

Behavioral Health:

- **Report Item:**

- The workgroup met Tuesday June 6th 2016.
- They worked on identifying additional Behavioral Health Clinical Quality Measures. Burke Jensen indicated that the new measure that is to be selected will not be implemented for another year. It was agreed that this would be a topic of further discussion for the next meeting in August.
- Dr. Kirsten Williams gave a presentation on Telehealth Initiatives at Saint Alphonsus'. It started about 2 years ago with \$200,000 in grant funding. St. Al's recognized that there was limited psychiatric access. Service locations included PCMH sites at St. Al's on Eagle, McMillian and Overland via Telehealth location suite on Emerald.
- Update on Regional Behavioral Health Boards and Regional Collaborative partnership discussions. Rachel Blanton described that the District 3 Regional Collaborative is focusing on three primary initiatives regarding Behavioral Health Integration. Gina Pannell discussed that

she has also been attending the Region 4 Behavioral Health Board meetings and hopes to facilitate better communication and relationships in much the same way as Rachel. Gina has been working to develop a questionnaire to the PCMH clinics regarding their Behavioral Health Integration interests and needs.

- Discussion of the Behaviorist Peer to Peer Consultation model, now called the Idaho Integrated Behavioral Health Network. Jen Yturriondobeitia shared the IIBHN charter that supports the development of a professional learning collaborative to enhance and support the growth of Integrated Behavioral Health. The IIBHN will focus on professional development, networking and support, as well as provide clinical training opportunities.
- NASHP will provide additional TA training targeted to PHD staff and members of the 7 Regional Collaboratives. Four training topics have been identified to include enhancing communications between PCMH and specialty providers, general behavioral health integration concepts, clinical applications and funding mechanisms. Training is scheduled for Friday, July 29th.

- **Next steps:**

- The next BHI Sub-Committee meeting will be held on Tuesday, August 9, 2016 @ 9:00-11:00 am at the DHW Office 1720 Westgate Drive, Suite A, room 131.



Population Health:

- **Report Item:**

- The Population Health Workgroup did not meet the month of July.

- **Next Steps:**

- The next meeting of the PHWG is August 3.
- No actions items are required of the IHC.

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN FINANCIAL ANALYSIS

IDAHO DEPARTMENT OF
HEALTH AND WELFARE

MAY 27, 2016

Government Human Services Consulting

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1

Introduction

Idaho's Statewide Healthcare Innovation Plan (SHIP) is designed to lower the overall cost of healthcare for Idahoans by transforming the way healthcare is delivered. The SHIP is designed to transform payments for healthcare from volume-based payments to payments based on outcomes coinciding with the implementation of the patient-centered medical home (PCMH) model of care. The PCMH model has been described by policymakers and clinicians across the country as a cornerstone of health system transformation. Evidence of improved patient care, health outcomes, and savings from implementing PCMH models has been demonstrated across the country¹.

Target Populations and Stakeholders

Idaho's SHIP is designed to lower the overall cost of care for Idahoans, thus generating savings for the healthcare system. To determine these savings, the model classified Idaho's population by these three payer types: Medicaid, Medicare, and commercial insurance. Medicaid was further divided into dual eligible² recipients, non-dual aged/disabled recipients, children, and adults that did not fall into any other category. Commercial insurance participants were classified by the number of people on their policy: individual or family. Medicare participants were classified into dual eligibles, fee-for-service (FFS) non-duals, and non-duals with Medicare Advantage coverage (also known as Medicare Part C). These classifications were consistent with the Model Test Grant Application. A summary of base year costs can be seen below in Table 1: Populations Reported and Health Care Costs as PMPM and Total Costs.

Medicaid

Children represent 73% of Medicaid recipients in Idaho, but children represent only about 32% of the annual Medicaid expenses, or \$217.92 per member per month (PMPM) in Year 0, the base experience period. An area of particularly high costs for children is the neonatal intensive care unit (NICU) for premature and ill newborns. At an annual cost trend of 5.0% the cost of providing care to children would, without intervention, increase to \$252.29 PMPM for Year 3 of SHIP Model Test.

The highest per-person cost population among Medicaid recipients is the non-dual aged/disabled population, who typically has chronic medical conditions. Their Year 0 cost of

¹ Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012. Nielsen, Langner, Zema et al. Patient-Centered Primary Care Collaborative)

² Dual eligibles are persons with both Medicare and Medicaid coverage. Medicaid provides coverage for the cost – sharing (deductibles and coinsurance) in the Medicare benefits, as well as benefits for services not covered by Medicare, such as custodial care in nursing homes, home and community-based long-term care, and non-emergency transportation.

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\$2,293.50 PMPM is projected to grow, without intervention, at an annual rate of 4.9%, reaching \$2,648.90 PMPM in Year 3 of the Model Test.

Table 1: Populations Reported and Health Care Costs as PMPM and Total Costs

Participants	Member Months	Year 0 Total Cost	Year 0 Cost * PMPM	Without Intervention	
				Projected Year 3 Cost PMPM	Annual Rate of Increase
Medicaid		\$1.6 billion			
Children**	2,335,974	32%	\$217.92	\$252.29	5.0%
Dual Eligible	292,160	25%	\$1,378.07	\$1,572.83	4.5%
Aged/Disabled (non-dual)	198,027	28%	\$2,293.50	\$2,648.90	4.9%
Other Adult	373,261	15%	\$644.45	\$751.86	5.3%
Commercial		\$2.6 billion			
Individual	1,222,091	22%	\$472.11	\$550.72	5.3%
Family	4,560,579	78%	\$438.23	\$512.20	5.3%
Medicare		\$0.8 billion			
Dual Eligible	26,233	7%	\$2,247.63	\$2,743.74	6.9%
FFS	511,552	35%	\$576.59	\$678.90	5.6%
Medicare Advantage (Part C)	624,663	58%	\$780.38	\$931.84	6.1%

* Year 0 calendar year 2015; ** Non-Dual, Not Disabled.

The dual eligible population, which cost \$1,378.07 PMPM in Year 0, was projected to grow, without intervention, at an annual rate of 4.5%, reaching \$1,572.83 PMPM in Year 3. These groups utilize emergency department (ED) services at a higher rate than the average population and have a higher rate of hospital admissions and high-end diagnostic services. Other cost drivers for the Medicaid population in general include behavioral health drugs. Roughly one-third of the total costs of Medicaid pharmaceutical drugs are spent on behavioral health drugs.

The remaining adult Medicaid population has a Year 0 cost of \$644.45 PMPM, which is projected to grow, without intervention, at an annual rate of 4.7%, reaching \$751.86 PMPM in Year 3 of the Model Test.

Commercial Insurance

Commercial insurance costs are driven by specialty care, high-cost prescription drugs, radiology and laboratory services, outpatient care (including surgeries and ED), and inpatient maternity. Trends for both individual and family plans ran between 5.2% and 5.4% due to high ED usage, as well as high-cost diagnostics. Without intervention, individual costs are projected to grow from \$472.11 PMPM in Year 0 to \$550.72 PMPM in Year 3 and family costs from \$438.23 to \$512.20 PMPM over the same time period. The annual rate for both is 5.3%.

Medicare

Cost increases for both FFS Medicare and Medicare Advantage members are being driven by prescription drugs, home health, and inpatient hospital costs. (The available data did not have ED costs as a separate category.) Dual eligibles have a Medicare cost of \$2,247.63 PMPM in Year 0. Without intervention it is projected to grow at a 6.9% annual trend to \$2,743.74 PMPM in Year 3. FFS members have a Medicare cost of \$576.59 PMPM in Year 0, growing, without intervention, at a slightly lower annual trend rate of 5.6% to \$678.90 PMPM in Year 3. Medicare Advantage members have a cost of \$780.38 PMPM in Year 0, growing, without intervention, at an annual rate of 6.1% to \$931.84 PMPM in Year 3.

Interventions for Reducing Costs

Recent data published from the Patient-Centered Primary Care Collaborative supports the assumptions of lower ED usage, lower inpatient admissions, fewer inpatient readmissions, and increased usage of generic pharmaceuticals³. Access to PCMHs reduces ambulatory care sensitive hospital admissions and avoidable ED visits. Studies show that introducing intensive outpatient care programs (IOCP) reduced per capita spending by 20%⁴, and IMPACT⁵ treatment of depression resulted in per capita spending drop by an estimated 20%, primarily due to lower spending for ED visits and hospitalizations⁶. Coordination of care and transition management by PCMHs reduces duplicative care and decreases hospital readmission rates. In a study done for the U.S. Department of Health and Human Services, simplified hospital discharge instructions given to patients in order to help them transition from the hospital to their homes led to a 30% reduction in hospitalization readmission rates⁷. An increase in the generic prescription drug fill

³ Nielsen, Marci PhD; et al. Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of COST & QUALITY RESULTS, 2012

⁴ Schilling, Brian; Boeing's Nurse Case Managers Cut Per Capita Costs by 20 Percent; Purchasing High Performance, March 25, 2011.

⁵ IMPACT is an evidence-based depression care program developed by the University of Washington. Most IMPACT materials, training, consultation and other assistance to adapt and implement IMPACT are offered free thanks to the generous support of the John A. Hartford Foundation.

⁶ Gilbody S, Bower P, Fletcher J, et al. Collaborative Care for Depression: A Cumulative Meta-analysis and Review of Longer-term Outcomes. Arch Intern Med. 2006;166:2314-2321

⁷ Koh HK1, Berwick DM, Clancy CM, Baur C, Brach C, Harris LM, Zerhusen EG.; Health Aff (Millwood). 2012 Feb;31(2):434-43. doi: 10.1377/hlthaff.2011.1169. Epub 2012 Jan 18. New federal policy initiatives to boost health literacy can help the nation move beyond the cycle of costly 'crisis care'.

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rate is also expected from an emphasis on primary care doctors prescribing generic pharmaceuticals. Studies in New Jersey and Washington both showed decreases in expense through a concerted effort to find generic equivalents by primary care doctors⁸. Specific to Medicaid, an effort to increase participation in prenatal programs to reduce preterm births and early elective deliveries is expected to reduce avoidable NICU usage as described above.

Additionally, the payers in Idaho have agreed to implement payment strategies that are alternatives to traditional FFS for primary care physicians (PCPs). Alternative payment strategies, such as incentive payments tied to performance measure improvement, are expected to reduce escalating medical costs by rewarding high quality over volume of care, while also expanding access to care. The participating payers in Idaho will work with specialists (such as orthopedists, cardiologists, oncologists, and radiologists) to implement evidence-based practice guidelines. Increasing accountability through adherence to quality of care guidelines is key to overall trend reductions.

The PCMH model is for all of Idaho's 1.6 million people. The implementation of the model, however, is a phased approach, as the population will be served by PCMHs in varying stages by payer. Beneficiaries at the end of the model test are expected to reach at least 825,000. Medicaid recipients and FFS Medicare beneficiaries are expected to engage quickly, but commercial beneficiaries will phase in based on acuity and location. Better managed care tools and cost containment for high-cost cases will drive cost savings early in the Model Test. However, through preventive activities focusing on socioeconomic and behavioral determinants of health, the PCMH model will also reduce downstream healthcare (such as, reducing the smoking rate in the population) in the future.

⁸ Nielsen; p.8, p. 13, p. 27, p. 29

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Table 2: Cost Targets, Milestones, and Savings for Public/Private Populations Combined

Issue	Year 3 Targets	Mechanism	Savings Assumptions
Early Deliveries (in weeks 37–39 of gestation)	5% reduction in expenses related to elective and non-elective preterm birth, prior to 39 weeks	1%–4% of total NICU admissions (\$40-\$70K/admit) are preventable with later deliveries	0.56% reduction in Inpatient Hospital utilization for Medicaid child per year
Appropriate Generic Drug Use	Generic fill rate of 85%	Each 1% improvement in generic fill rates reduces total pharmacy spend (0.5%-1.0% Medicaid, 0.5%-1.0% Commercial)	0.17% reduction in prescription unit costs for Medicaid and Commercial per year over 3 years
Hospital Readmissions	5%–10% reduction	20% of all hospitalizations are preventable re-hospitalizations	0.5% reduction in Inpatient Hospital utilization for Medicare and Medicaid, 0.33% reduction for Commercial
Acute Care Hospitalizations	1%–5% reduction	PCMHs reduce with IMPACT & IOCP training	0.5% reduction in Inpatient and Outpatient Hospital unit cost for Medicare and Medicaid, 0.25% reduction for Commercial
Non-Emergent ED use	5%–10% reduction in total ED use	10%–30% of ED visits are non-emergent.	1.0% reduction in ED utilization for all payers
General Primary-Care Savings	Reduction in utilization	Savings typical when moving to a care management setting	0.5% reduction for Medicare and Medicaid for Specialists, PT/OT, & Radiology; 0.25% in DME for Medicaid Duals, 0.25% for Medicare Duals

Financial Analysis Methodology

The payers were surveyed using the category of service classifications and definitions included in Appendix A. A comparison model of care was built using medical expense data supplied by the Idaho Department of Health and Welfare (IDHW) for 2013 and 2014 incurred expenses, from the Center for Medicare and Medicaid Service (CMS) for 2012 and 2013 incurred expenses, from three of the four largest commercial payers for 2014, and from Mercer's (Idaho's project management consultant) proprietary commercial claims database. Mercer also used commercial payers' public filings, as available from 2013 and 2014. The costs were trended forward using trend rates based on the U.S. Consumer Price Index (CPI) for medical care services to align reporting periods, yielding a baseline for comparison of calendar year 2015 as Year 0. Trend assumptions for each Model Test year for Medicare and Medicaid were derived from the National Health Expenditure projections from the CMS Office of the Actuary. Trend assumptions

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for commercial data for the same periods were derived from Mercer's proprietary commercial claims database. Although the Model Test years begin on February 1 and end on January 31, calendar year projections were not adjusted for the lagging month.

Table 3: PMPM Comparison of Costs by Payer After Intervention

Participants	Without Intervention			With Intervention	
	Year 0* PMPM	Annual Increase	Estimated Year 3 PMPM	Annual Increase	Estimated Year 3 PMPM
Medicaid:					
Children**	\$217.92	5.0%	\$252.29	4.5%	\$249.05
Dual Eligible	\$1,378.07	4.5%	\$1,572.83	4.5%	\$1,570.56
Aged/Disabled (Non-Dual)	\$2,293.50	4.9%	\$2,648.90	4.6%	\$2,625.11
Other Adult	\$644.45	5.3%	\$751.86	4.7%	\$739.46
Commercial:					
Individual	\$472.11	5.3%	\$550.72	5.1%	\$547.46
Family	\$438.23	5.3%	\$512.20	5.1%	\$509.41
Medicare:					
Dual Eligible	\$2,247.63	6.9%	\$2,743.74	6.7%	\$2,727.03
Fee-For-Service	\$576.59	5.6%	\$678.90	5.1%	\$668.59
Medicare Advantage	\$780.38	6.1%	\$931.84	5.7%	\$921.52

* Year 0 calendar year 2015; ** Non-Dual, Not Disabled.

Savings assumptions based on the interventions described above and calculations using data obtained from initiatives in other states and other public sources were used to estimate reductions in trend for the six areas determined to have high potential savings for Idaho as shown in Table 2. The baseline data was then projected, taking into account those savings assumptions and offset by increased costs due to expected increased utilization of PCPs. The resulting data was then compared to the baseline data to estimate cost savings over the three-year period (gain from investment).

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Table 4: Assumed Cost-Savings Over Three Years by Payer

Savings Category	Medicaid	Commercial	Medicare	Total
Generic Rx Usage	\$1,811,240	\$3,623,890	\$0	\$ 5,435,131
Re-Hospitalizations	\$10,096,525	\$12,946,745	\$8,130,252	\$ 31,173,522
Acute Care Hospitalizations	\$14,756,959	\$19,162,488	\$13,561,266	\$ 47,480,713
Non-Emergent ED Usage	\$3,810,148	\$4,708,511	\$656,227	\$ 9,174,886
Early Delivery	\$4,593,497	\$0	\$0	\$ 4,593,497
General Primary Care Savings	\$5,876,725	\$0	\$2,694,887	\$ 8,571,613
PCMH Operational Payment	(\$6,822,432)	(\$8,446,961)	(\$1,503,962)	\$(16,773,355)
Net Savings	\$34,122,662	\$31,994,674	\$23,538,670	\$ 89,656,006

Total Expected Cost Savings and Return on Investment

Return on Investment (ROI) was calculated using the following formula:

$$\text{ROI} = \frac{(\text{Gain from Investment} - \text{Cost of Investment})}{\text{Cost of Investment}}$$

Cost of investment was identified as the \$40 million model testing grant IDHW received from the Center for Medicare & Medicare Innovation. Over the three-year testing period, the Model is expected to result in projected total savings of \$89.6 million, after factoring in payments to primary care providers to coordinate care and adhere to the PCMH model. Net savings are \$34.1 million for Medicaid, \$32.0 million for commercial payers, and \$23.5 million for Medicare. Projected ROI for Medicare and Medicaid populations is 44% for the three years. The projected ROI for all populations combined is 124% for three years.

2

Actuarial Certification of the Financial Plan for Idaho’s Integrated Multi-Payer PCMH Model

Applicants for the State Innovation Model grants are required to obtain and submit an external actuarial certification with their application. The undersigned actuary is a member of the American Academy of Actuaries (MAAA) and is qualified to render this certification.

By certifying a financial plan, the actuary attests to the following:

- The data, assumptions, and projected savings outlined in the financial plan are consistent and reasonable.
- The financial plan was reviewed in compliance with the current standards of practice, as promulgated by the Actuarial Standards Board of the American Academy of Actuaries, and that the plan complies with the current Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board.
- The actuarial work supporting the applicant complies with applicable laws, rules, applicant instructions, and current CMS guidance.

Name:	F. Kevin Russell
Designation (ASA, FSA):	FSA, MAAA
Organization:	Mercer Health & Benefits
Address/City/State/Zip:	2325 E. Camelback Road, Suite 600 Phoenix, AZ 85016
Email:	kevin.russell@mercercor.com
Certification (Y/N):	Yes
Signature:	
Date:	May 27, 2016
Potential Risks or Concerns:	Savings estimates were developed from published studies and other sources. Published sources generally provide a range of potential savings. The savings percentages used in the model have been taken from the middle of the range of potential savings and are, therefore, conservative compared to the highest potential levels of saving. However, actual achievement of savings requires changing of current medical treatment practices, so it is not certain.

All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

3

Appendix A: Data Request

Data Request Template Sent to Payers on July 17, 2015

Dear Multi-payer workgroup participants,

Thank you for the opportunity to speak with you on July 8th. As we discussed, CMMI requires reports to monitor financial progress for the grant Idaho received. We finalized the financial data request needed to start the reporting process, for which the first step is to rebase the cost-savings assumptions with current data, preferably 2014 data or later for **allowed** costs. Please review the attached spreadsheet and let me know if you have any concerns providing the requested data. Costs should be aggregated based on the category of service logic provided, but split by the category of aid or contract type listed in row 4 of the Report Template tab.

I've also attached the standard Mercer Client Confidentiality Agreement for review by you and your legal teams to ensure your data is protected and kept private. Reporting to CMMI will be done in aggregate such that no individual payer data will be discernable.

Please review both documents and let me know if you have any concerns about either document by **August 5th**. If not, we'd like to start receiving data on **September 8th**. If you're unable to meet that date, please let me know when you think you can get the template completed. I appreciate your participation in the SHIP and would like to make the reporting process as simple as possible.

Thank you!

Scott Banken, CPA

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	Medicaid/CHIP				Private/Other		Medicare		
	Adult	Child	Dual Eligibles (Only)	Disabled/Elderly (Without Duals)	Individual	Family	Dual Eligible	Fee for Service/Non-Duals (Parts A and B)	Medicare Advantage Part C
Member Months									
Inpatient Hospital	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Emergency Dept	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Urgent Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Outpatient Hospital	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Primary Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Specialty Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Diagnostic Imaging/X-Ray	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Laboratory Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DME	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Dialysis Procedures	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Other (e.g., PT, OT)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Skilled Nursing Facility	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Home Health	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Custodial Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ICF/MR	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Home and Community-Based Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Behavioral Health	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Prescription Drugs (Outpatient)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

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Category of Service Logic

Use the following logic in order to classify claims and expenses.

Emergency Dept.

837I or UB04: Revenue codes 0450, 0451, 0452, 0459, 0981
837P or CMS1500: Procedure codes 99281-99285, G0380-G0384,
G0390

Urgent Care

837I or UB04: Revenue code 0456
837P or CMS1500: Procedure codes S9083, S9088 and/or Place of
Service code = 20

Dialysis

837I or UB04: Revenue codes 082x-088x
837P or CMS1500: Place of Service = 65 or Rendering Provider Type
= ESRD Treatment or Dialysis Facility

Inpatient Hospital

837I or UB04
Bill Type: 011x or 012x
BH is to be split out into the BH bucket by revenue codes: 0114,
0116, 0124, 0126, 0134, 0136, 0144, 0146, 0154, 0156, 0204,

Outpatient Hospital (excludes ER)

837I or UB04
Bill Type: 013x or 083x

SNF

837I or UB04: Bill Type 02xx

Professional Primary Care

837P or CMS1500: Rendering Provider Type: Family Practice,
General Practice, Internal Medicine, Pediatrics, Preventive Medicine,
Geriatrics

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2161CP.pdf>

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Professional Specialty Care

837P or CMS1500: Rendering Provider Type: Allergy&Immunology, Anesthesia, Dermatology, Emergency Medicine, Surgery, OBGYN, Ophthalmology, Orthopedics, Otolaryngology, Pathology

<http://cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/taxonomy.pdf>
Specialists are Allopathic and/or Osteopathic physicians with specialties in the attached list OTHER than the primary care specialties. Only CMS Specialty Codes 01 - 99 are to be included.

Professional Other

837P or CMS1500: Rendering Provider Type: All other specialties that do not fall into Primary Care or Specialty Care.

Diagnostic Imaging/X-Ray

837P or CMS1500: Procedure Codes 70000-79999

Lab Services

837P or CMS1500: Procedure Codes 80000-89999

DME

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html>

DME15-C is the more current file, but probably would not match data as well. File will need to be filtered to Idaho only data.

HH

837I or UB04: Bill Type 03xx or Revenue codes 0550, 0551, 0559, 057x, 0989

837P or CMS1500 Procedure Codes:T0221, S5180, S5181, S9122-S9125, T1019-T1022, G0160-G0161,
POS = 05 or Provider Type = Home Health Agency

Custodial Care

837P or CMS1500: POS = 13, 14, 32, or 33
or Procedure Code: 99324-99339

ICF/MR

837I or UB04: Bill Type 065x or 066x and
Diagnosis codes 317.x-319.x for MR

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BH

837P or CMS1500: Primary diagnosis codes 290-319 (excluding ICF claims)

837I or UB04: Inpatient BH revenue codes: 0114, 0116, 0124, 0126, 0134, 0136, 0144, 0146, 0154, 0156, 0204,

HCBS HCBS Services from Waiver Application:

Residential Habilitation
Respite
Supported Employment
Community Support Services
Financial Management Services
Support Broker Services
Adult Day Health
Behavior Consultation/Crisis Management
Chore Services
Environmental Accessibility Adaptations
Home Delivered Meals
Non-Medical Transportation
Personal Emergency Response System
Skilled Nursing
Specialized Medical Equipment and Supplies

Prescription Drugs

NCPDP or presence of NDC code.

Other

All other claims that don't fall into the above COS.



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