



# Idaho Healthcare Coalition

## Meeting Agenda

Wednesday, September 13, 2017 1:30PM – 4:30PM

JRW Building (Hall of Mirrors)  
First Floor, East Conference Room  
700 W State Street, Boise, Idaho

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

**Attendee URL:** <https://rap.dhw.idaho.gov/meeting/40253779/827ccb0eea8a706c4c34a16891f84e7b>

**Attendee Smartphone URL:**

<pulsesecure://?method=meeting&action=join&host=rap.dhw.idaho.gov&meetingid=40253779&signin=rap.dhw.idaho.gov%2Fmeeting%2F&stoken=827ccb0eea8a706c4c34a16891f84e7b>

**Password:** 12345

1:30 p.m.	Opening remarks; roll call; introduce any new members, guests, any new IDHW staff; agenda review; and approval of 8/9/2017 meeting notes – <i>Lisa Hettinger, IHC Co-Chair</i> <b>ACTION ITEM(S)</b>
1:45 pm	CMMI Site Visit Debrief – <i>Cynthia York, SHIP Administrator</i>
1:55 pm	SHIP Idaho Financial Report – <i>Scott Banken, Senior Associate, Mercer</i> <b>ACTION ITEM</b>
2:20 pm	Goal 6 Charter, Multi-Payer Workgroup Charter and Dashboard updates – <i>Katie Falls, Principle, Mercer</i> <b>ACTION ITEM(S)</b>
2:40 pm	MACRA/MIPS Update – <i>Linda Rowe, Idaho State Director, and Deanna Graham, Quality Improvement Consultant, Qualis Health</i>
3:00 pm	Break
3:15 pm	State Evaluator Report – <i>Janet Reis, PhD, Principle Investigator, Boise State University</i>
3:35 pm	IHDE Update – <i>Brad Erickson, Executive Director, Idaho Health Data Exchange</i>
3:50 pm	PCMH Mentorship Update – <i>Kym Schreiber, SHIP PCMH Project Manager</i>
4:00p.m.	SHIP Operations and Advisory Group reports/ Updates – Please see written report (SHIP Operations and IHC Workgroup reports): <ul style="list-style-type: none"><li>• Presentations, Staffing, Contracts, and RFPs status – <i>Cynthia York, IDHW</i></li><li>• Regional Collaboratives Update – <i>Madeline Russell, IDHW</i></li><li>• Telehealth, Community EMS, Community Health Workers – <i>Madeline Russell, IDHW</i></li><li>• Data Governance Workgroup – <i>Dr. Andrew Baron, Terry Reilly and Janica Hardin, Saint Alphonsus, Workgroup Chairs</i></li><li>• Multi-Payer Workgroup – <i>Dr. David Peterman, Primary Health and Norm Varin, PacificSource, Workgroup Chairs</i></li><li>• Behavioral Health/Primary Care Integration Workgroup – <i>Ross Edmunds, IDHW and Dr. Charles Novak, MD, Workgroup Co-Chairs</i></li><li>• Population Health Workgroup – <i>Elke Shaw-Tulloch, IDHW and Carol Moehrle, Public Health Idaho North Central District, Workgroup Chairs</i></li><li>• IMHC Workgroup – <i>Dr. Scott Dunn, Family Health Center and Matt Wimmer, IDHW Workgroup Chairs</i></li></ul>
4:15 p.m.	Additional business & next steps – <i>Lisa Hettinger, IHC Co-Chair</i>
4:30 p.m.	Adjourn

## Mission and Vision

The goal of the SHIP is to redesign Idaho's healthcare system, evolving from a fee-for-service, volume based system to a value based system of care that rewards improved health outcomes.

**Goal 1:** Transform primary care practices across the state into patient-centered medical homes (PCMHs).

**Goal 2:** Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood.

**Goal 3:** Establish seven Regional Collaboratives to support the integration of each PCMH with the broader medical neighborhood.

**Goal 4:** Improve rural patient access to PCMHs by developing virtual PCMHs.

**Goal 5:** Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level and statewide.

**Goal 6:** Align payment mechanisms across payers to transform payment methodology from volume to value.

**Goal 7:** Reduce overall healthcare costs



# Idaho Healthcare Coalition (IHC) September 13, 2017 Action Items

- Action Item 1 – Minutes

IHC members will be asked to adopt the minutes from the August 2017 IHC meeting:

Motion: I, \_\_\_\_\_ move to accept the minutes of the August 09, 2017, Idaho Healthcare Coalition (IHC) meeting as prepared.

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

Motion Carried.

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- Action Item 2 – IHC Membership

IHC members will be asked to recommend that the governor appoint Norm Varin to the IHC representing the Multi-Payer Workgroup.

Motion: I, \_\_\_\_\_ move to recommend the governor appoint Norm Varin to the IHC.

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

Motion Carried.

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- Action Item 3 – SHIP Idaho Financial Report

IHC members will be asked to accept the SHIP Financial Analysis Assessment as presented by Scott Banken with Mercer.

Motion: I, \_\_\_\_\_ move to accept SHIP Financial Analysis Assessment as presented.

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

Motion Carried.

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■ Action Item 4 – Goal 6 Charter Update

IHC members will be asked to accept the Goal 6 Charter as presented to the IHC:

Motion: I, \_\_\_\_\_ move to accept the Goal 6 Charter as presented.

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

Motion Carried.

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■ Action Item 5 – Multi-Payer Workgroup Charter Update

IHC members will be asked to accept the Multi-Payer Workgroup Charter update as presented.

Motion: I, \_\_\_\_\_ move to accept the Multi-Payer Workgroup Charter update as presented.

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

Motion Carried.

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# Idaho Healthcare Coalition

## Meeting Minutes:

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**SUBJECT:** IHC August Minutes

**ATTENDEES:** Director Russ Barron, Josh Bishop, Pam Catt-Oliason, Dr. Keith Davis, Gina Westcott on behalf of Ross Edmunds, Dr. Ted Epperly, Janica Hardin, Yvonne Ketchum, Deena LaJoie, Dr. James Lederer, Amy Mart, Tammy Perkins, Susie Pouliot, Dr. Kevin Rich, Dr. Rhonda Robinson-Beale, Elke Shaw-Tulloch, Mary Sheridan, Karen Vauk, Matt Wimmer, Cynthia York, Nikole Zogg

**Teleconference:** Michelle Anderson, Dr. Andrew Baron, Kathy Brashear, Alison Palmer on behalf of Maggie Mann, Casey Meza, Carol Moehrle, Neva Santos, Lora Whalen, Jennifer Wheeler

**Members**  
**Absent:** Dr. Richard Bell, Melissa Christian, Russell Duke, Dr. Scott Dunn, Senator Lee Heider, Lisa Hettinger, Dr. Mark Horrocks, Dr. Glenn Jefferson, Nicole McKay, Daniel Ordyna, Dr. David Pate, Dr. David Peterman, Geri Rackow, Dr. Boyd Southwick, Larry Tisdale, Representative Fred Wood

**IDHW Staff**  
Rachel Blanton, Jeff Crouch, Melissa Dilley, Ariel Foster, James Hague, McKenzie Hansen, Burke Jensen, Taylor Kaserman, Alexis Macorvitz, Rob Moriarty, Casey Moyer, Madeline Russell, Stephanie Sayegh, Kym Schreiber, Joey Vasquez, Ann Watkins, Michelle Watson, Gina Westcott

**Guests:** Sarah Baker, Dr. Stephen Cha, Joe Christensen, Chris Crider, Katie Falls, Jayne Josephson, Elwood Kleaver, Janice Lung, Patricia MacTaggart, Kate Perkins, Madeline Priest, Janet Reis, Linda Rowe, Dr. John Schott, Dr. Jeff Seegmiller, Jeanene Smith, Chelsea Stevenson, Senator Thayn, Norm Varin, Molly Volk, Dr. Richard Whitten, Dr. Shenghan Xu

**STATUS:** Draft (08/15/2017)

**DATE:** August 09, 2017

**LOCATION:** 700 W State Street, 1<sup>st</sup> Floor East Conference Room

## Summary of Motions/Decisions:

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<b>Motion:</b>	<b>Outcome:</b>
Mary Sheridan moved to accept the minutes of the July 12, 2017, Idaho Healthcare Coalition (IHC) meeting as prepared. Dr. Kevin Rich seconded the motion.	PASSED
Elke Shaw-Tulloch moved to accept the Data Governance Workgroup Charter as presented. Yvonne Ketchum seconded the motion.	PASSED
Dr. Keith Davis moved to support the Cohort Three recruitment plan as presented. Susie Pouliot seconded the motion.	PASSED
Yvonne Ketchum moved to support the Cohort Three final application as presented. Mary Sheridan seconded the motion.	PASSED
Elke Shaw-Tulloch moved to support the adjustment of the telehealth success measure metric target and inclusion of Project ECHO in the Goal 4 scope. Gina Westcott seconded the motion.	PASSED

## Agenda Topics:

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### **Opening remarks, Introductions, Agenda review, Approve minutes – Dr. Ted Epperly, IHC Chair**

- ◆ Dr. Epperly welcomed everyone to the meeting and introduced guests from CMMI, Dr. Stephen Cha, Chris Crider, and Patricia MacTaggart. Following the introduction of guests and the approval of the July meeting minutes Dr. Epperly started the meeting with a quote, "Alone we can do so little, together we can do so much." - Hellen Keller.

### **CMMI SIM Model Test Update - Dr. Stephen Cha, Director, State Innovations Group and Chris Crider, SIM Project Officer**

- ◆ Dr. Stephen Cha thanked the IHC for inviting the CMMI team to their meeting. He thanked Dr. Davis for hosting the team at his Shoshone Clinic this morning.
- ◆ CMMI is excited about the work being done in Idaho. State stakeholders are the key to improving healthcare outcomes that align across state lines and are meaningful for providers. Dr. Cha mentioned some critical points regarding SIM Model Test updates: at the federal level all business is proceeding as usual even with the director of Health and Human Services resigning at the end of September; there is still strong support for states to be transformative agents in healthcare; and Idaho is continuously recognized as being a best practice state for the SIM model.
- ◆ The next steps CMMI would like to see Idaho work toward are a sustainability plan and a connection to what is going on now and what will be done next.
- ◆ Chris Crider also thanked the Idaho SHIP team and the members of the IHC for hosting CMMI and engaging with. Patricia MacTaggart commented that every time she has visited Idaho and the SHIP team she learns something new to take back to other states. Ms. MacTaggart also offered that anything the Idaho SHIP team needs that the federal and technical assistance partners are there to help.
- ◆ Following their update Dr. Cha, Chris Crider, and Patricia MacTaggart answered questions from IHC members regarding what other states are doing and what can be learned from them. There is a lot of information distributed by the Center for Health Care Strategies (CHCS) on how other SIM states are tackling various issues in their SIM models. The Research Triangle Institute also has published their first report on round one SIM model states; their next report should be available soon.

- ◆ Dr. Epperly thanked the CMMI team for attending the IHC meeting. He also commented on how thankful he is for Governor Otter for believing in healthcare transformation in Idaho and helping make important strides. “The states are the laboratories for our nation.” - Ben Franklin

**Idaho Medicaid Healthy Connections Value Care CHOICE discussion** – *Jeff Crouch, IDHW, Regional Director and Elke Shaw-Tulloch, IDHW, Administrator Division of Public Health*

- ◆ Jeff Crouch gave a presentation on the Medicaid Program Payment Reform. The payment transition is working to move away from fee-for-service care and toward shared savings with RCO payments, specialist bundled payments, and PCMH shared savings.
- ◆ The PCMH is a clinical delivery model that needs an accompanying financial model, while an RCO is a financial model that needs a clinical delivery model. The RCO model is trying to create an organization that includes a provider system. CHOICE advisory group would bring a new emphasis on the marketplace for that area to improve on community engagement and support.
- ◆ Following his presentation Jeff Crouch answered questions from IHC members on the new Medicaid Program Payment Reform’s shared savings model, the role of patients in this model, and how the model would affect population health and critical access hospitals. This payment reform would put accountability on patients in their choice of primary care physician and ability to switch providers. The model is not mandatory but as the rewards associated with this reform occur it will move more organizations over to the RCO model. The model is entirely voluntary, giving greater flexibility to how care is paid for.

**Idaho Medicare Update from Noridian** – *Dr. Dick Whitten, Noridian, Vice President of Medical Policy and Sarah Baker, Noridian, Product Director for Care and Delivery Management*

- ◆ Dr. Dick Whitten and Sarah Baker presented current events going on at Medicare and fee-for-service practices. They also provided an update on MACRA/MIPS. Since the Medicare Access and CHIP Reauthorization Act (MACRA) was introduced in 2015 there have been a few key milestones: the Sustainable Growth Rate (SGR) was repealed, CMS established a new Quality Payment Program, there was a move to a value-not-volume payment basis, a Merit-Based Incentive Payment System (MIPS) was introduced, and incentives in Alternative Payment Models (APMs) were introduced. The MIPS will start on January 1, 2019. This system will consolidate negative adjustments, add clinical practice improvement activity (CPIA) as a component, increase potential incentives, and rank peers nationally.
- ◆ Dr. Whitten went over more aspects of MACRA, what is currently available to providers, and what will be available in the future. He concluded his presentation by going over the clinical outcomes assessment program (COAP) and the type of data they capture and monitor.

**Public Health Immunization Data Availability** – *Kathy Turner, PHD MPH, Bureau of Communicable Disease Prevention, Idaho Division of Public Health*

- ◆ Dr. Kathy Turner presented childhood immunization data for Idaho at the clinic, regional collaborative, and statewide level. Immunization rates are run annually with patient populations being updated before the rates are run. Starting in September 2017 clinics will be able to run immunization data for their own clinics.
- ◆ Dr. Turner discussed the dissemination of this information to clinics and regional collaboratives and the possibility of displaying the data on the HealthTech Solutions dashboard.
- ◆ There have been some major changes to Idaho’s rank nationally in childhood immunizations. These changes are primarily a result of increased efforts to get children vaccinated but are also due to the sample size used in the calculation.

**IHDE Update** – *Julie Lineberger, IHDE, Interim Executive Director*

- ◆ Cyndi Stegall provided a brief update on the current activities of IHDE and the connections between IHDE and SHIP cohort clinics. Currently there are 48 clinics from Cohorts One and Two that are fully connected bi-directionally; there are 28 in progress and two that are on hold pending participation agreements.

**Cohort Three Recruitment and Mentorship Update** - *Kym Schreiber, PCMH Project Manager, IDHW*

- ◆ Kym Schreiber went over the recruitment plan for Cohort Three clinics. The process will closely follow the recruitment plan for Cohort Two. The interest survey for Cohort Three, which is online now, will close on September 18th and the final application for Cohort Three will be made available until October 13<sup>th</sup>.
- ◆ During the time that the application is open there will be interest and application webinars, and the Cohort Three recruitment timeline will be online.
- ◆ The Cohort Three application is similar to the Cohort Two application with only minor changes to the section regarding clinics’ electronic health record capabilities. Selection criteria for Cohort Three will also be similar to the selection criteria for Cohort Two with minor updates being made to reflect the new edits to the final application.

**WWAMI ECHO - Jeff Seegmiller**

- ◆ Dr. Jeff Seegmiller presented information on the WWAMI/ECHO program. The ECHO model follows people's needs for access to specialty care and trains primary care providers in rural communities to provide specialty care where it is needed. Dr. Seegmiller talked about the focus of Project ECHO, what it could provide to Idaho healthcare, and how the model works in other states.
- ◆ Following his presentation, Dr. Seegmiller answered questions on the ECHO model and how it would be implemented in Idaho. If the ECHO model is set up in Idaho, the University of Idaho and Boise State University would take over maintaining the infrastructure of this program.

**Telehealth Update - Mary Sheridan, Bureau of Rural and Primary Care IDHW, Bureau Chief**

- ◆ Mary Sheridan provided an update on the current development of telehealth in Idaho. The telehealth grant application has been re-released and Mary and Madeline Russell are hosting a webinar on the application Friday, August 11th.

**Timeline and Next Steps –**

There being no further business, Chairman adjourned the meeting at **4:35pm.**

Health Wealth Career

# IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN FINANCIAL ANALYSIS

## ANALYSIS ASSESSMENT OF 2016 RESULTS

AUGUST 28, 2017

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# 1

## EXECUTIVE SUMMARY

Idaho's Statewide Healthcare Innovation Plan (SHIP) is designed to improve the health of all Idahoans by shifting the healthcare delivery system to a patient-centered focus while lowering the overall cost of healthcare. Idaho's SHIP is promoting the transformation of healthcare payments from volume-based payments to payments focused on outcomes coinciding with the implementation of the patient-centered medical home (PCMH) model of care.

To support testing of Idaho's SHIP, Idaho received a four-year federal State Innovation Model (SIM) Model Test grant. As part of the grant's requirements, the State of Idaho (State) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits, LLC to analyze financial metrics for the State's population health in an effort to determine the impact of changes occurring through the SHIP on the State's healthcare costs. Targeted areas for expected cost savings through trend reductions from the implementation of the SHIP PCMH model were identified as: generic prescription drug usage, inpatient hospital admission and readmissions, emergency room usage, early deliveries and general primary care savings.

It is important to note that, in addition to the SHIP, the State's payers and providers are implementing a number of other delivery and payment strategies with the goal of improving health outcomes and lowering costs. Thus, the dynamic environment in which the SHIP is being implemented limits the ability to determine the impact of the changes in healthcare costs that can be attributed solely to the SHIP. However, based on national research that shows decreased costs have resulted from the PCMH model, the SHIP is on pace to "bend the cost curve" and is believed to be a significant contributor to the impacts identified through this analysis.

The analysis showed that overall per member per month (PMPM) trend costs rose 2.9% from 2015 to 2016, which was less than the projected per capita trend of 4.7% projected for 2016 through 2025 by the CMS Office of the Actuary<sup>1</sup>. Furthermore, Medicaid and commercial payers showed significant progress overall toward achieving their cost avoidance targets. The cost avoidance assumptions for Medicaid show overall rate improvements in all projected categories. However, commercial payers did not realize the projected cost avoidance for generic drug usage, inpatient

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<sup>1</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf>

stays and other professional services. The majority of costs avoided for commercial payers were in the outpatient category. Medicare showed increases in costs in all categories except specialty physician services and diagnostic imaging/X-ray.

For the reported population, including three of the four largest commercial payers in Idaho, Idaho Medicare and Idaho Medicaid, representing roughly 975,000 of Idaho's 1.6 million people, there was an increase in costs from 2015 to 2016 of \$156 million (2.9% increase). Based on projections using trend assumptions from the CMS office of the actuary, the increase in cost from 2015 to 2016 could have been significantly higher.

Actual costs for 2016 are just over \$1 million lower than if no intervention for the SHIP or payment reform were taking place. The lower costs, though slight, indicate the financial goals of the SHIP are progressing as expected after year one of the model test. However, the payers reported significant fluctuations in membership and member months (MMs)<sup>2</sup> from the baseline year in 2015 through 2016, which further complicates any correlation of lower costs to the SHIP. Factoring out the effects of changes in membership resulted in significantly lower overall PMPM costs for Medicaid and commercial payers compared to projected 2016 costs.

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<sup>2</sup> "Member months" describes the count of membership by month aggregated for the time period described. For example, a member enrolled for an entire year with the same payer would be counted as 12 member months.

# 2

## INTRODUCTION

Idaho's Statewide Healthcare Innovation Plan (SHIP) is designed to improve the health of all Idahoans by shifting the healthcare delivery system to a patient-centered focus while lowering the overall cost of healthcare. Idaho's SHIP is promoting the transformation of healthcare payments from volume-based payments to payments focused on outcomes coinciding with the implementation of the patient-centered medical home (PCMH) model of care.

To support testing of Idaho's SHIP, Idaho applied for and received a federal State Innovation Model (SIM) Model Test grant. The four-year grant is comprised of an initial year of preparing to implement the model and referenced as Award Year (AY) 1. The following three years of the grant are to test the model's impact, including the financial impact on Idaho's healthcare system. The "Model Test Years" correspond to AYs 2 to 4. Idaho's selection of the patient-centered medical home (PCMH) model of care as a key tenant of its SHIP is supported by both national and state experience. Recently the Patient-Centered Primary Care Collaborative released the results of its review of 45 reports from peer-reviewed literature. The Collaborative's review also included outcomes from Centers for Medicare and Medicaid Services (CMS) initiative reports, and certain independent state evaluations, reporting on the effects of cost, quality and utilization, which met the Collaborative's rigorous research standards. While acknowledging the results differed across some studies, the review of the research found that "In general, the PCMH showed a decrease in overall cost, with a more positive trend for more mature PCMHs and for those patients with more complex medical conditions."<sup>3</sup> A decrease in cost was also a finding from the 2014 evaluation of Idaho's pilot PCMH model. Piloted through the Idaho Medical Home Collaborative in 2013 and serving approximately 9,000 patients, the evaluation found approximately \$2.4 million in savings for Idaho's Medicaid program over each year of the project. The majority of primary care practices participating in Idaho's pilot were nationally certified PCMH practices.

While the PCMH model was selected to be tested through the SHIP, there are other important delivery and payment approaches being implemented by payers with the common goal of improved health outcomes and lower costs. The largest commercial payers in the State have all implemented

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<sup>3</sup> The Impact of Primary Care Practice Transformation on Cost, Quality, and Utilization: A Systematic Review of Research Published in 2016, The Patient-Centered Primary Care Collaborative & The Robert Graham Center of the American Academy of Family Physicians (AAFP), July 2017.

alternatives to fee-for-service (FFS) payments to incentivize and reward quality and improved health outcomes. These payment models include:

1. Pay-for-Performance (P4P)
2. Enhanced P4P
3. Shared Savings
4. Shared Risk
5. Full Risk
6. Quality Bonuses
7. Population-Based Payments
8. Episode-Based Payments

In addition to the PCMH model, commercial payers are testing alternative models including accountable care organizations (ACOs) with many of the State's acute care hospitals, including total cost of care programs with shared savings payments for improving and managing patients with chronic conditions to reduce avoidable emergency room visits. Payers are also aligning their product portfolios so that payment methodologies and value-based reimbursement are more aligned with product designs that guide members to providers delivering high quality care. They are also working to expand value-based programs in an effort to align reimbursements, empower providers with data, focus on overall health and establish shared decision making between patients and their physicians. Together, payers and providers are developing the infrastructure to support partnerships to be successful in new payment arrangements and align payment systems with benefits, network design and consumer engagement.

Medicaid, Idaho's largest public payer, is expanding the payment reform model in Idaho by incentivizing participation in the PCMH model. Medicaid is encouraging value-based purchasing through the development of accountable Regional Care Organizations where physicians, providers and hospitals join together to create a regional system of care. Through both models, healthcare providers are rewarded for delivering better care instead of being paid for providing "more care" regardless of outcomes.

Idaho believes that the combined efforts of Idaho's commercial payers, Medicaid and the SHIP to implement delivery and payment models that incentivize and reward quality care will have a significant impact on improving the health of Idahoans. In addition, as demonstrated through this financial analysis, there is evidence that these combined efforts are bending the cost curve of the State's healthcare system.

# 3

## BACKGROUND

As part of the SIM grant, the Idaho Department of Health and Welfare (IDHW), together with the Idaho Healthcare Coalition, engaged Mercer to analyze financial metrics for the State’s population health in an effort to determine the impact of healthcare cost changes occurring through the SHIP. This financial analysis also fulfills a grant requirement as the CMS Innovation seeks to understand the financial impact of healthcare delivery and payment models being tested across the nation.

Idaho’s SHIP model testing is occurring within a dynamic health system environment. As such, this analysis is limited in that the impact of the SHIP PCMH model on utilization and costs cannot be isolated. Furthermore, while the population health metrics selected for this analysis are those that are most expected to be impacted by the PCMH model, it is expected that these metrics are also impacted by other payer models being implemented in Idaho. Regardless of these inherent limitations, national research supports the assumption that the PCMH model is a significant contributor to the findings of this financial analysis.

### GRANT YEAR VERSUS CALENDAR YEAR

The grant period runs from February 1, 2015 through January 31, 2019, and is divided into award years as described above and shown in Table 1 below. For ease of data collection and participation from the payers, Mercer is collecting and calculating data on a CY basis without adjusting for the lagging grant month. Therefore, although the Model Test years begin on February 1 and end on January 31, CY projections were not adjusted for the lagging month.

**TABLE 1: REFERENCES TO TIME PERIODS**

Financial Analysis Year Data/GRANT YEAR	GRANT AY	MODEL TEST YEAR
CY 2015 / February 1, 2015 through January 31, 2016	AY 1	Baseline (Year 0)
CY 2016 / February 1, 2016 through January 31, 2017	AY 2	Year 1
CY 2017 / February 1, 2017 through January 31, 2018	AY 3	Year 2
CY 2018 / February 1, 2018 through January 31, 2019	AY 4	End of Model Test (Year 3)

# 4

## PROJECTED IMPACT OF IMPLEMENTING PCMH

In 2015, Mercer projected cost mitigation through trend reductions from the implementation of the PCMH model over the Model Test period. The areas expected to be impacted by the PCMH model were generic prescription drug usage, inpatient hospital admission and readmissions, emergency room usage, early deliveries and general primary care savings. The cost savings assumptions were based on research from similar PCMH impact studies. Cost increases associated with new PCMH operations being implemented were also built into the model.

Table 2 below identifies the cost mitigation assumptions.

**TABLE 2: COST TARGETS, MILESTONES AND SAVINGS FOR PUBLIC/PRIVATE POPULATIONS COMBINED**

COST AVOIDANCE CATEGORY	END OF MODEL TEST 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 thousand–\$70 thousand/admit) are preventable with later deliveries	0.56% reduction in Inpatient Hospital utilization for Medicaid child per year <sup>4</sup>
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 <sup>5</sup>

<sup>4</sup> Ohio Perinatal Quality Collaborative 39-Weeks Delivery Charter Project (2008) <https://opqc.net/node/157>

<sup>5</sup> 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 viewable at [http://www.pcpcc.org/sites/default/files/media/benefits\\_of\\_implementing\\_the\\_primary\\_care\\_pcmh.pdf](http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf)

COST AVOIDANCE CATEGORY	END OF MODEL TEST TARGETS	MECHANISM	SAVINGS ASSUMPTIONS
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 <sup>6</sup>
Acute Care Hospitalizations	1%–5% reduction	PCMHs reduce with IMPACT <sup>7</sup> & Intensive Outpatient Care Programs training	0.5% reduction in Inpatient and Outpatient Hospital unit cost for Medicare and Medicaid, 0.25% reduction for commercial <sup>8</sup>
Non-Emergent Emergency Department (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 <sup>9</sup>
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, Physical therapy, Occupational therapy and Radiology; 0.25% in DME for Medicaid Duals, 0.25% for Medicare Duals <sup>10</sup>

<sup>6</sup> 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 viewable at [http://www.pcpcc.org/sites/default/files/media/benefits\\_of\\_implementing\\_the\\_primary\\_care\\_pcmh.pdf](http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf)

<sup>7</sup> 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.

<sup>8</sup> Health Affairs, Health Policy Brief on Patient Engagement. February 14, 2013 viewable at [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=86](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86)

<sup>9</sup> Effect of a Multipayer Patient-Centered Medical Home on Health Care Utilization and Quality: The Rhode Island Chronic Care Sustainability Initiative Pilot Program. JAMA Internal Medicine, Report Abstract published online, September 9, 2013 viewable at <http://archinte.jamanetwork.com/article.aspx?articleid=1735895>

<sup>10</sup> Health Affairs, Health Policy Brief on Patient Engagement. February 14, 2013 viewable at [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=86](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86)

As part of the model testing grant application, Mercer built a comparison model of care using medical expense data supplied by 1) the IDHW for 2013 and 2014 incurred expenses, 2) the CMS for 2012 and 2013 incurred expenses, 3) three of the four largest commercial payers for 2014 and 4) Mercer's proprietary commercial claims database. Mercer also used commercial payers' public filings, as available from 2013 and 2014. 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 CY 2015 as the Baseline. 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 for commercial data for the same periods were derived from Mercer's proprietary commercial claims database. The results showed a projected cost savings of \$89 million over the model testing period.

To collect the data for the analysis, commercial, Medicare and Medicaid (payers) were surveyed using the category of services classifications and definitions included in Appendix A. To isolate the effect on cost per member, member shifts between payers and membership growth was removed from the assumption, leaving MMs as a constant in the original model.

# 5

## 2016 FINANCIAL ANALYSIS AND FINDINGS

Commercial, Medicare and Medicaid (payers) were sent the same survey, shown in Appendix A, in March, 2017 to gather CY 2016 results for comparison to the original projection after one year. The 2015 baseline projection using CY 2014 data was significantly different for all payers compared to 2015 actual data. As a result, Mercer rebased the projected cost avoidance starting from actual 2015 PMPM data by collecting 2015 data from Medicare and Medicaid and from the commercial payers through their public filings. Mercer re-projected the Model Test Years again using trend assumptions from the CMS Office of the Actuary. For this study, Medicare data for dual eligible and FFS for CY 2015 and 2016 were provided by Noridian Government Solutions, the Idaho Medicare carrier, whereas previously that data was calculated and trended forward from data available on the CMS website. Mercer believes the CY 2016 data from Noridian is a more accurate representation of the Medicare population in Idaho and included data representing significantly more membership.

The resulting baseline of CY 2015 data and 2016 actual reported data are shown in Table 3 below. CY 2016 projected trends were calculated based on data from the CMS Office of the Actuary, calculated and accumulated by category of service and by payer. While actual trends were held relatively steady for Medicaid, Commercial and Medicare experienced significant volatility. For example, the PMPM for commercial individual was significantly higher than what had been projected by CMS but commercial family was less than projected. The Medicare Dual Eligible PMPM was more than four times greater than what had been projected and Medicare Advantage was more than double the projection.

**TABLE 3: ACTUAL PMPM COST TREND BY PAYER THROUGH 2016**

PARTICIPANTS	BASELINE PMPM*	2016 ACTUAL PMPM	VARIANCE	2016 ACTUAL TREND	2016 PROJECTED TREND
<b>MEDICAID</b>					
Children	\$ 219.05	\$ 218.94	\$ (0.10)	-0.05%	6.1%
Dual Eligible	\$ 1,359.92	\$ 1,349.41	\$ (10.51)	-0.77%	4.5%
Aged/Disabled (non-dual)	\$ 2,106.54	\$ 2,160.96	\$ 54.42	2.58%	4.9%
Other Adult**	\$ 584.86	\$ 576.47	\$ (8.40)	-1.44%	5.4%

PARTICIPANTS	BASELINE PMPM *	2016 ACTUAL PMPM	VARIANCE	2016 ACTUAL TREND	2016 PROJECTED TREND
<b>COMMERCIAL</b>					
Individual	\$ 403.38	\$ 530.14	\$ 126.76	31.43%	5.2%
Family	\$ 375.52	\$ 347.91	\$ (27.61)	-7.35%	5.3%
<b>MEDICARE</b>					
Dual Eligible	\$ 660.09	\$ 876.43	\$ 216.34	32.77%	6.9%
Fee-For-Service	\$ 412.54	\$ 425.64	\$ 13.09	3.17%	5.6%
Medicare Advantage	\$ 756.23	\$ 849.44	\$ 93.21	12.33%	6.1%

\* Baseline calendar year 2015

\*\* Non-Dual, Not Disabled

### CHANGES DUE TO LOWER RATES VERSUS POPULATION SHIFTS

Table 4 shows that there was a significant increase in Medicaid enrollment, particularly children which contributed to lower PMPMs but higher overall costs than in 2015. The Commercial family population decreased significantly which lowered the PMPM and overall cost, whereas the individual population increased slightly. The effects of these shifts in MMs are displayed in Table 5.

Additionally, Table 5 shows the total actual change in costs for the representative sample of data provided by the payers from 2015 to 2016. Because the changes in membership may affect PMPM amounts, reported changes in cost were categorized into changes due to volume versus changes due to rate. Changes in volume are calculated multiplying the change in MMs by the originally projected PMPM by payer category and category of service (COS). Changes in rates are calculated multiplying change in PMPM rate by the 2016 MMs. Added together, both calculated changes equal the total difference of projected costs versus actual costs.

#### EXAMPLE OF RATE CHANGES

Membership for children in Medicaid grew by 99,844 MMs from 2015 to 2016. The effect of this growth can be measured by multiplying the change in MMs by the 2015 PMPM rate:

$$99,844 \times \$219.05 = \$21,870,422$$

The PMPM rate for Medicaid children dropped by \$0.10 from 2015 to 2016. The effect of this drop in the PMPM multiplied by the 2016 member month count gives us the change in cost due to a lower PMPM rate.

$$\$(-0.10) \times 2,614,057 = \$(-266,741)$$

Added together, these amounts equal the total change in cost for Medicaid children from 2015 to 2016.

$$\$21,870,422 + \$(-266,741) = \$21,603,681$$

**TABLE 4: REPORTED MM CHANGES FROM BASELINE TO 2016**

MEMBER MONTHS			
PARTICIPANTS	BASELINE	2016	INCREASE (DECREASE)
<b>MEDICAID</b>			
Children	2,514,213	2,614,057	99,844
Dual Eligible	309,047	320,421	11,374
Aged/Disabled (non-dual)	205,855	212,376	6,521
Other Adult	379,410	408,381	28,971
<b>COMMERCIAL</b>			
Individual	1,222,091	1,261,180	39,090
Family	4,560,579	3,748,770	(811,809)
<b>MEDICARE</b>			
Dual Eligible	393,473	453,841	60,368
FFS	1,926,669	1,994,524	67,855
Medicare Advantage	624,663	702,649	77,986

While costs increased for Medicare and Medicaid, costs decreased for commercial payers. For Medicaid, the total change in cost can largely be attributed to increases in the number of MMs in Children and the increase in the PMPM rate for Aged/ Disabled (non-dual). For Medicare, costs increased due to both membership and changes in PMPM rate. Cost decreases for Commercial are largely attributed to the decrease in MMs for Commercial Family but offset by rate increases for Individual. Overall, the increase in cost of \$156 million represents an increase of 2.9%, which is less than the projected trends in Table 3 and less than the overall projected trend of 4.7% from the CMS Office of the Actuary<sup>11</sup>.

<sup>11</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2016.pdf>

**TABLE 5: TOTAL CHANGES IN COST FROM 2015 TO 2016 FOR REPORTED MEMBERSHIP**

PARTICIPANTS	CHANGE IN COST DUE TO MEMBERSHIP	CHANGE IN COST DUE TO RATE	TOTAL CHANGE IN COST
<b>MEDICAID</b>			<b>4.5%</b>
Children	\$ 21,870,422	\$ (266,741)	\$ 21,603,681
Dual Eligible	\$ 15,467,736	\$ (3,368,068)	\$ 12,099,668
Aged/Disabled (non-dual)	\$ 13,736,727	\$ 11,558,227	\$ 25,294,954
Other Adult	\$ 16,944,095	\$ (3,429,348)	\$ 13,514,747
<b>COMMERCIAL</b>			<b>-10.6%</b>
Individual	\$ 15,767,898	\$ 159,870,373	\$ 175,638,271
Family	\$ (304,848,309)	\$ (103,485,100)	\$ (408,333,410)
<b>MEDICARE</b>			<b>20.7%</b>
Dual Eligible	\$ 39,848,262	\$ 98,183,588	\$ 138,031,849
FFS	\$ 27,993,175	\$ 26,113,054	\$ 54,106,228
Medicare Advantage	\$ 58,975,098	\$ 65,496,668	\$ 124,471,766
<b>TOTAL</b>	<b>\$ (94,244,896)</b>	<b>\$ 250,672,652</b>	<b>\$ 156,427,756</b>

In addition to the comparison of 2015 to 2016 actual costs in Table 5, Mercer also calculated the comparison against projected costs if the PCMH model had not been made. Noting that these results are based purely on assumed trends, the projected cost avoidance is shown in Table 6 as Cost Increases (Decreases) for 2016. The simultaneous occurrence of multiple healthcare delivery and payment changes impacting Idaho’s healthcare system makes it difficult to attribute all cost avoidance to the implementation of the PCMH model. Based on national research and Idaho’s experience, it is believed that PCMH is a significant contributor to the cost avoidance shown in Table 6.

Changes in cost attributed to changes in volume are ignored when attempting to evaluate the contribution of the SHIP. However, Mercer recognizes that changes in volume often contribute to changes in rate. For example, there is no evidence that the reduction in the Medicaid Other Adult PMPM from \$615.49 to \$576.47 is due primarily to the change to the PCMH model, or if the increase in MMs from 379,410 to 408,381 simply added 28,971 people who rarely used medical services and therefore added little cost. Likely, the combination of factors, including the transformation to paying for value rather than volume contributed to the reduction in PMPM cost

rates. Based on the net effect of avoiding \$1.2 million in cost, the SHIP model test is progressing as expected.

**TABLE 6: PROJECTED COSTS AVOIDED FOR 2016**

PARTICIPANTS	2016 PROJECTED PMPM*	2016 ACTUAL PMPM	2016 ACTUAL MMS	COST INCREASES (DECREASES)
<b>MEDICAID</b>				
Children	\$ 231.42	\$ 218.94	2,614,057	(\$ 32,623,431)
Dual Eligible	\$ 1,380.49	\$ 1,349.41	320,421	(\$ 9,958,685)
Aged/Disabled (non-dual)	\$ 2,197.58	\$ 2,160.96	212,376	(\$ 7,777,209)
Other Adult	\$ 615.49	\$ 576.47	408,381	(\$ 15,935,027)
<b>COMMERCIAL</b>				
Individual	\$ 423.48	\$ 530.14	1,261,180	\$ 134,517,459
Family	\$ 394.30	\$ 347.91	3,748,770	(\$ 173,905,440)
<b>MEDICARE</b>				
Dual Eligible	\$ 691.53	\$ 876.43	453,841	\$ 83,915,201
FFS	\$ 433.24	\$ 425.64	1,994,524	(\$ 15,158,382)
Medicare Advantage	\$ 798.56	\$ 849.44	702,649	\$ 35,750,781
<b>TOTAL:</b>				<b>(\$ 1,174,734)</b>

The rate changes shown in Table 6 include all categories of service and not just those identified by the savings assumptions used in Mercer's original projection. There is no direct correlation that can be drawn from this analysis between the changes in these cost categories and the PCMH model. However, based on research from similar PMCH impact studies, the PCMH model likely had some influence on these results.

# 6

## CONCLUSION

Idaho's SHIP model testing is occurring within a dynamic health system environment; and therefore, the results of this analysis cannot be directly attributed to the impact of the SHIP PCMH model on utilization and costs. These metrics are also impacted by other payer models being implemented in the State, changes occurring in membership enrollment, and changes in members' utilization of services.

While costs increased from 2015 to 2016 by \$156 million, the cost trend of 2.9% was lower than CMMI projected which indicates a level of cost avoidance. Despite the increase in costs shown in Table 5, by comparing trends in Table 3 and comparing projected PMPM costs in Tables 6, Medicaid and commercial payers showed progress overall toward achieving their cost avoidance targets.

When combining the actual CY 2016 results reported for three of the four largest commercial payers, Medicare and Medicaid show overall costs running lower than projected by just over \$1 million. However, the payers reported significant fluctuations in membership and MMs from the baseline year in CY 2015 to CY 2016 that were the primary contributors to cost fluctuations. Factoring out the effects of changes in membership resulted in significantly lower PMPM costs for Medicaid and commercial payers, overall. The baseline PMPM rates by payer and category of service are significantly lower than the Model Test Year 1 rates projected in 2015. The cost avoidance assumptions for Medicaid show overall rate improvements in all projected categories. However, commercial payers did not realize the projected cost avoidance for generic drug usage, inpatient stays and other professional services. The majority of costs avoided for commercial payers were in the outpatient category. Medicare showed increases in costs in all categories except specialty physician services and diagnostic imaging/X-ray.

In summary, significant changes in membership resulted in increased costs for Medicaid and decreased costs for Commercial payers. Medicare costs increased the most due to both increased enrollment and increased utilization of services. These combined changes resulted in an increase of overall costs of \$156 million from 2015 to 2016. However, the overall cost trend of 2.9% is less than the projected trend from the CMS Office of the Actuary. Actual costs from 2016 are \$1.2 million less than projected, suggesting that the SHIP is progressing financially as expected.

# Appendix A

## DATA REQUEST

Data Request Template Sent to Payers on March 2, 2017:

Dear Multi-payer workgroup participants,

CMMI requires reports to monitor financial progress for the grant Idaho received. Therefore, we are sending you the exact same template sent in 2015 and request that you send us updated results for calendar year 2016. 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.

For those whose current agreement needs updating, 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.

We'd like to start receiving data on **March 31, 2017** to meet the CMMI reporting requirements due at the end of April. If you're unable to meet that date, please let me know when you think you can get the template completed. We appreciate your participation in the SHIP and would like to make the reporting process as simple as possible.

Thank you!

Scott Banken, CPA

**TABLE 8: CY 2016**

	MEDICAID/CHIP				PRIVATE/OTHER		MEDICARE		
	ADULT	CHILD	DUAL ELIGIBLES (ONLY)	DISABLED/ELDERLY (WITHOUT DUALS)	INDIVIDUAL	FAMILY	DUAL ELIGIBLE	FFS/NON-DUALS (PARTS A AND B)	MEDICARE ADVANTAGE PART C
Member Months									
Inpatient Hospital	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Emergency Department	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Urgent Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Outpatient Hospital	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Primary Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Specialty Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Diagnostic Imaging/X-Ray	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Laboratory Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DME	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

	MEDICAID/CHIP				PRIVATE/OTHER		MEDICARE		
	ADULT	CHILD	DUAL ELIGIBLES (ONLY)	DISABLED/ELDERLY (WITHOUT DUALS)	INDIVIDUAL	FAMILY	DUAL ELIGIBLE	FFS/NON- DUALS (PARTS A AND B)	MEDICARE ADVANTAGE PART C
Dialysis Procedures	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Other (e.g., PT, OT)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Skilled Nursing Facility	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Home Health	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Custodial Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ICF/MR	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
HCBS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Behavioral Health	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Prescription Drugs (Outpatient)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

## CATEGORY OF SERVICE CLASSIFICATIONS

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

### Emergency Department

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>

### 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-](http://cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/taxonomy.pdf)

[Certification/MedicareProviderSupEnroll/downloads/taxonomy.pdf](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

### 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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## Project Charter

# GOAL 6: Align payment mechanisms across payers to transform payment methodology from volume to value.

Version 3.0 – FINAL

## Summary

<b>Mercer Lead</b>	Scott Banken
<b>SHIP Staff</b>	Cynthia York
<b>Key Participants</b>	PCMHs, Commercial payers, Medicare, and the Idaho Department of Health and Welfare
<b>IHC Charge</b>	<ul style="list-style-type: none"> <li>Through collaboration across payers and providers, transform payment methodology from volume to performance-based value.</li> <li>Develop a phased-in system of payment transformation that supports primary care practices in maintaining an infrastructure as a patient-centered medical home (PCMH) through transition to a payment system based on outcomes.</li> </ul>

## Success Measures

Success Measures	SHIP Desired Outcomes	Measurement					
1.	<ul style="list-style-type: none"> <li>Payers representing at least 80% of the Idaho population adopt new reimbursement models.</li> </ul>	<ul style="list-style-type: none"> <li>Count of payers representing at least 80% of the beneficiary population that adopt new reimbursement models.</li> <li>Numerator: Total number of payers that adopt new reimbursement models</li> <li>Denominator: Total number of payers targeted to adopt new reimbursement models (Model Test target = 4)</li> </ul>	<b>AYR</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
			<b>1</b>	0	0	0	0
			<b>2</b>	0	0	0	4
			<b>3</b>	4	4	4	4
			<b>4</b>	4	4	4	4

GOAL 6 PROJECT CHARTER

Success Measures	SHIP Desired Outcomes	Measurement										
2.	<ul style="list-style-type: none"> <li>Beneficiaries are attributed to PCMHs for purposes of alternative reimbursement payments.</li> </ul>	<ul style="list-style-type: none"> <li>The count of beneficiaries attributed to all providers for purposes of alternative reimbursement payments from SHIP participating payers.</li> <li>Numerator: Total number of beneficiaries attributed to providers with value-based payment contracts from SHIP participating payers.</li> <li>Denominator: Total number of beneficiaries enrolled with SHIP participating payers.</li> </ul> <table border="1"> <thead> <tr> <th>AYR</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>0</td> </tr> <tr> <td>2</td> <td>275,000</td> </tr> <tr> <td>3</td> <td>550,000</td> </tr> <tr> <td>4</td> <td>825,000</td> </tr> </tbody> </table>	AYR	Q4	1	0	2	275,000	3	550,000	4	825,000
AYR	Q4											
1	0											
2	275,000											
3	550,000											
4	825,000											
3.	<ul style="list-style-type: none"> <li>80% of all payments are under alternative reimbursement models</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of payments made in non-FFS arrangements compared to total payments made.</li> <li>Numerator: Total cost of payments to providers for value-based payment contracts from SHIP participating payers.</li> <li>Denominator: Total cost of all payments to providers from SHIP participating payers.</li> </ul> <table border="1"> <thead> <tr> <th>AYR</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>10%</td> </tr> <tr> <td>2</td> <td>20%</td> </tr> <tr> <td>3</td> <td>50%</td> </tr> <tr> <td>4</td> <td>80%</td> </tr> </tbody> </table>	AYR	Q4	1	10%	2	20%	3	50%	4	80%
AYR	Q4											
1	10%											
2	20%											
3	50%											
4	80%											

**Planned Scope**

Deliverable 1	Result, Product or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>Payer matrix summary.</li> </ul>	<ul style="list-style-type: none"> <li>Matrix of payers and payment methods included in contracts with PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>Multi Payer Workgroup</li> </ul>	<ul style="list-style-type: none"> <li>IMHC</li> </ul>
Est. Timeframe	Start: 06/01/2015		End: 08/12/2015	



2 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.

GOAL 6 PROJECT CHARTER

<b>Milestones</b>	<b>Event</b>	<b>Target Date</b>		
	<ul style="list-style-type: none"> <li>Payer submissions of draft matrix with updates of parameters for the payers' patient attribution, population risk/stratification methodology upon which the payers will build their payment amounts.</li> <li>Approval of final matrix.</li> </ul>	<ul style="list-style-type: none"> <li><a href="#">Completed</a> 07/31/2015</li> <li><a href="#">Completed</a> 08/12/2015</li> </ul>		
<b>Deliverable 2</b>	<b>Result, Product or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Attribution Report</li> </ul>	<ul style="list-style-type: none"> <li>Number of beneficiaries attributed to providers under alternative (non-fee-for-service) payment models</li> </ul>	<ul style="list-style-type: none"> <li>Multi Payer Workgroup</li> </ul>	<ul style="list-style-type: none"> <li>IMHC</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/31/2015		<b>End:</b> 01/31/2019	
<b>Milestones</b>	<b>Event</b>	<b>Target Date</b>		
	<ul style="list-style-type: none"> <li>Year 1</li> <li>Year 2</li> <li>Year 3</li> <li>Year 4</li> </ul>	<ul style="list-style-type: none"> <li><a href="#">11/30/2016</a></li> <li><a href="#">06/30/2017</a></li> <li><a href="#">04/30/2018</a></li> <li>01/31/2019</li> </ul>		
<b>Deliverable 3</b>	<b>Result, Product or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Alternative Payments Report</li> </ul>	<ul style="list-style-type: none"> <li>Total payments made to providers under alternative reimbursement models (Note: total payments made to all providers are gathered in goal 7)</li> </ul>	<ul style="list-style-type: none"> <li>Multi Payer Workgroup</li> </ul>	<ul style="list-style-type: none"> <li>IMHC</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/31/2015		<b>End:</b> 01/31/2019	
<b>Milestones</b>	<b>Event</b>	<b>Target Date</b>		
	<ul style="list-style-type: none"> <li>Year 1</li> <li>Year 2</li> <li>Year 3</li> <li>Year 4</li> </ul>	<ul style="list-style-type: none"> <li><a href="#">11/30/2016</a></li> <li><a href="#">06/30/2017</a></li> <li><a href="#">04/30/2018</a></li> <li>01/31/2019</li> </ul>		



3 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.

GOAL 6 PROJECT CHARTER

<b>Deliverable 4</b>	<b>Result, Product or Service</b> <ul style="list-style-type: none"> <li>Providers with alternative reimbursement contracts</li> </ul>	<b>Description</b> <ul style="list-style-type: none"> <li>Count of providers under contract with at least one payer to receive alternative (non-volume based) reimbursements.</li> </ul>	<b>Owner</b> <ul style="list-style-type: none"> <li>Mercer, IMHC</li> </ul>	<b>Impacted Parties</b> <ul style="list-style-type: none"> <li>IMHC</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/31/2015	<b>End:</b> 01/31/2019		
<b>Milestones</b>	<b>Event</b> <ul style="list-style-type: none"> <li>Year 1</li> <li>Year 2</li> <li>Year 3</li> <li>Year 4</li> </ul>	<b>Target Date</b> <ul style="list-style-type: none"> <li>01/31/2016</li> <li>01/31/2017</li> <li>01/31/2018</li> <li>01/31/2019</li> </ul>		

**Project Risks, Assumptions, and Dependencies**

Risk Identification	Event	Likelihood	Seriousness	Potential Mitigation
	<ul style="list-style-type: none"> <li>Enough beneficiaries fail to attribute to each provider for each payer, making risk arrangements unfeasible.</li> </ul>	L	M	Lower minimum threshold for beneficiary attribution and institute risk corridors to minimize risk for both payer and providers.
<b>Assumptions</b>	<ul style="list-style-type: none"> <li>[TBD]</li> </ul>			
<b>Dependencies and Constraints</b>	<ul style="list-style-type: none"> <li>[TBD]</li> </ul>			

**Project Reporting and Scope Changes**

Changes to scope must be reflected at the Workgroup Charter level as approved by the IHC after review by SHIP team.

**Version Information**

<b>Author</b>	Scott Banken	<b>Date</b>
<b>Reviewer</b>	Casey Moyer	<b>Date</b>



4 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.

GOAL 6 PROJECT CHARTER

**Final Acceptance**

<b>Name / Signature</b>	<b>Title</b>	<b>Date</b>	<b>Approved via Email</b>
Cynthia York	SHIP Administrator		<input type="checkbox"/>
Katie Falls	Mercer Lead		<input type="checkbox"/>



# PROJECT CHARTER

## Multi-Payer Workgroup

Version 4.0 – August 2017

### Workgroup Summary

<b>Chair/Co-Chair</b>	Norm Varin, PacificSource; Dr. David Peterman, Primary Health Medical Group
<b>Mercer Lead</b>	Scott Banken
<b>SHIP Staff</b>	Cynthia York
<b>IHC Charge</b>	<ul style="list-style-type: none"><li>• Through collaboration across payers and providers, transform payment methodology from volume to performance-based value.</li><li>• Develop a phased-in system of payment transformation that supports primary care practices in maintaining an infrastructure as a patient-centered medical home (PCMH) through transition to a payment system based on outcomes.</li></ul>
<b>SHIP Goals</b>	<ul style="list-style-type: none"><li>• Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value.</li><li>• Goal 7: Reduce overall healthcare costs.</li></ul>

### Business Alignment

<b>Business Need</b>	<ul style="list-style-type: none"><li>• The workgroup is needed to help develop a phased-in system of payment transformation that supports primary care practices in maintaining an infrastructure as a PCMH through transition to an outcome-based payment system. The workgroup relies on collaboration across payers and providers, working to transform payment methodology from volume to performance-based value.</li></ul>
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<b>Success Measures</b>	<b>SHIP Desired Outcomes</b>	<b>Measurement</b>	<b>Workgroup's Role</b>
1	<ul style="list-style-type: none"><li>• Over 80% of payments to providers from all payers are in fee-for-service alternatives that link payment to value.</li></ul>	<ul style="list-style-type: none"><li>• Methods of payment that incent outcomes versus volume.</li></ul>	<ul style="list-style-type: none"><li>• Review financial analysis report to monitor progress in establishing payment approaches that link payment to value.</li></ul>

MULTI-PAYER WORKGROUP PROJECT CHARTER

Success Measures	SHIP Desired Outcomes	Measurement	Workgroup's Role
2	<ul style="list-style-type: none"> <li>Beneficiaries are attributed for purposes of alternative reimbursement payments.</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of beneficiaries attributed for varying levels of alternative reimbursement payments. OR</li> <li>The count of beneficiaries attributed to all providers for purposes of alternative reimbursement payments from SHIP participating payers.</li> <li>Numerator: Total number of beneficiaries attributed to providers with value-based payment contracts from SHIP participating payers. Denominator: Total number of beneficiaries enrolled with SHIP participating payers</li> </ul>	<ul style="list-style-type: none"> <li>Review and advise IDHW/IHC on information to be collected.</li> </ul>
3	<ul style="list-style-type: none"> <li>80% of all payments are under alternative reimbursement models</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of payments made in non-FFS arrangements compared to total payments made.</li> <li>Numerator: Total cost of payments to providers for value-based payment contracts from SHIP participating payers.</li> <li>Denominator: Total cost of all payments to providers from SHIP participating payers.</li> </ul>	<ul style="list-style-type: none"> <li>Review progress of payments transitioning to alternative reimbursement models.</li> </ul>

**Planned Scope**

Deliverable 1	Result, Product, or Service	Description
	Payer transformation summary.	Summary of transformation by payers and payment methods included in contracts with entities that include PCMHs.
Est. Timeframe	Start: 7/8/2015	End: 8/12/2015
Milestones	<b>Event</b> <ul style="list-style-type: none"> <li>Payer submissions of draft matrix with updates of parameters for the payers' patient attribution, population risk/stratification methodology upon which the payers will build their payment amounts.</li> <li>Approval of final payer transformation summary.</li> </ul>	<b>Target Date</b> <ul style="list-style-type: none"> <li>7/31/2015</li> <li>8/12/2015</li> </ul>

MULTI-PAYER WORKGROUP PROJECT CHARTER

<b>Deliverable 2</b>	<b>Result, Product or Service</b> Report on the percentage of beneficiaries attributed for varying levels of alternative reimbursement payments.	<b>Description</b> The count of beneficiaries attributed to all providers for purposes of alternative reimbursement payments from SHIP participating payers. <ul style="list-style-type: none"><li>• Numerator: Total number of beneficiaries attributed to providers with value-based payment contracts from SHIP participating payers.</li><li>• Denominator: Total number of beneficiaries enrolled with SHIP participating payers</li></ul>
<b>Est. Timeframe</b>	<b>Start:</b> 10/31/2015	<b>End:</b> 1/31/2019
<b>Milestones</b>	<b>Event</b> <ul style="list-style-type: none"><li>• Pre-testing phase reporting.</li><li>• Year 1.</li><li>• Year 2.</li><li>• Year 3.</li></ul>	<b>Target Date</b> <ul style="list-style-type: none"><li>• 10/31/2015</li><li>• 9/30/2017</li><li>• 3/31/2018</li><li>• 3/31/2019</li></ul>
<b>Deliverable 3</b>	<b>Result, Product or Service</b> Report on the percentage of payments made in alternatives to FFS arrangements.	<b>Description</b>
<b>Est. Timeframe</b>	<b>Start:</b> 10/31/2015	<b>End:</b> 1/31/2018
<b>Milestones</b>	<b>Event</b> <ul style="list-style-type: none"><li>• Pre-testing phase reporting</li><li>• Year 1.</li><li>• Year 2.</li><li>• Year 3.</li></ul>	<ul style="list-style-type: none"><li>• 10/31/2015</li><li>• 1/31/2017</li><li>• 1/31/2018</li><li>• 1/31/2019</li></ul>
<b>Deliverable 4</b>	<b>Result, Product or Service</b> Summarized financial results.	<b>Description</b> Provide summarized financial information to track progress in reducing overall healthcare costs.
<b>Est. Timeframe</b>	<b>Start:</b> 7/8/2015	<b>End:</b> 1/31/2019
<b>Milestones</b>	<b>Event</b> <ul style="list-style-type: none"><li>• Data request delivered to payers.</li><li>• Initial data received from payers.</li><li>• Cost savings assumptions developed.</li><li>• Initial report on financial savings projection.</li><li>• Model Test year 1 data request.</li><li>• Test year 1 data received from payers.</li><li>• Test year 1 comparison to financial savings projection report.</li><li>• Model Test year 2 data request.</li></ul>	<b>Target Date</b> <ul style="list-style-type: none"><li>• 7/17/2015</li><li>• 10/5/2015</li><li>• 11/2/2015</li><li>• 1/1/2016</li><li>• 1/31/2017</li><li>• 3/31/2017</li><li>• 8/31/2017</li><li>• 1/31/2018</li></ul>

- Test year 2 data received from payers. • 3/31/2018
- Test year 2 comparison to financial savings projection report. • 4/30/2018
- Model Test year 3 data request. • 1/31/2019
- Test year 3 data received from payers. • 3/31/2019
- Test year 3 comparison to financial savings projection report. • 4/30/2019

### Project Risks, Assumptions, and Dependencies

Risk Identification	Event	H – M – L	Potential Mitigation	Potential Contingency
	<ul style="list-style-type: none"> <li>• Practices fail to achieve a high enough level of beneficiary attribution to justify risk-based compensation from each payer.</li> </ul>	H	[TBD]	Higher level of quality-based incentives but not moving away from FFS as the primary payment.
<b>Assumptions</b>	<ul style="list-style-type: none"> <li>• [TBD]</li> </ul>			
<b>Dependencies and Constraints</b>	<ul style="list-style-type: none"> <li>• [TBD]</li> </ul>			

### Project Reporting and Scope Changes

Changes to scope must be approved by the IHC after review by SHIP team.

### Version Information

<b>Author</b>	Scott Banken	<b>Date</b>
<b>Reviewer</b>	Cynthia York	<b>Date</b>

### Charter Approval Signatures

Date Approved by the Workgroup: \_\_\_\_\_

### Final Acceptance

Name /Signature	Title	Date	Approved Via Email
Norm Varin	Chair		<input type="checkbox"/>
David Peterman	Co-Chair		<input type="checkbox"/>
Cynthia York	SHIP Administrator		<input type="checkbox"/>
Scott Banken	Mercer Lead		<input type="checkbox"/>

# Spring 2017 IHC Member Interviews

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SHIP State-level Evaluation Team  
Summary  
September 13, 2017

# Introduction

- IHC members have unique perspectives on the history, progress, and future of the SHIP grant.
- The SHIP State-Level Evaluation team sought to capture these perspectives.
- Presenting key themes today.

# Methods

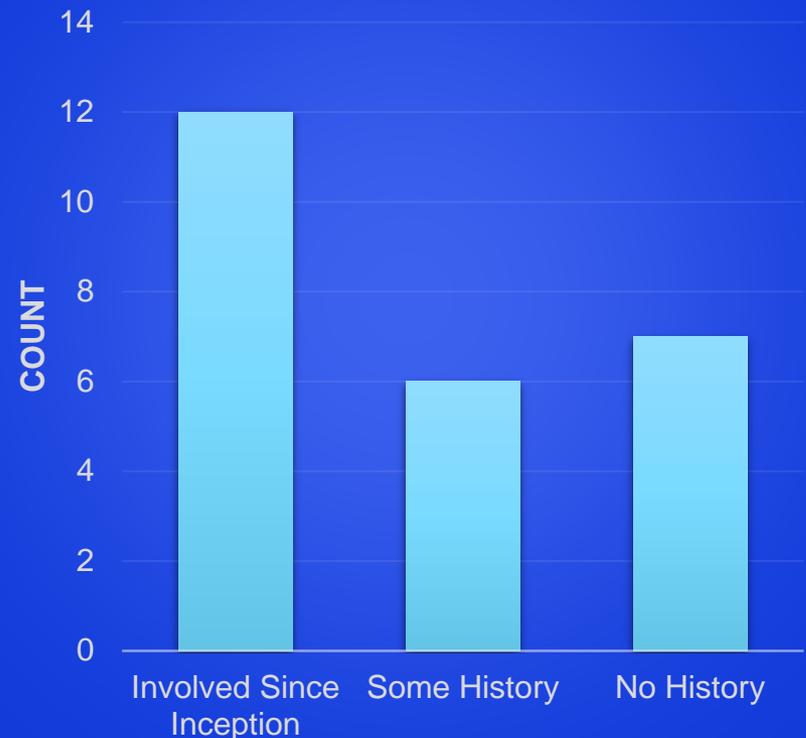
- 30-minute, one-on-one, confidential interviews.
- Six questions.
- 25 (63%) of eligible IHC members participated in the interview.

(Thank you !)

# Question 1

- *What is your history with the Idaho Medical Home Initiative (IMHI)?*
- Majority (72%) of IHC members have some history with important Idaho medical home initiative.

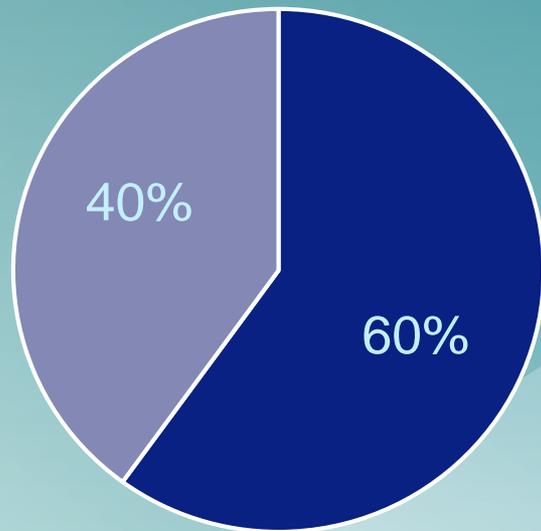
## Survey Participant History with IMHI



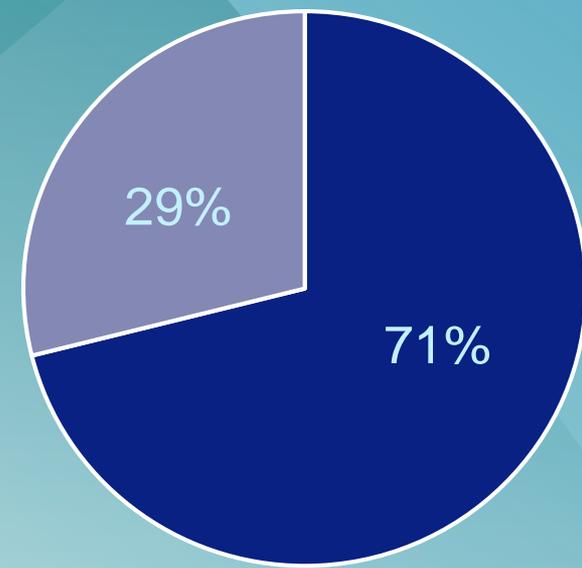
# Question 2

- *What professional lens or perspective would you say you bring to the Idaho Healthcare Coalition?*

Survey Participants



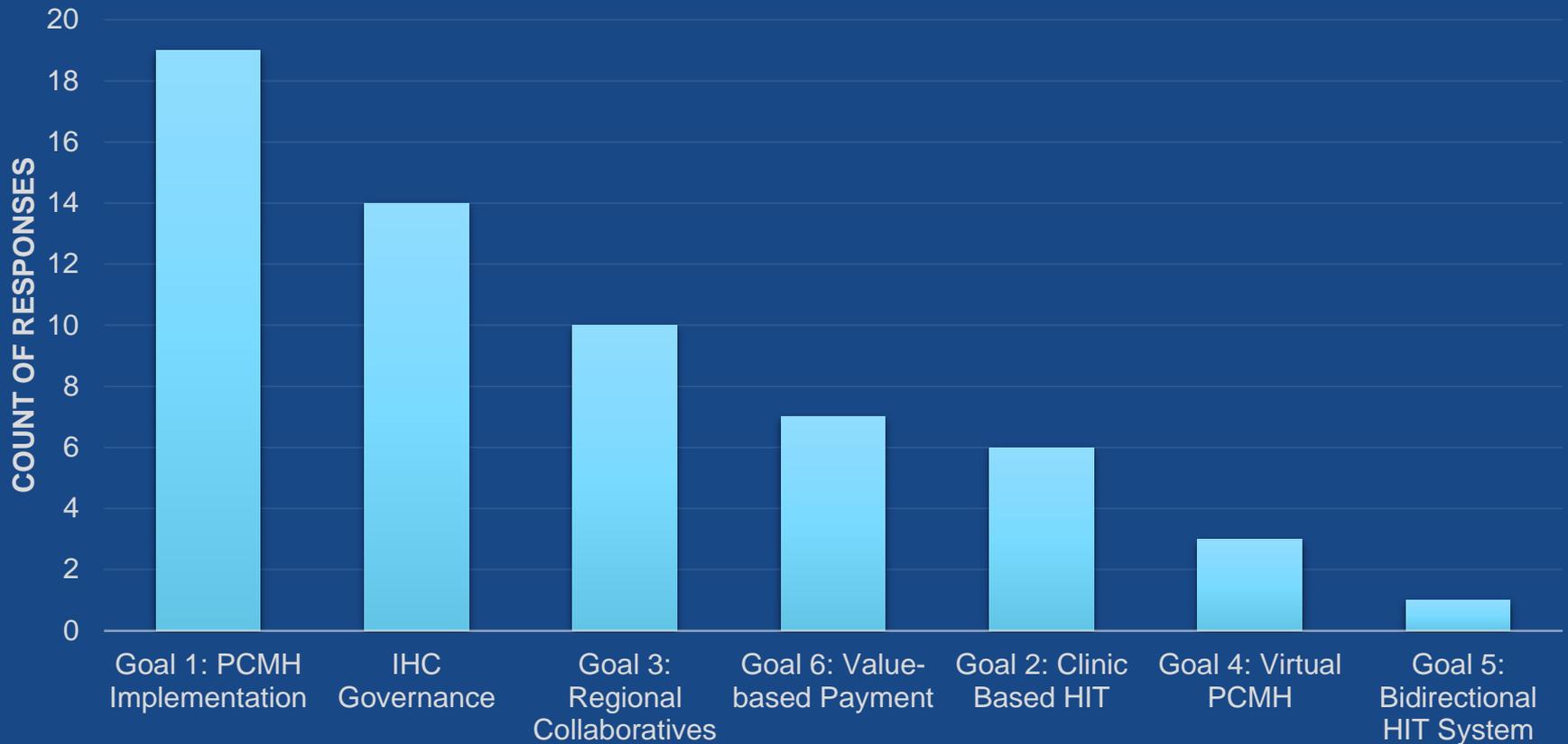
All IHC Members



# Question 3

- What would you say are the key accomplishments of SHIP so far?*

## Number of Responses by Key Accomplishment



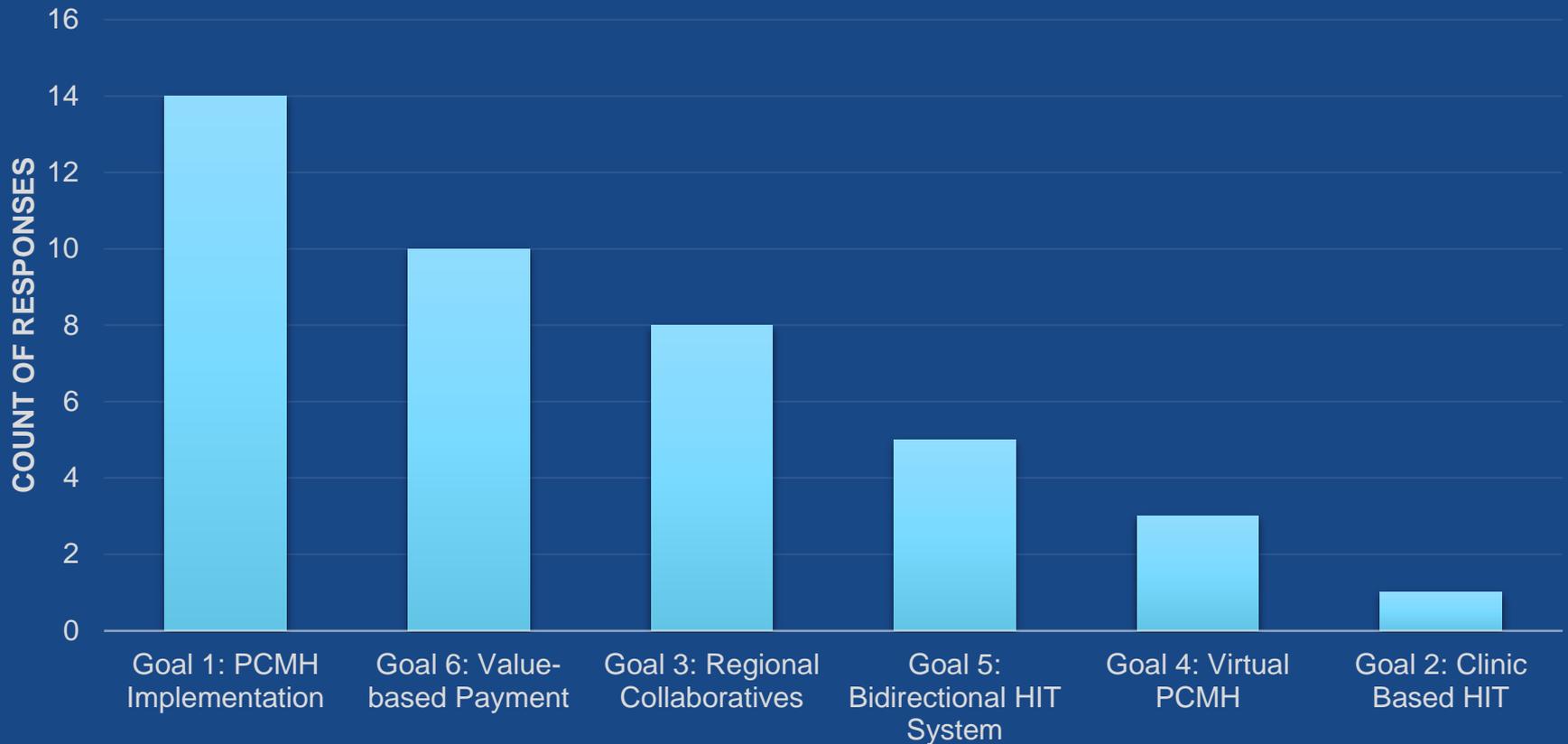
# Question 3 Response Breakdown

	<u>%(n)</u>	<u>Categories</u>	<u>(n)</u>
<b>Goal 1: Implementation of Patient Centered Medical Home</b>	76% (19)	<b>implementation of PCMH with team based care</b>	<b>18</b>
		increase in patient engagement	1
		improvement in patient experience (from Triple Aim)	1
<b>Other (IHC Governance)</b>	66% (14)	<b>bringing people together: stake holder engagement</b>	<b>11</b>
		workgroups	2
		population perspective	2
		innovating healthcare	1
		working together	1
<b>Goal 3: Regional Collaboratives</b>	40% (10)	<b>establishment of RCs</b>	<b>9</b>
		use of RCs to improve referrals in Medical Health Neighborhood	1
<b>Goal 6: Payer alignment from volume to value</b>	28% (7)	agreement among payers as to how to convert from volume to value	7
<b>Goal 2: Implementation of clinic based health information technology</b>	24% (6)	implementation of HIT at clinic	5
		use of HIT registry development for population health	2
<b>Goal 4: Virtual Patient Centered Medical Home</b>	12% (3)	implementation of VPCMH by at least one element (Community Health Workers, telehealth and/or Community Health Emergency Medical services)	3
<b>Goal 5: Statewide bidirectional HIT system</b>	4% (1)	implementation of bidirectional HIT system	1

# Question 4

- *What future accomplishments do you hope to see completed by the end of the SHIP grant?*

## Number of Responses by Future Accomplishment



# Question 4 Response Breakdown

	<u>%(n)</u>	<u>Categories</u>	<u>(n)</u>
<b>Goal 1: Implementation of Patient Centered Medical Home</b>	56% (14)	<b>coordination of care</b>	<b>10</b>
		expansion of PCMH in state	5
		educated public	3
		stabilization of PCMH with improved reimbursement	1
<b>Goal 6: Payer alignment from volume to value</b>	40% (10)	stable alignment of payments according to value	
<b>Goal 3: Regional Collaboratives</b>	32% (8)	<b>stabilization of RCs as ongoing not for profit</b>	<b>6</b>
		stabilization of IHC	3
		streamline RC practices	2
		one vision of medical health neighborhood	1
<b>Goal 5: Statewide bidirectional HIT system</b>	20% (5)	comprehensive use of state bidirectional HIT system	
<b>Goal 4: Virtual Patient Centered Medical Home</b>	12% (3)	expansion of VPCMH	
<b>Goal 2: Implementation of clinic based health information technology</b>	4% (1)	Successful implementation of clinic's HIT at clinic	

# Question 5

- *What major barriers do you foresee to the accomplishments of SHIP?*

<u>Barriers</u>	<u>% (n)</u>
payer-related	64% (16)
limited resources & sustainable funding	48% (12)
IHDE-related	32% (8)
RC-related	24% (6)
physician-related	16% (4)
hospital or clinic-related	16% (4)
patient and community-related	12% (3)
IHC-related	12% (3)
legislative	12% (3)
CMS	8% (2)

# Question 6

- ***Are there actions the IHC could take to address these barriers?***

<u>Actions</u>	<u>% (n)</u>
maintain commitment and contributions by IHC members	40% (10)
educate providers and clinics	40% (10)
increase awareness	36% (9)
cultivate mentorship and leadership	24% (6)
seek sources of sustainable funding	24% (6)
convene payers	16% (4)
influence state policy	12% (3)
build evidence of success	8% (2)

# Issues for Discussion



- Principles related to Goal 1 (PCMH)
- Goal 3 (Regional Collaboratives)
- Goal 6 (payment alignment from volume to value)
- IHC stakeholder & governance

*Improved health, improved healthcare, and lower cost for all Idahoans*

# Idaho Healthcare Coalition

September 13, 2017



Brad Erickson, Executive Director

# Organizations with Bidirectional Connections by end of September

## Cohort 1

- 37 of 55 Clinics connected (2 Clinics withdrew)
- 16 of 30 Organizations connected (2 Organizations withdrew)

## Complete

- Adams County Health Center (1 Clinic)
- Benewah Medical & Wellness Center (1 Clinic)
- Family Health Center (1 Clinic)
- Family Health Services (2 Clinics)
- Family Medicine Health Center (FMRI) (3 Clinics)
- Heritage Health (3 Clinics)
- Kaniksu Health Services (2 Clinics)
- Primary Health Medical Group (5 Clinics excludes IB-CCDA)
- Saint Alphonsus (4 Clinics no outbound interface)
- Unified Healthcare of Idaho – Tueller (1 Clinic)
- Terry Reilly Health Center (4 Clinics)
- Valley Family Health Care (1 Clinic)
- Valley Medical Center (1 Clinic)

## Expected by September

- Pocatello Children's (1 Clinic – EMR vendor risk)
- Madison Memorial Rexburg Medical Clinic (1 Clinic)
- St. Luke's (3 Clinics)
- SMH\_CVH Hospital Clinics (3 Clinics)

## Cohort 2

- 34 of 56 Clinics connected (1 Clinic withdrew)
- 12 of 30 Organizations connected (1 Organization withdrew)

## Complete

- Family Medicine Health Center (FMRI) (3 Clinics)
- Family Health Services (1 Clinic + 5 Healthy Connection Clinics)
- Heritage Health (1 Clinic)
- Kaniksu Health Services (2 Clinics)
- Primary Health Medical Group (4 Clinics + 8 Healthy Connection)
- St. Al's (5 Clinics)
- Coeur d'Alene Pediatrics (3 Clinics)
- Terry Reilly (4 Clinics + Health Connection Clinic)
- Valley Family Health Care (2 Clinics + remaining Healthy Connection Clinics)

## Expected by September

- Seasons (3 Clinics)
- Treasure Valley Family Medicine ( 1 Clinic)
- St. Luke's (2 Clinics)
- SMH\_CVH Hospital Clinics (3 Clinics)

# 27 Organizations Pending

- Organization(s) Waiting on Next Steps from Clinic/EMR Vendor:
  - Bear Lake Community Health Centers (1 Clinic)
  - Cascade Medical Center (1 Clinic)
  - Clearwater Medical Clinic (1 Clinic)
  - HealthWest (6 Clinics)
- Organizations Pending or in progress
  - Bingham Memorial Hospital (4 Clinics)
  - Family Health Associates (1 Clinic)
  - Genesis Community Health (1 Clinic)
  - Physicians Immediate Care Center (2 Clinics)
  - Southfork (1 Clinic)
- Organization(s)– Pending PA/BAA:
  - Sonshine Family Health Clinic (1 Clinic)
  - Syringa Primary Care (1 Clinic)
- Organization unable to integrate with HIE
  - All Seasons (1 Clinic)
  - Children and Family Clinic (1 Clinic)

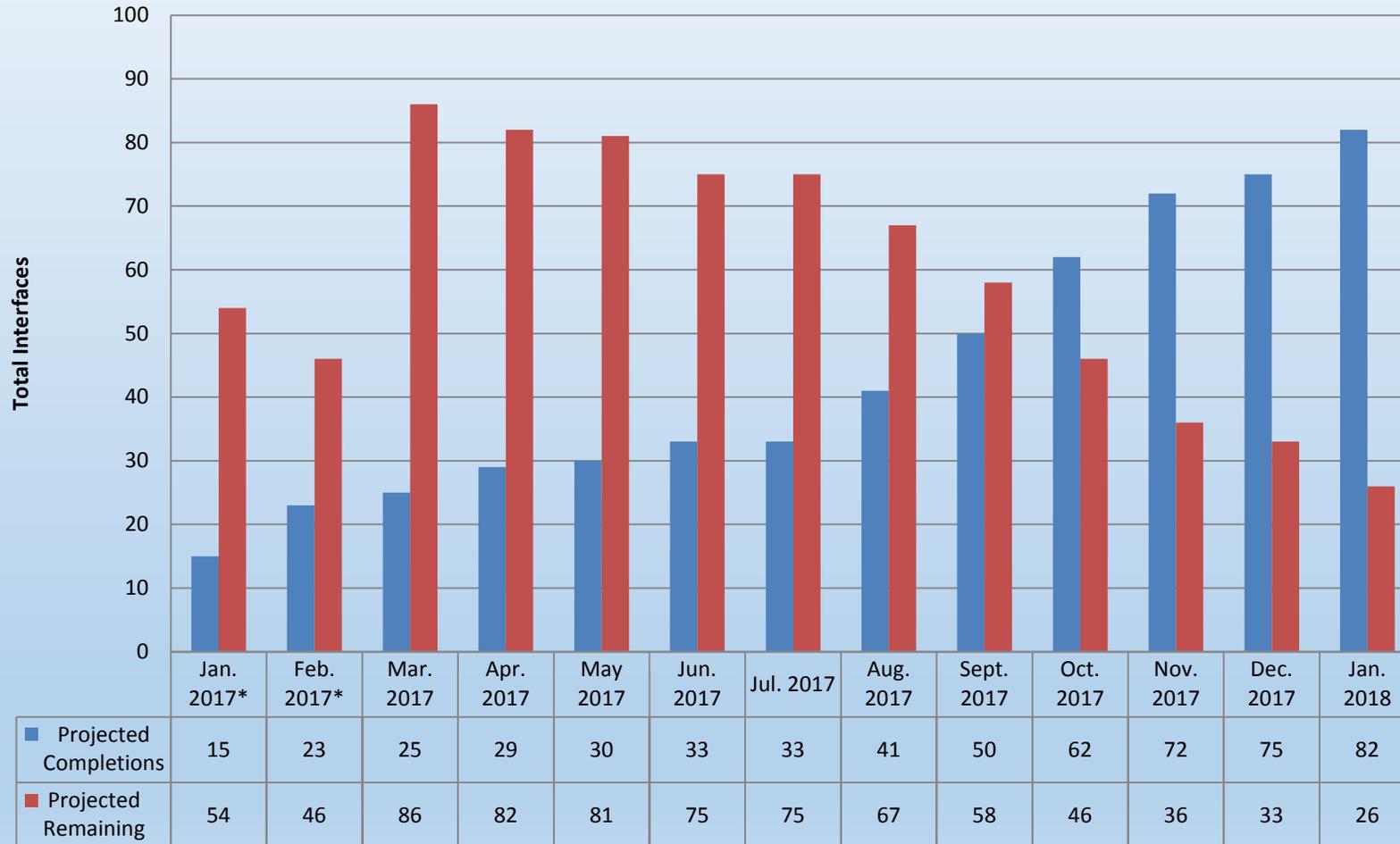
- Organization(s) On Hold – BH Filtering:
  - Glens Ferry (3 Clinics)
  - CHAS (IB CCDA) (2 Clinics)
- Organization(s) On Hold – PA “Modified” Agreements:
  - Driggs & Victor (PA Agreement Pending – 2 Clinics)
  - Not-tsoo Gah-nee (Pending IHS legal/ PA – 1 Clinic)
- Organization(s) On Hold – eCW Decision (IB HL7 and/or IB CCDA):
  - Complete Family Care (1 Clinic)
  - Family First Medical Group (1 Clinic)
  - Rocky Mountain Diabetes and Osteoporosis Center (1 Clinic)
  - Shoshone Family Medical Center (1 Clinic)
  - Upper Valley Community Health Services (GrandPeaks) (2 Clinics)
  - The Pediatric Center (1 Clinic)
  - Primary Health (No IB CCDA)
- Organization(s) Pending Withdrawn Confirmation:
  - Portneuf (1 Clinic)
  - Crosspointe (1 Clinic)
  - Saltzer Medical Group (1 Clinic)

# Appendix

## Graphs as of 9-8-17

# Interface Projections

## Projected Interfaces 2017



Note: 26 interfaces are on PERM HOLD and are NOT anticipated to be built based on current projections.

# Interface Summary

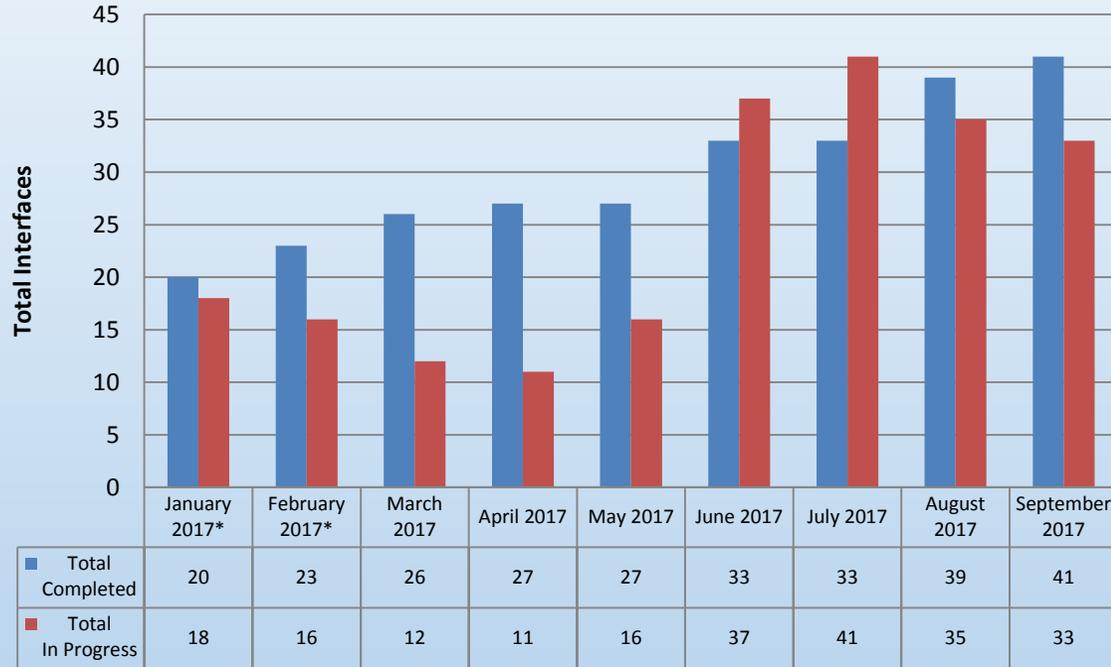
## Cohort 1 & 2 Interface Summary



26 Interfaces (13 Participants) identified as “PERM HOLD” from interface builds from Cohort 1 & 2 due to inability to build interface – refer to risk list for description of reason.

# Interfaces – Cohort 1 & 2 Status

## Interfaces (Cohort 1 & 2)



**Note:** 26 Interfaces (13 Participants) identified as "PERM HOLD" from interface builds from Cohort 1 & 2 due to inability to build interface – refer to risk list for description of reason . Three participants CANCELLED from statistics and interface builds from Cohort 1 & 2

## % Interfaces Completed



Interface Cohort 1 & 2	Total Completed	Total In Progress	Total Remaining	Total Interfaces	% Completed
January 2017*	20	18	31	69	29%
February 2017*	23	16	30	69	33%
March 2017	26	12	72	110	24%
April 2017	27	11	72	110	25%
May 2017	27	16	67	110	25%
June 2017	33	37	40	110	30%
July 2017	33	41	32	106	31%
August 2017	39	35	34	108	36%
September 2017	41	33	34	108	38%

\* Cohort 1 only  
8/2017 - 2 ADT interfaces added

# PCMH Mentorship Webinars Update

Idaho Healthcare Coalition  
September 13, 2017



PCMH Transformation Team – PCMH Mentorship Update  
September 13, 2017



# PCMH Mentorship Webinars

- PCMH Mentorship Kickoff webinar was held on July 31<sup>st</sup> for Cohort 1 and Cohort 2 clinics, and PHD SHIP QI staff
- PCMH Team discussed Mentorship goals and clinic needs
- Team sent a survey to clinics to assess interest among potential mentors and mentees, and to solicit feedback on topics
- PCMH Coaches are working with PHD SHIP QI staff to identify topics as well as recruit mentors and mentees

# PCMH Mentorship Webinars

- First Mentorship webinar focused on *Community Health Workers in the PCMH Model* and was held on August 17<sup>th</sup>
- Mentoring clinics provided information about how they started their programs, and the challenges and barriers they faced
- Over 50 participants
- Mentors shared their contact information for further questions

# PCMH Mentorship Webinars

- Next Mentorship webinar - *Behavioral Health Integration (BHI)*
  1. First BHI webinar will focus on Federally Qualified Health Centers (FQHCs) and community health sites – to be held at the end of September (tentative)
  2. Second BHI webinar will focus on examples and experiences from other clinics - to be held in October (tentative)
- Additional Mentorship topics suggested thus far:
  - Approaches to Risk stratification
  - Approaches to engage providers and staff to address the needed clinic culture changes for successful implementation of the PCMH model

Stay tuned for more information on PCMH Mentorship!



# SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition September 13, 2017

## **SHIP OPERATIONS:**

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

- **Report Items:**
  - CMMI requests for release of funds were approved for: 1) the University of Idaho (UI) State Evaluator; 2) City of Idaho Falls Ambulance CHEMS agency; 3) a request for out-of-state travel to attend the Patient Centered Primary Care Collaborative; 4) CHEMS agency Technical Assistance (TA) sub-grantee in-state travel; 5) out-of-state travel for MetaEHCO Summit; and 6) Idaho State University (ISU) funding for eight Health Specific Modules (HSM) and a live in-person course;
  - CMMI requests for release of Award Year Two carryover and Award Year Three funds were submitted for: 1) PCMH Technical Assistance (TA) contractor line item transfers; 2) line item transfers for out-of-state travel to attend PCMH Congress for PHD3 QI Specialist; and 3) line item transfers for out-of-state travel to attend PCMH Congress for PHD2 QI Specialist.
  - The Quarterly Report for Award Year Three second quarter was submitted to CMMI on August 29, 2017.

### **SHIP Administrative Reporting:**

- **Report Items:**
  - Four graduate research assistants from Boise State University (BSU) started with SHIP during the week of August 21, 2017.
  - Nineteen virtual PCMH applications/designations have been approved for Cohort One and Cohort Two clinics. Budget templates will be distributed to the selected clinics for completion to process the virtual PCMH reimbursement payments.
  - The first webinar for the MentorSHIP program was held in late July and featured four SHIP clinics that utilize CHWs in their primary care practices.
  - The telehealth grant application submissions are due September 15, 2017.
  - The Cohort Three application for consideration for the SHIP PCMH transformation initiative will open on September 18, 2017.
  - Cohort Three informational webinars began the first week of September to orient clinics to the PCMH application process, timelines, and the features and benefits of participation.

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

- **Report Items:**
  - District 1: 7/26/17 RC meeting at Panhandle Health District offices. Discussed diabetes QI project update, Idaho Integrated Behavioral Health Network regional conference call results and setting up the first meeting, August PCMH meeting agenda, Community Health Assessment update and next steps, Medical Health Neighborhood (MHN) - diabetes education sources at Kootenai Health and Bonner General and prediabetes program through PHD, quarterly RC executive team conference call discussion, RC CHEMS grant update with data from Bonner County EMS, and Healthy Connections Value Based Care discussion.

- District 2: 9/19/17 will be the date of the next RC2 meeting. Discussion will be focused on shared medical appointments (group visits) with a presentation from Corbett Carver from Pfizer. There will also be a short discussion with the State Evaluation team on their future endeavors with the clinics.
- District 3: Oral Health Workgroup (7/6): discussed the data collection tool and BP monitoring toolkit; crisis center (7/14): review of Canyon County meeting and white paper review; ED utilization (7/17): assessment draft and messaging campaign; PCMH Workgroup (7/18): MIPS resources; BHI Workgroup (7/24): school project update, matrix review, co-management update, crisis center update; Senior Workgroup (7/25): resource guide for CHEMS and run sheet project. Discussion included oral health: the Oral Health Workgroup is actively collecting data from four dental sites (two private and two FQHCs) on PCP attribution and high blood pressure. This work is crucial to driving oral health integration in the region. Behavioral health: this workgroup is currently supporting an effort to help increase access to behavioral health services for students and their families. This work is going well and will serve as a framework for future efforts. In addition, the group discussed the first partnership to support co-management partnerships/agreements. This MOU was signed in July. ED utilization: the group finalized the four form letters for frequent utilizers to be sent by PCPs. It continues the work of developing an assessment for CHWs and is exploring a public messaging campaign to reduce inappropriate utilization. Senior: the group discussed how to collect data on the resource navigation work and how to reach PCPs on the run sheet project.
- District 4: CHC meeting - No CHC meeting this month - transitioned to a bi-monthly frequency. Exec. Leadership meeting 7/19/17. Discussion at the CHC Executive Leadership meeting on 7/19/17 included the need to facilitate a mid-point evaluation/discussion with RC members to get qualitative feedback regarding their experience as a member of the RC, what has been done collectively as a group, and where the group needs to go in the future. Also discussed was the need to brainstorm ideas for RC sustainability at an upcoming CHC meeting, the Medicaid Healthy Connections Value Care White Paper, the role of the Idaho Integrated Behavioral Health Network (IIBHN), Prescription Drug Overdose Prevention grant, and the RC sub-grant project (Caregiver Integration Project) updates. Plans to share all information at upcoming CHC meeting on 8/1/17 as time permits.
- District 5: The SCHC did not meet in July. The next scheduled meeting is August 18.
- District 6: No RC meetings were convened. An Executive Committee meeting was scheduled for July 12th but was cancelled.
- District 7: RC meeting July 13th.
- **Next Steps:**
  - District 1: Evaluate possible role of the RC in the future CHOICE advisory board with Medicaid. Strategic Plan update.
  - District 2: None right now.
  - District 3: In the months of Aug. and Sept., the SHIP team will work on updating the community health assessments and workgroup project plans based on new data to support population health focus. The team will also plan to meet with CHC to discuss their role in the new RCO model to support sustainability. In addition, the SHIP manager and the district director will continue to lead project planning for Together Southwest, a key component of sustainability. The workgroups will continue their project plans to support both the prevention (population health) and clinical (PCMH support) arms of the SWHC work.
  - District 4: Next CHC meeting is scheduled for 8/1/17.

- District 5: The next SCHC meeting will occur August 18. Topics of discussion will be a review of the IHC meeting, RC membership, an IDHW SHIP Central update, and an update from Ruby Cash regarding the data quality improvement process.
- District 6: Plan August 9 Executive Committee meeting and August 17 Clinic Committee meeting. Will consider RC grant opportunity.
- District 7: Continue meeting with MHN resources that can help further PCMH work. Child Protection Services and Drug Prescription resources to present during next RC meeting. Work with partners on Community Health Needs assessments in area.

## **ADVISORY GROUP REPORTS:**



### **Telehealth SHIP Subcommittee:**

- **Report Items:**
  - Current participating telehealth clinics had their kick-off site visit with the technical assistance contractor, Health Management Associates (HMA), at the end of August. This was a very productive and beneficial meeting for those clinics.
  - The telehealth grant application for SHIP Cohorts One and Two clinics and SHIP CHEMS agencies is now available, and due September 15, 2017. A total of \$225,000 is available for nine awards in the amount of up to \$25,000 each.
  - IDHW and telehealth expert subcommittee to meet at the end of September to review and score telehealth applicants. Notice of awards to accepted clinics will be sent out by October 2, 2017.
- **Next Steps:**
  - Continue marketing the telehealth grant opportunity and follow up with clinics that have expressed interest in the past or that are currently utilizing telehealth in their clinics.



### **Community Health Workers:**

- **Report Items:**
  - Due to lack of student participants, the in-person CHW course was cancelled. The live online course started Wednesday August 23, 2017.
  - ISU will develop eight and host up to twelve asynchronous topics as Health Specific Modules (HSM) that may be used for elective modules or continuing education modules for students completing the core courses.
    - First HSMs being developed are: Pre-Diabetes and Diabetes, Congestive Heart Failure, and Oral Health.
    - Second set of HSMs are in the process of being developed and topics include: Caregiver Resources, Tobacco (Smoking Cessation), Congestive Obstructive Pulmonary Disease (COPD), and Medication Adherence.
- **Next Steps:**
  - Will begin data collection for students who completed the course in December 2016.
  - Conduct marketing research for spring 2018 semester and if there is interest in a physical in-person course, where the best place to deliver that may be.

## **WORKGROUP REPORTS:**



### **Community Health EMS:**

- **Report Items:**

- The statewide CHEMS Workgroup met on August 23, 2017.
- The next statewide CHEMS Workgroup meeting is scheduled for September 27, 2017 from 10:00 to 11:00 AM MST.
- ISU CP Program 3rd Cohort
  - Interested agencies: Parma Rural Fire District, Shoshone County EMS, Payette County Paramedics, Donnelly Fire Department, Cascade Rural Fire District, and Canyon County Paramedics.
  - Total of 12 students.
- BLS/ILS Curriculum
  - Thirteen agencies, 54 students are interested.
  - Curriculum development still underway.
- CMMI tiered funding requests:
  - A total of 11-tiered funding opportunities are available.
  - Bonner, Boundary, Canyon, Payette, and Shoshone have received funding.
  - Idaho Falls has submitted their budget.
  - No further progress from Blackfoot.
- Learning Collaborative and Webinars
  - Learning Collaborative is tentatively scheduled for January 17, 2017.
    - Keynote speaker: Matt Zavadsky.
  - The first webinar is scheduled for September 14, 2017 from 2:00-3:00 MST.
    - Presenter: Teresa Shackelford, LCSW, Region IV Behavioral Health Clinic Supervisor.
    - Focus: the importance of mental and behavioral health in healthcare and healthcare recovery, accessible statewide resources for CHEMS agencies, and how to incorporate mental and behavioral health into CHEMS programs.
    - Possible focus of 2nd webinar: Transitional Care.

- **Next Steps:**

- Project Charter, deliverable 3 – in progress.
  - BLS/ILS curriculum development – drafting CRF.
- Project Charter, deliverable 6 – in progress.
  - Upcoming learning collaborative and webinar logistics.
- Continue to promote CMMI tiered funding and CP ISU Certificate Program.
- The internal CHEMS Workgroup continues to meet every Monday.



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

- **Report Item:**

- The Idaho Medical Home Collaborative did not meet this month.

- **Next Steps:**

- The workgroup will continue to meet on an ad hoc basis.



## Data Governance:

- **Report Item:**

- The Data Governance Workgroup met on August 14, 2017.
  - Dr. Kathy Turner, from the Bureau of Communicable Disease Prevention, presented data on childhood immunization within the state of Idaho. This included how the data will be reported at the clinic, region, and statewide levels.
  - Janica Hardin, the Data Governance Workgroup Co-chair, presented the issue resolution process flow chart that will serve as the backbone for identifying and resolving issues in the data reporting from clinics to the Idaho Health Data Exchange (IHDE) and HealthTech Solutions (HTS).
  - With a discussion on the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measure, workgroup members determined that the HTS measure calculation logic needed to be updated to accurately align with the federal requirements.
  - The workgroup also discussed the *Preventive Care and Screening: Adult Body Mass Index Screening and Follow-Up Plan* measure and determined that further federal clarification would be helpful in defining what an “eligible encounter” is so that the measure rules would be accurately applied to the SHIP analytics.

- **Next Steps:**

- The next SHIP Data Analytics Workgroup meeting is scheduled for October 2<sup>nd</sup>.
- HTS will update the measure calculation logic for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measure, to ensure it accurately aligns with the federal requirements.
- The SHIP Operations team will receive technical assistance from CMMI with regard to the *Preventive Care and Screening: Adult Body Mass Index Screening and Follow-Up Plan* measure to determine the correct definition of an eligible encounter and report back to the workgroup.



## Multi-Payer:

- **Report Item:**

- The Multi-Payer Workgroup (MPW) met August 31, 2017. The SHIP Financial Analysis Assessment of 2016 was presented by Scott Banken, CPA, Senior Associate from Mercer. The workgroup recommended the report, as presented, be provided to the IHC at the September meeting. The IHC will review and make a recommendation about forwarding the report, as presented, to CMMI.
- The updated SHIP Goal 6 Project Charter and updated MPW Charter were presented to the workgroup by Katie Falls, Principal at Mercer. The workgroup recommended the Goal 6 Charter and the MPW Charter be presented to the IHC for approval at the September 13th IHC meeting.
- Scott Banken and Cynthia York provided an update on the Alternate Payment Model framework. Scott reminded the workgroup about how the information for the SHIP Payer

Financial and Enrollment Metrics report was captured for calendar year 2015. He will contact the payers individually, within the next two weeks, requesting the data for calendar year 2016.

- Julie Lineberger and James Wong provided an IHDE update. A discussion was held about what data from IHDE would add value to their business models.
- Josh Bishop is leaving PacificSource and resigned as the MPW co-chair. Norm Varin, PacificSource, was elected as the new co-chair. SHIP staff and members of the workgroup expressed their gratitude for Josh's leadership and participation in Idaho's efforts to transform healthcare.

- **Next Steps:**

- The SHIP Administrator will work with the SHIP team to produce a telehealth payment matrix from information received from Medicaid, Medicare and commercial payers.
- The workgroup will continue to meet on an ad hoc basis.

## **BHI**

### **Behavioral Health:**

- **Report Item:**

- The BHI Sub-Committee met on August 1, 2017
- An update on telehealth/CHW and CHEMS was provided by Madeline Russell.
- The IIBHN provided a report on the strategic planning session and discussed next steps for broadening connections statewide.
- A presentation was provided by Jennifer Yturriondobeitia of St. Luke's Health Partners.
- Dr. Ben Miller with the Farley Policy Center will be working with Idaho about behavioral health integration in the State of Idaho, barriers, goals, and potential areas for TA.

- **Next Steps:**

- The next Behavioral Health Integration Workgroup meeting will be held October 3<sup>rd</sup> 2017.

## **PHW**

### **Population Health:**

- **Report Item:**

- The PHW met September 6, 2017.
- The Get Healthy Idaho website ([gethealthy.dhw.idaho.gov](http://gethealthy.dhw.idaho.gov)) experienced a failure last month and is still in the process of being rebuilt by the vendor and the Division of Public Health. The revisions will also include more data relevant to the social determinants of health.
- Sonja Schriever presented an update on the Prescription Drug Overdose grant being conducted by the Division of Public Health. Recently the program moved into the Bureau of Community and Environmental Health and a program manager is in the process of being hired. The grant continues to fund the Office of Drug Policy to conduct strategic planning (plan due to be completed at the end of September), the Board of Pharmacy (just connected over 300 prescribers to the Prescription Drug Monitoring Program through their EHRs using a product called Gateway), and the local public health districts (continuing to conduct prescriber education). A supplemental grant opportunity for media/marketing and additional healthcare provider outreach and education was received. Lastly, staff from DHW divisions of Public Health, Behavioral Health, and Medicaid are attending a Region X summit in Seattle, WA, September 7-8 to focus on developing a regional strategy.

- Kathy Turner and Robert Graff presented syndromic surveillance data that is being collected across the state from hospital EDs using a web-based platform called Essence. Syndromic surveillance looks at chief complaints (self-reported, free text), triage notes if available, discharge diagnosis (ICD-10), discharge disposition (discharged, admitted, transferred, died), as well as the person's demographics (age, sex, race, ethnicity, zip code) and visit time and date. The data can be used in preparedness planning and response. The example of how the data can be used was given for opiate-related ED visits in Idaho. Currently there are 10 EDs providing data into the system. The Division of Public Health can then pull down the data for analysis.
  - Burke Jensen, provided an update on the status of the connectivity of the clinics to IHDE, the status of the clinical measures, and HealthTech's development of the data dashboards. HealthTech will be training health district staff on how to access the dashboard. He also reviewed how clinic data flow and the program's data quality improvement process.
  - Kym Schreiber provided a draft of the PCMH Mentorship Resource guide and asked for feedback by the end of October. The resource guide is one of four components to the PCMH Mentorship Toolkit. The other three components are a master list of resources, a webinar series, and a provider panel.
  - Madeline Russell provided an update on Goal 4, the virtual PCMH: CHEMS, CHW, and telehealth. There are 19 new clinics designated as virtual. There are six CHEMS agencies and educational opportunities are underway in webinars and learning collaboratives. The BLS/ILS CHEMS training course development is also underway. A live, online CHW course started in late August with 17 students enrolled. There are six health-specific modules already developed: breast health and screening, cervical health and screening, colorectal health and screening, cardiovascular health and screening, oral health, and behavioral health and substance abuse. Six additional modules under development are: prediabetes and diabetes, congestive heart failure, caregiver resources, smoking cessation, COPD, and medication adherence. For telehealth, there is still funding available for nine telehealth grant projects in single awards of up to \$25,000 each. HMA has been hired as the technical assistance contractor on telehealth. Project ECHO is being established in Idaho by the University of Idaho, WAMMI Program and the SHIP program is providing the opportunity to have ECHO established in three clinical focus areas: opioid addiction, chronic pain management, and mental/behavioral health. The program is being established for clinics statewide, not just SHIP cohort clinics.
  - The PHWG created an inventory of initiatives being conducted in clinics across the state and have also created an interactive map. The group discussed additions to the inventory and map and who the owner of the product will be to keep it updated and relevant.
  - The Idaho Oral Health Alliance is working on oral health integration in approximately 60 primary care settings; 22 clinics have integrated fluoride varnish in the primary care office and are receiving reimbursement under a medical code.
- **Next Steps:**
    - The next Population Health Workgroup meeting will be held October 4<sup>th</sup> 2017 from 3:00-4:30pm MST.