



Idaho Healthcare Coalition

Meeting Agenda

August 8, 2018 2:00PM – 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: 773079

Join from PC, Mac, Linux, iOS or Android:

<https://zoom.us/j/463737800?pwd=VFRUdnBjeTNRG05YjduUE4xM3RPdz09>

Password: 12345

****Please note new meeting platform will be used, same dial in number****

2:00 p.m.	Opening remarks; roll call; introduce any new members, guests, any new IDHW staff; agenda review; and approval of meeting minutes – <i>Dr. Ted Epperly, IHC Chair</i> – ACTION ITEM(S)
2:10 p.m.	Financial Analysis Report Update – <i>Scott Banken, Principal, Mercer</i> – ACTION ITEM
2:35 p.m.	SHIP Data Quality Pivot - <i>Burke Jensen, SHIP Project Manager & Janica Hardin, DGW Co-Chair</i> – ACTION ITEM
3:00 p.m.	Sustainability Plan Part 2 – <i>Katie Falls, Mercer</i> ACTION ITEM
3:15 p.m.	IHDE Connection Update – <i>Jim Borchers, IHDE Marketing Director</i>
3:25 p.m.	Public Meeting Law Update – <i>Nicole McKay, Deputy Attorney General</i>
3:35 p.m.	Break
3:45 p.m.	Transformation Sustainability Workgroup Update – <i>Ted Epperly, IHC Chair & Katie Falls, Mercer</i>
4:00 p.m.	RC Survey Presentation of Results – <i>Elizabeth Spaulding, Langden Group</i>
4:15 p.m.	CHW Learning Collaborative Update – <i>Madeline Russell, SHIP Project Manager</i>
4:20 p.m.	SHIP Operations and Advisory Group reports/ Updates - Please see written report (SHIP Operations and IHC Workgroup reports): <ul style="list-style-type: none">• Presentations, Staffing, Contracts, and RFPs status – Casey Moyer, IDHW• Regional Collaboratives Update - Madeline Russell, IDHW• Telehealth, Community Health EMS, Community Health Workers - Madeline Russell, IDHW• Data Governance Workgroup - Dr. Andrew Baron, Terry Reilly and Janica Hardin, Saint Alphonsus, Workgroup Chairs• Multi-Payer Workgroup - Norm Varin, PacificSource and Dr. Kelly McGrath, Workgroup Chairs• Behavioral Health/Primary Care Integration Workgroup - Ross Edmunds, IDHW and Dr. Charles Novak, Workgroup Co-Chairs• Population Health Workgroup - Elke Shaw-Tulloch, IDHW & Carol Moehrle, Public Health Idaho North Central District, Workgroup Chairs• IMHC Workgroup – Dr. Scott Dunn, Family Health Center and Matt Wimmer, IDHW Workgroup Chairs
4:25 p.m.	Additional business & next steps - <i>Dr. Ted Epperly, IHC 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-health neighborhood.

Goal 3: Establish seven Regional Collaboratives to support the integration of each PCMH with the broader medical-health 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

Meeting Minutes:

SUBJECT: IHC July Minutes

ATTENDEES: Russ Barron, Russell Duke, Ted Epperly, MD, Lisa Hettinger, Drew Hobby, David Pate, MD, Susie Pouliot, Kevin Rich, MD, Rhonda Robinson-Beale, MD, Elke Shaw-Tulloch, Mary Sheridan, Larry Tisdale, Karen Vauk, Jennifer Wheeler, Beth Kriete as proxy for Matt Wimmer, Casey Moyer as proxy for Cynthia York

Teleconference: Michelle Anderson, Kathy Brashear, Pam Catt-Oliason, Janica Hardin, Mark Horrocks, MD, Maggie Mann Yvonne Ketchum-Ward, Deena LaJoie, Neva Santos, Lora Whalen

Members Absent: Andrew Baron, MD, Richard Bell, MD, Melody Bowyer, Melissa Christian, Keith Davis, MD, Scott Dunn, MD, Ross Edmunds, Lee Heider, Glenn Jefferson, MD, Amy Mart, Kelly McGrath, MD, Nicole McKay, Carol Moehrle, Casey Meza, Daniel Ordyna, Tammy Perkins, David Peterman, MD, Geri Rackow, Boyd Southwick, MD, Norm Varin, Fred Wood, Nikole Zogg

IDHW Staff Jeff Crouch, Madeline Russell, Kymberlee Schreiber, Sherie Thompson, Ann Watkins,

STATUS: Draft 7/16/2018

DATE: July 11, 2018

LOCATION: 700 W State Street, 1st Floor East Conference Room

Summary of Motions/Decisions:

Motion:

Larry Tisdale moved that the IHC accept the June 13, 2018 meeting minutes.
Mary Sheridan seconded the motion.

Outcome:

Passed

Russ Duke moved that IHC members be asked to support the creation of a letter to the Health Quality Planning Commission (HQPC) to ask for their help in continuing the momentum of the telehealth work that has begun and finding potential solutions to identified challenges.

Passed

Susie Pouliot seconded the motion.

Agenda Topics:

Opening remarks, Introductions, Agenda review, Approve minutes – Ted Epperly, MD, IHC Co-Chair

- ◆ Lisa Hettinger welcomed everyone to the meeting and took role.
- ◆ Lisa Hettinger announced that Casey Moyer has accepted the position of program administrator of OHPI, replacing Cynthia York who retired in June.
- ◆ A motion to approve June's IHC meeting minutes was made by Larry Tisdale; the motion was seconded by Mary Sheridan. The motion carried

Financial Analysis Report for AY3 – Scott Banken, CPA, Principal, Mercer

- ◆ Scott Banken announced that he is still awaiting data from Medicaid. He will present the report to the IHC following submission of the Medicaid data and review of the revised report by the Multi-Payer Workgroup.

Telehealth Council Update – Stacey Carson, Telehealth Council Chair; Mary Sheridan, Bureau Chief, Bureau of Rural Health and Primary Care

- ◆ Stacey Carson reviewed the history of the Idaho Telehealth Council (ITC) which was created by House Concurrent Resolution 46. It defined telehealth as a mode of delivering healthcare services that use information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health providers.
- ◆ The charter of the ITC is to coordinate and develop a comprehensive set of standards, policies, rules, and procedures for the use of telehealth and telemedicine in Idaho.
- ◆ Chapter 57, Title 54 of the Idaho Code enacted the Idaho Telehealth Access Act in 2015 which clarifies practice standards.
- ◆ In 2016, the ITC goals were to:
 - Develop a roadmap to operationalize and expand telehealth services in SHIP PCMHs and CHEMS programs.
 - Examine reimbursement policies and determine telemedicine payment models that support the Triple Aim.
 - Act in an advisory capacity to regulatory boards and state agencies proposing rules and regulations specific to the use of telemedicine.

- ◆ The Telehealth Council has not met since 2016. Stacey Carson recommended that since there are only eight members remaining, if the ITC is to continue, a new group be convened.
- ◆ A reimbursement matrix for telehealth was developed by payers in 2015 and was updated by the Multi-Payer Workgroup in 2018.
- ◆ Mary Sheridan reviewed the May 23 Telehealth Planning meeting. (The executive summary of the meeting is included in the IHC meeting packet.) Stakeholders agreed that telehealth holds value in Idaho for rural and underserved communities and recommended that the stakeholder organization carry this initiative forward post-SHIP.
- ◆ It was moved by Russ Duke that IHC members be asked to support the creation of a letter to the HQPC to ask for their help in continuing the momentum of the telehealth work that has begun and finding potential solutions to identified challenges. Susie Pouliot seconded and the motion carried.

Sustainability Plan Update & Success Measure Dashboard – *Maggie Wolfe, Senior Associate, Mercer*

- ◆ Maggie Wolfe announced that phase one of the CMMI-required sustainability plan was submitted to CMMI April 30, 2018. Phase two is due August 31, 2018. She also presented the most recent quarterly success measures data submitted to CMMI. Highlights include:
 - Seventy-five SHIP clinics have achieved national PCMH recognition/accreditation.
 - Eight additional individuals finished the in-person CHW course in Q1 but did not receive their certificate of completion until Q2.
 - Reporting for the new Goal 4 metric (number of SHIP clinics that participate in Project ECHO) will start next quarter.
- ◆ In response to a question from Ted Epperly about Goal 3, Maddy Russell answered that all trained CHWs to date are employed either through a healthcare organization or a community-based organization.
- ◆ A discussion took place about Goal 5 and its significant data quality issues. It was agreed that it's important to have reliable quality improvement data and that valuable information has been garnered on best practices and lessons learned relating to data quality/management issues. Effective payment reform models rely on accurate quality data as well. Additional information will be presented on Goal 5 at the next meeting.

Transformation Sustainability Workgroup Update – *Dr. Ted Epperly, IHC Chair; Dr. Jeanene Smith, HMA*

- ◆ The workgroup is meeting every 2-3 weeks. A charter is being completed that will be brought to the IHC for approval in September.

PCMH Learning Collaborative Update – *Kym Schreiber, Project Manager, SHIP Operations; Dr. Jeanene Smith, HMA*

- ◆ The learning collaborative was held June 27 and 28 in Boise with 151 attendees. One hundred of the attendees represented all 53 Cohort Three clinics. The remaining 51 attendees were PHD SHIP staff, speakers, payers, sponsors, IDHW, Healthy Connections, the State Evaluator Team (SET), and the PCMH team.
- ◆ Day one included a discussion panel on success stories, presentations from the SET and IHDE, and breakout sessions. Ninety-seven percent of respondents to a survey were very satisfied/satisfied with the day's activities.

- ◆ Day two included an introduction to the Blue Cross of Idaho Foundation Rural Health Initiative, a multi-payer panel, breakout sessions, and a world café group activity. One hundred percent of respondents were very satisfied/satisfied with the day's activities.

IHDE Connection Update – *Brad Erickson, IHDE Executive Director*

- ◆ Seventy-five clinics are now fully bi-directional. This is up from last month's connection count of 60 clinics. One hundred forty-two of 165 clinics are connected or are projected to be by January 31, 2019. This is up from last month's projection of 129.
- ◆ Since February 2018, there have been 112 clinic and 27 hospital visits and 773 new users trained.

Additional Business and Next Steps- *Ted Epperly, MD, IHC Co-Chair*

- ◆ As a reminder, IHC meetings are now being held from 2:00 to 4:30pm on the second Wednesday of each month.
- ◆ Dr. Epperly closed the meeting with a quote: "All of us are smarter than any of us." ~ Douglas Merrill
- ◆ There being no further business, the meeting was adjourned at 4:20PM.



Idaho Healthcare Coalition (IHC) August 8, 2018

Action Items

- Action Item 1 – July IHC Meeting Minutes

IHC members will be asked to adopt the minutes from the July 11, 2018 IHC meeting:

Motion: I, _____ move to accept the minutes of the July 11, 2018, Idaho Healthcare Coalition (IHC) meeting as prepared.

Second: _____

Motion Carried.

- Action Item 2 – IHC Membership

IHC members will be asked to support a change in membership. Cynthia York in her capacity as Administrator of OHPI was a member of the IHC. Since her retirement, Casey Moyer has assumed these job duties and will represent OHPI on the IHC.

Motion: I, _____ move that the Idaho Healthcare Coalition (IHC) recommend to the Governor, that Casey Moyer be appointed to the IHC to replace Cynthia York.

Second: _____

Motion Carried.

- Action Item 3 – Financial Report

IHC members will be asked to support submission of the SHIP Financial Analysis, as presented by Mercer, to CMMI as required by the grant.

Motion: I, _____ move that the Idaho Healthcare Coalition (IHC) support the submission of the Financial Analysis report to CMMI as presented by Mercer.

Second: _____

Motion Carried.

■ Action Item 4 – Data Quality Pivot

IHC members will be asked to support the change of scope and reporting related to Goal 5 of the project. Certain reporting is mandated as part of the grant funding and this shift allows Idaho to remain compliant with the remaining time left in the grant.

Motion: I, _____ move that the Idaho Healthcare Coalition (IHC) support the change in scope to Goal 5 as presented by Burke Jensen and Janica Hardin.

Second: _____

Motion Carried.

■ Action Item 5 – Sustainability Plan Part 2

IHC members will be asked to support the submission of the Sustainability Plan Part 2 to CMMI as presented by Katie Falls.

Motion: I, _____ move that the Idaho Healthcare Coalition (IHC) support the submission of the Sustainability Plan Part 2 to CMMI.

Second: _____

Motion Carried.

HEALTH WEALTH CAREER

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN

FINANCIAL ANALYSIS FOR AWARD YEAR 3

AUGUST 2, 2018

Idaho Healthcare Coalition

CONTENTS

1. Executive Summary	2
2. Introduction	4
3. Background.....	6
• Grant Year Versus Calendar Year.....	6
4. Projected Impact of Implementing the SHIP	7
5. 2017 Financial Analysis Observations.....	10
• Membership Shifts.....	10
• Changes in Trend.....	10
• Analysis by Payer Type	11
6. Conclusion	13
Appendix A: Data Request.....	14
Appendix B: Data Request Table	15
• CY 2017	15
Appendix C: Category of Service Classifications.....	18

1

EXECUTIVE SUMMARY

In 2017, Idaho's Statewide Healthcare Innovation Plan (SHIP) continued promoting the transformation of healthcare payments from volume-based payments to payments focused on outcomes coinciding with the implementation of the patient-centered medical home (PCMH) model of care. To support testing of Idaho's SHIP, Idaho received a four-year federal State Innovation Model (SIM) 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 population's 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 avoidance 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 which 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 3.4% from 2016 to 2017 and 9.5% from 2015 to 2017, which was on par with the projected per capita trend of 4.6% projected for 2016 to 2017 and 9.0% from 2015 to 2017, respectively, by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT)¹. However, when analyzing cost avoidance by payer, Medicare (\$57.3 million) and Medicaid (\$66.3 million) cost avoided exceeded increased costs incurred by commercial payers (\$30.1 million) by \$93.5 million. Furthermore, Medicare and Medicaid showed significant progress overall toward achieving their cost avoidance

¹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2017Tables.zip>

targets for PCMH services. In 2017, Medicare showed decreases in PMPM costs in nearly all categories except other professional services.

The reported population includes three of the four largest commercial payers in Idaho, Idaho Medicare and Idaho Medicaid, representing roughly 1.1 million of Idaho's 1.6 million people. Actual costs for the demonstration are projected to be over \$93.5 million lower than if no intervention for the SHIP or payment reform were taking place. The costs indicate the financial goals of the SHIP continue to progress as expected after year two of the model test.

2

INTRODUCTION

The objective of Idaho's SHIP is 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 through the implementation of the PCMH model of care. One method to lower overall costs is by shifting healthcare payments from volume-based payments to payments focused on outcomes.

The Center for Medicare and Medicaid Innovation (CMMI) selected Idaho for a federal SIM Test grant to support testing of Idaho's SHIP. 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 PCMH model of care as a key tenant of its SHIP is supported by both national and state experience.

A decrease in cost was shown 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.

However, payers are concurrently testing other initiatives along with the PCMH model. Other important delivery and payment approaches share the common goal of improved health outcomes and lower costs. The largest commercial payers in the State have all implemented alternatives to fee-for-service (FFS) payments to incentivize and reward quality and improved health outcomes. These payment models include:

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

- Episode-Based Payments

In addition to the PCMH model, commercial payers are continuing to test alternative models including accountable care organizations (ACOs) with many of the State's 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 incentivized quality metrics to 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 is expanding the payment reform model in Idaho by incentivizing participation in the PCMH model.² Medicaid also is encouraging value-based purchasing through the development of accountable Regional Coalition 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.

² <http://healthandwelfare.idaho.gov/Default.aspx?TabId=216>

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 Center for Medicare and Medicaid Innovation (CMMI) 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 previously and shown in Table 1 below. For ease of data collection and participation from the payers, Mercer is collecting and calculating data on a calendar year (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 THE SHIP

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)	5.0% reduction in expenses related to elective and non-elective preterm birth, prior to 39 weeks	1.0%–4.0% of total Neonatal Intensive Care Unit (NICU) admissions (\$40 thousand–\$70 thousand/admit) are preventable with later deliveries	0.56% reduction in Inpatient Hospital utilization for Medicaid child per year ³
Generic Drug Use	Generic fill rate of 85.0%	Each 1.0% 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 ⁴

³ Ohio Perinatal Quality Collaborative 39-Weeks Delivery Charter Project (2008) <https://opqc.net/node/157>

⁴ 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.pccpc.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	5.0%–10.0% reduction	20.0% of all hospitalizations are preventable re-hospitalizations	0.5% reduction in Inpatient Hospital utilization for Medicare and Medicaid, 0.33% reduction for commercial ⁵
Acute Care Hospitalizations	1.0%–5.0% reduction	PCMHs reduce with IMPACT ⁶ & Intensive Outpatient Care Programs training	0.5% reduction in Inpatient and Outpatient Hospital unit cost for Medicare and Medicaid, 0.25% reduction for commercial ⁷
Non-Emergent Emergency Department (ED) Use	5.0%–10.0% reduction in total ED use	10.0%–30.0% of ED visits are non-emergent	1.0% reduction in ED utilization for all payers ⁸
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 ⁹

⁵ 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

⁶ 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.

⁷ Health Affairs, Health Policy Brief on Patient Engagement. February 14, 2013 viewable at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86

⁸ 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>

⁹ Health Affairs, Health Policy Brief on Patient Engagement. February 14, 2013 viewable at 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 OACT 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. Membership was assumed to remain constant and no shift between payers was included in the model. 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 OACT. Trend assumptions for commercial data for the same periods were derived from Mercer's proprietary commercial claims database. The results showed a projected cost avoidance 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 member months as a constant in the original model.

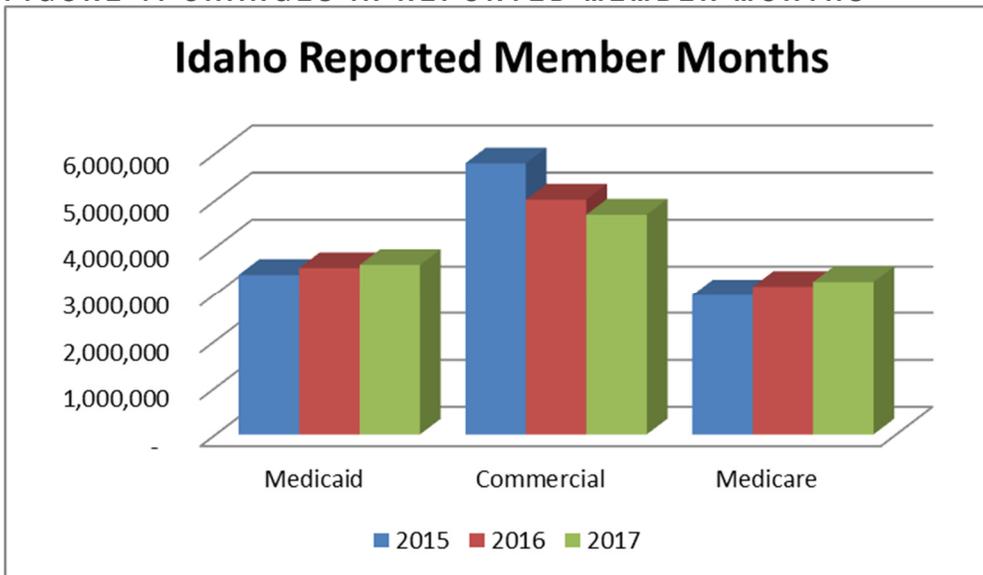
5

2017 FINANCIAL ANALYSIS OBSERVATIONS

MEMBERSHIP SHIFTS

In the projected model, membership was held constant by the payer type. Enrollment trends show a decline in reported commercial membership and steady growth in the public sectors. Member months, as reported by the payers, counts each month of the year for each member reported as one. As shown in Figure 1, the increase in both Medicaid and Medicare member months was more than offset by the reduction in commercial payers reported member months.

FIGURE 1: CHANGES IN REPORTED MEMBER MONTHS



Shifts in membership can affect trend and PMPM costs by payer if there is a change in the overall acuity of the membership base. For instance, Medicaid experienced a large influx of membership in 2016 because of the introduction of Idaho’s marketplace, which identified several beneficiaries as eligible for Medicaid. These beneficiaries were likely healthier as a whole than the base population used in original forecast. Conversely, the commercial payers reported significant decreases in family membership from 2015 to 2016 and showed a decrease in per member costs, indicating movement of high acuity beneficiaries to another payer.

CHANGES IN TREND

Restated costs for Medicaid recipients in 2015 and 2016 led to a restated Idaho trend of 0.8%, down from the previously reported 2.9% in the 2016 financial analysis. Reported trends in total for Idaho increased by 3.4% in 2017. The overall reported PMPM cost of care increased from \$476.58 in 2016 to \$492.96 in 2017.

TABLE 3: REPORTED TRENDS

PARTICIPANTS	BASELINE PMPM	2016 ACTUAL PMPM	2016 ACTUAL TREND	2017 ACTUAL PMPM	2017 ACTUAL TREND	2015–2017 TOTAL ACTUAL TREND	2015–2017 PROJECTED TREND
MEDICAID							
Children	\$262.18	\$265.87	1.41%	\$271.51	2.12%	3.56%	11.33%
Dual Eligible	\$1,392.94	\$1,405.23	0.88%	\$1,437.51	2.30%	3.20%	4.42%
Aged/Disabled (non-dual)	\$2,145.39	\$2,207.54	2.90%	\$2,265.95	2.65%	5.62%	8.54%
Other Adult	\$422.70	\$410.47	-2.89%	\$407.09	-0.82%	-3.69%	9.53%
COMMERCIAL							
Individual	\$403.38	\$530.14	31.42%	\$558.63	5.37%	38.49%	10.29%
Family	\$375.52	\$347.91	-7.35%	\$381.42	9.63%	1.57%	10.40%
MEDICARE							
Dual Eligible	\$756.49	\$876.43	15.85%	\$790.41	-9.81%	4.48%	9.71%
FFS	\$412.54	\$425.64	3.18%	\$432.23	1.55%	4.77%	9.98%
Medicare Advantage	\$756.23	\$849.44	12.33%	\$818.63	-3.63%	8.25%	11.02%

ANALYSIS BY PAYER TYPE

Medicaid

Medicaid showed decreases in PMPM costs for adult non-dual, non-aged or disabled beneficiaries, dropping from PMPM costs of \$422.70 in 2015 down to \$407.09 in 2017. Medicaid showed an increase in overall PMPM costs from \$495.92 in 2016 to \$508.52 in 2017—an increase of 3.32%. Categories of service identified in the PCMH model were Inpatient, Emergency Room, Outpatient, Professional Specialty Care, Physical and Occupational Therapies (PT/OT) and Pharmacy. While those cost categories held to a 2.1% trend in 2016, the cost of Inpatient and Outpatient services drove the trend up 4.1% in 2017; and professional primary care costs increased by 4.6% in 2017. Overall, Medicaid cost avoided for 2016 and 2017, as shown in Table 4 is \$66,335,153.

Commercial

While public payers showed decreases in PMPM trend, commercial payers reported a 9.2% increase in PMPM costs, driven by significant increases in costs for Outpatient services, Durable Medical Equipment (DME), and nearly doubling the cost of PT/OT. Like Medicaid, PCMH model assumption categories showed an increase of 17.6% in 2017 compared to 1.7% in 2016.

Professional primary care costs decreased by 13.5% in 2017. Commercial payers in the State exceeded payments nationally in 2016 and 2017 by \$30,089,913.

Medicare

Increases driven by only the rise in PT/OT, Medicare reported significant improvement with negative trends in inpatient, emergency room, DME and prescription drug PMPM costs. Medicare reported PCMH model assumption categories with a 2.6% PMPM decrease in 2017 compared to an increase of 12.7% in 2016. Professional primary care costs decreased by 6.3% in 2017. While exceeding costs nationally in 2016, Idaho Medicare PMPMs went down in 2017 to show two-year costs avoided of \$57,276,736.

TABLE 4: COST AVOIDED BY PAYER

PAYER	BASELINE PMPM	ACTUAL PMPM	ACTUAL TREND	OACT TREND	PROJECTED PMPM	COST AVOIDED PMPM	TOTAL COST AVOIDED
MEDICAID							
2015/2016	\$492.18	\$495.82	0.76%	3.95%	\$511.61	\$15.69	\$59,193,893
2016/2017	\$495.92	\$508.52	2.54%	2.92%	\$510.38	\$1.86	\$7,141,261
COMMERCIAL							
2015/2016	\$381.41	\$393.79	3.25%	5.11%	\$400.89	\$7.10	\$35,582,245
2016/2017	\$393.79	\$429.96	9.19%	5.63%	\$415.95	\$(14.00)	\$(65,672,158)
MEDICARE							
2015/2016	\$533.39	\$585.07	9.69%	3.59%	\$552.53	\$(32.53)	\$(102,517,554)
2016/2017	\$585.07	\$565.35	-3.37%	5.02%	\$614.41	\$49.06	\$159,794,291
Total							\$93,521,977

6

CONCLUSION

As described in the AY2 Financial Analysis Report, Idaho's SHIP model testing is occurring within a dynamic health system environment; 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.

Cost avoided by Medicaid and Medicare exceeded the additional costs incurred by commercial payers by more than \$93 million dollars. The cost avoidance assumptions for Medicaid show overall rate improvements, but not necessarily in PCMH categories. Commercial payers reported significant increases in total cost PMPMs in both individual and family/group categories. The increases in outpatient and PT/OT more than offset the costs avoided in inpatient costs. Medicare showed reductions in costs in nearly all categories except PT/OT.

In summary, these combined changes in the State may be bending the cost curve for public payers. Actual costs are \$93.5 million less than projected for the first two years of the demonstration for all payers, and nearly \$124 million for public payers. If the State can maintain the current cost avoidance trends, Idahoans should exceed the \$89 million of projected cost avoidance in the SHIP Model Test Grant application.

APPENDIX A

DATA REQUEST

Data Request Template Sent to Payers on February 9, 2018:

Dear Multi-payer workgroup participants,

CMMI requires reports to monitor financial progress for the SIM grant Idaho received. Now that 2017 is complete, we are sending out the data request again. The attached spreadsheet is updated for 2017 but follows the exact same format reported in 2015 and 2016. Please review the spreadsheet and let me know if you have any concerns providing the requested data. Costs should be aggregated based on the category of service logic provided, but split by the category of aid or contract type listed in row 4 of the Report Template tab.

Your signed standard Mercer Client Confidentiality Agreement are still in effect. Reporting to CMMI will be done in aggregate such that no individual payer data will be discernable.

Please review both documents and let me know if you have any concerns about either document by February 15th. If not, we'd like to start receiving data on April 4th. If you're unable to meet that date, please let me know when you think you can get the template completed. I appreciate your participation in the SHIP and would like to make the reporting process as simple as possible.

Thank you!

Scott Banken, CPA

APPENDIX B

DATA REQUEST TABLE

CY 2017

	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	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

	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
Diagnostic Imaging/X-Ray	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Laboratory Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DME	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Dialysis Procedures	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Other (e.g., PT, OT)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Skilled Nursing Facility	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Home Health	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Custodial Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ICF/MR	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
HCBS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Behavioral Health	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

	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
Prescription Drugs (Outpatient)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

APPENDIX C

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-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.

MERCER (US) INC.
333 South 7th Street, Suite 1400
Minneapolis, MN 55402
www.mercer.com



Data Governance Workgroup Update

Burke Jensen
August 8, 2018

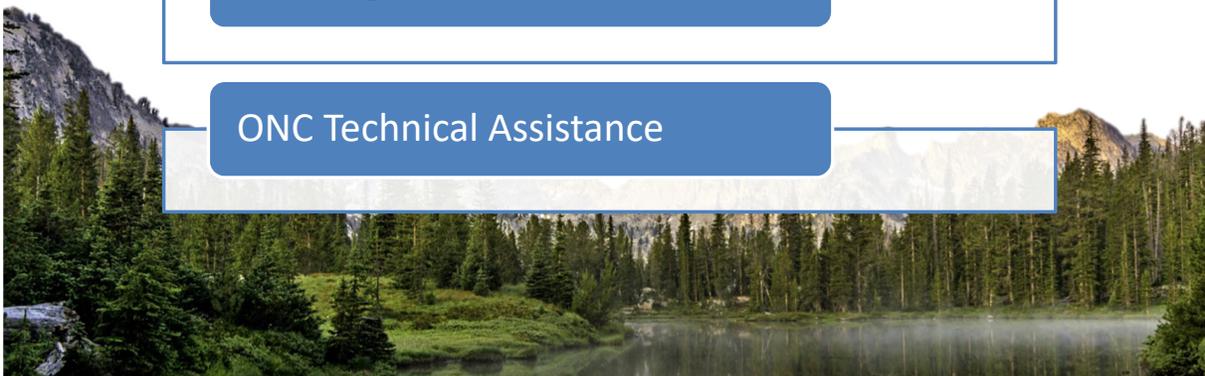


Background and Context

Challenge - Data Completeness

Challenge - EHR Variation in CCDs

ONC Technical Assistance





Key Constraints and Findings

Funding

- There are no plans or funds for HTS data analytics reporting to extend beyond the SHIP grant, which ends January 31, 2019.

Demand

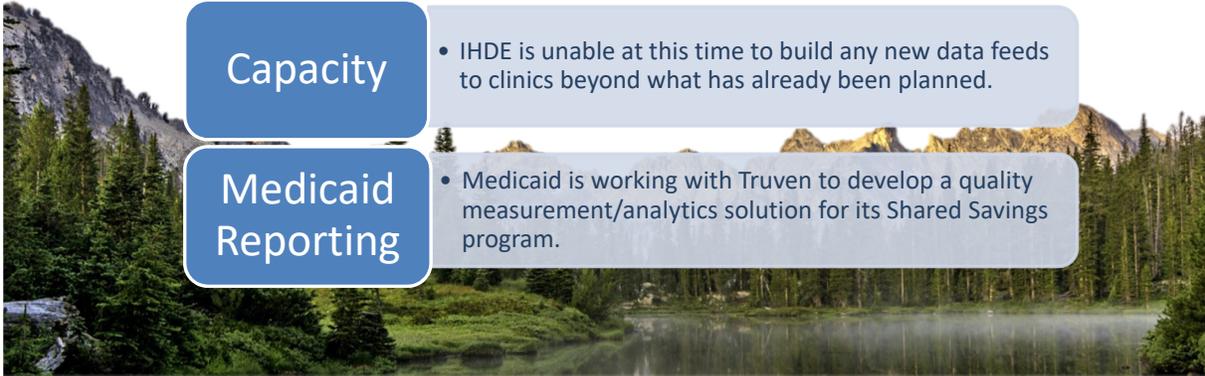
- Many health systems and payers do not plan to use SHIP data analytics reporting because they have their own analytic solutions.

Capacity

- IHDE is unable at this time to build any new data feeds to clinics beyond what has already been planned.

Medicaid Reporting

- Medicaid is working with Truven to develop a quality measurement/analytics solution for its Shared Savings program.



Data Analytics Pivot

- Need to continue to meet grant requirements
- SHIP data analytic reporting is changing
 - Substitute the HTS reporting for the Medicaid CQM reporting/provider portal
 - Add BFRSS survey data for smoking and obesity measures
 - Continue:
 - Child immunization reporting (via IRIS)
 - Access to care reporting (via State Evaluator)
 - Patient attribution process (reported through HTS)
- IHDE clinic connection builds will continue





New SHIP Measure List

Measure	Data Source
ADHD Drug Initiation Phase Visits	Medicaid
ADHD Drug Continuation Phase Visits	Medicaid
Depression Acute Phase Therapy	Medicaid
Depression Continuation Phase Therapy	Medicaid
Breast Cancer Screen	Medicaid
Colorectal Cancer Screen	Medicaid
Diabetes HbA1c Test	Medicaid
Influenza Vaccine	Medicaid
Well Child Adolescent	Medicaid
Well Child Visits First 15 months	Medicaid
Well Child Visits 3 to 6 years	Medicaid
Child Immunization	IRIS
Access to Care	State Evaluator
Smoking	BRFSS
Obesity	BRFSS



Questions



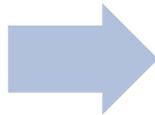


Sustainability Plan Overview



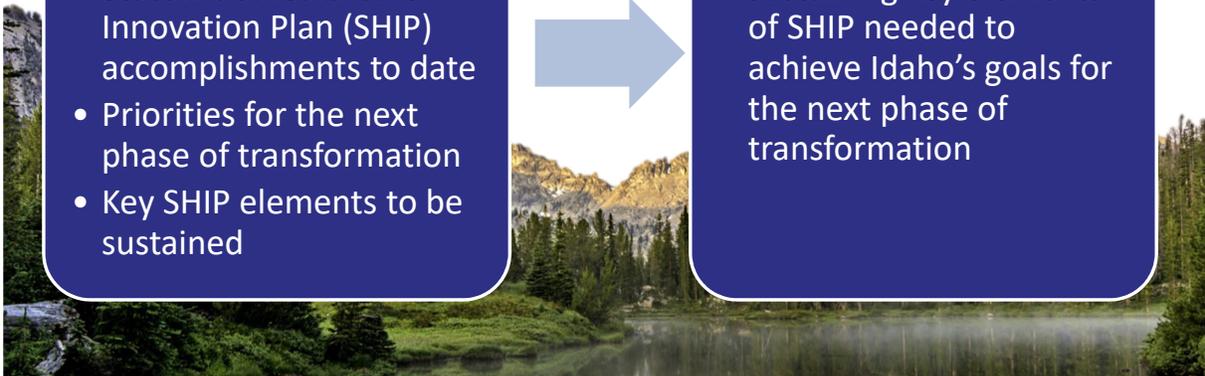
Part I (May 30th)

- Model changes and Statewide Healthcare Innovation Plan (SHIP) accomplishments to date
- Priorities for the next phase of transformation
- Key SHIP elements to be sustained



Part II (August 30th)

- Detailed plan for sustaining key elements of SHIP needed to achieve Idaho's goals for the next phase of transformation





Purpose of Today's Presentation

- Development of Center for Medicare and Medicaid Innovation's (CMMI) Part II Sustainability Plan – “The Roadmap for Sustaining State Innovation Model (SIM) Investments”
- Key Highlights of the “Roadmap”
 - Analysis of SHIP Activities
 - Post-SHIP Activities
 - Post-SHIP Governance and Stakeholder Engagement Plan



Development of the “Roadmap”





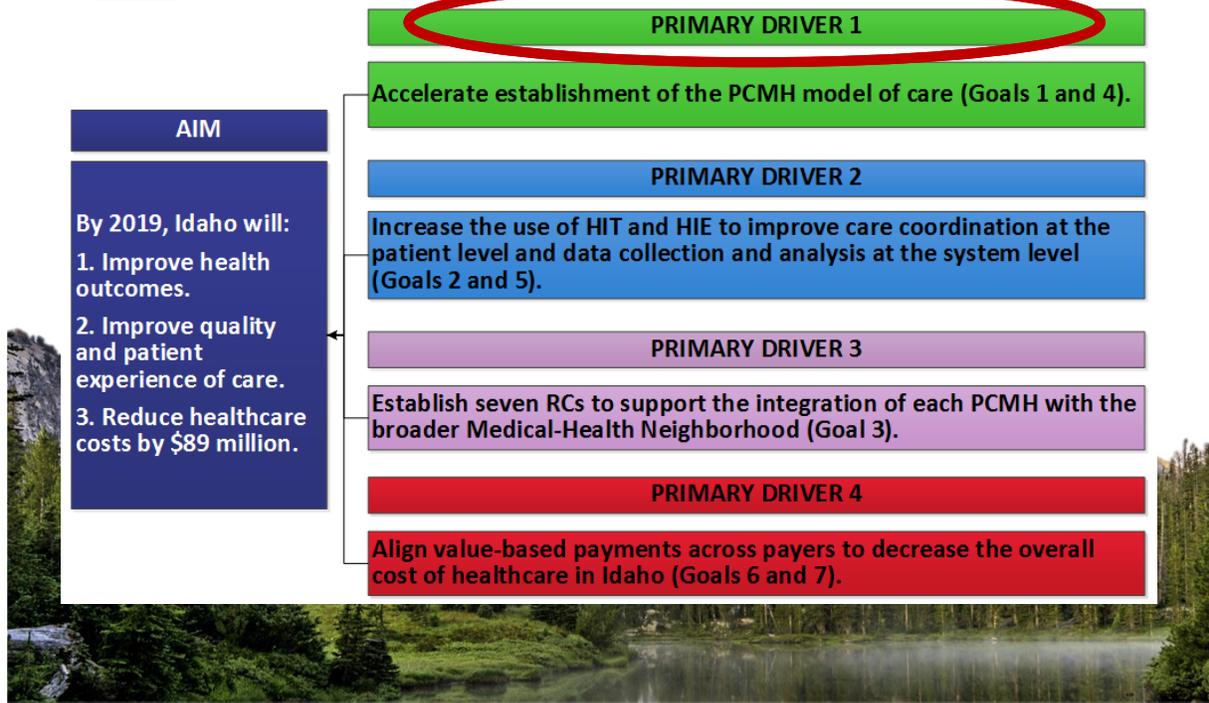
Development of the Plan

- Dual purpose of the “Roadmap”
 - Fulfill CMMI grant requirement
 - Plan post-SHIP activities to support and advance Idaho’s healthcare system transformation
- Sources of information
 - Patient Centered Medical Home (PCMH) Sustainability Planning Workshop
 - Office of Healthcare Policy Initiatives (OHPI)
 - Regional Collaborative (RC) Transition Workshop
 - RC Survey and Draft Transition Plans
 - Idaho Healthcare Coalition (IHC) Survey
 - IHC Transformation Sustainability Workgroup
 - Health Information Technology (HIT) Stakeholder Engagement
 - State Evaluation Team
 - Idaho Telehealth Planning Meeting
 - Learning Collaboratives (PCMH/Community Health Worker (CHW)/Community Health Emergency Medical Services (CHEMS)/Telehealth)
 - Contractors and Technical Assistance Partners



Analysis of SHIP Activities





Accelerate establishment of the PCMH model of care

- Continued support for PCMH transformation to achieve a new transformation goal:
 - Idaho aims to double the number of PCMH recognized practices by January 2024 by partnering with payers and other stakeholders in expanding value-based reimbursement supported through State leadership and broadening resources at the regional level





Accelerate establishment of the PCMH model of care

SIM Investment

- Clinic Reimbursement Payments for PCMH Transformation

Sustainability Analysis

- No state funding to replace SHIP grant dollars
- Medicaid providing financial support through Healthy Connections Program, PCMH Shared Savings Program

Roadmap

- Explore possibilities to centralize ongoing information about payment opportunities through the existing PCMH pages of the SHIP website following the conclusion of the grant to aid clinics in seeking resources (if available Department of Health and Welfare (DHW) staff support)



Accelerate establishment of the PCMH model of care

SIM Investment

- Clinic Training and Technical Support

Sustainability Analysis

- No state funding is allowed to be requested to replace SHIP grant funding that provided for contract technical assistance, quality improvement support, training and webinars, and other PCMH transformation supports.

Roadmap

- Explore current quality improvement activities underway in the State to assess potential linkages with PCMH model support
- OHPI could serve as a "hub" to connect clinics to identified existing quality improvement resources



Accelerate establishment of the PCMH model of care

SIM Investment

- Other tools that support PCMH transformation, including:
 - Clinic self-assessments of progress towards PCMH model of care
 - Transformation Plan Tool to track clinic's progress
 - PCMH Resource Library on the transformation portal
 - Clinic to clinic mentorship

Sustainability Analysis

- No state funding to maintain assistance with utilization of tools or convening and coordination of activities

Roadmap

- Explore where there is potential alignment with tools, particularly with Healthy Connections and other payers
- Work with contractor to maintain the PCMH Resource Library and keep the information, toolkits, and other resources available



Accelerate establishment of the PCMH model of care

SIM Investment

- Train and establish workforce of CHWs and CHEMS in Idaho
- Telehealth expansion
- Project Extension for Community Healthcare Outcomes (ECHO)

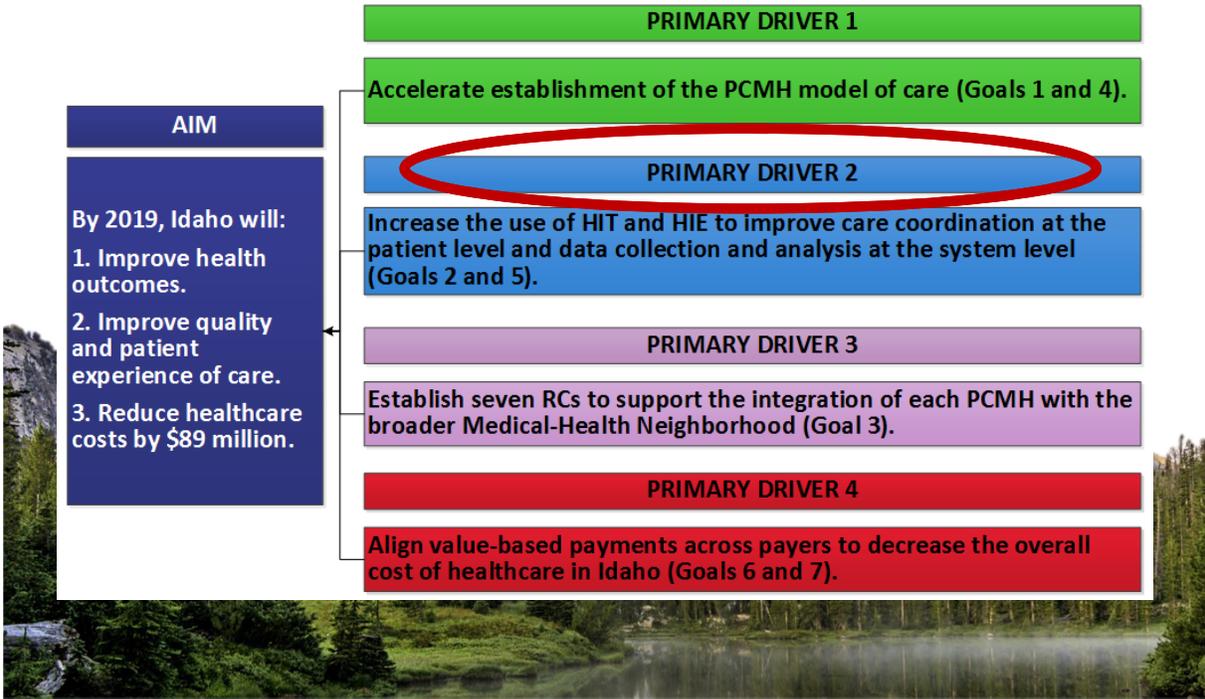
Sustainability Analysis

- Training of CHWs and CHEMS may continue, but individuals will need to pay tuition or sponsors will need to be found
- Several potential options to support Project ECHO
- Virtual PCMH designation and reimbursement will discontinue

Roadmap

- DHW Bureau of Emergency Medical Services and Preparedness is committed to supporting further CHEMS development and establishment
- Explore options to support delivery models that include CHWs. DHW Bureau of Community and Environmental Health is committed to supporting further CHW development and establishment
- Health Quality Planning Commission may take on promoting telehealth expansion
- University of Idaho platform for Project ECHO will continue. Public Health interested in supporting





Increase the use of HIT and HIE to improve care coordination at the patient level and data collection and analysis at the system level

- | | |
|--------------------------------|---|
| SIM Investment | <ul style="list-style-type: none"> • Support of Idaho Health Data Exchange (IHDE) as Idaho’s health information exchange (HIE) • Establishing HIE– clinic and hospital connections |
| Sustainability Analysis | <ul style="list-style-type: none"> • No state funding to replace SHIP funding for electronic health record (EHR) charges associated with connecting with IHDE • Medicaid will continue to support the IHDE portion of the connection cost through Health Information Technology for Economic and Clinical Health (HITECH) 90/10 funding |
| Roadmap | <ul style="list-style-type: none"> • IHDE will continue to build connections, including pursuing connections with hospitals, laboratories, and other provider types • Enhancement of system platform will continue; IHDE will continue to reinforce their infrastructure • Maintain goal to improve coordination of care by providing data |



Increase the use of HIT and HIE to improve care coordination at the patient level and data collection and analysis at the system level

SIM Investment

- Developing initial Statewide HIT Plan
- Increased stakeholder engagement in HIT efforts
- Development of quality metrics reports and data analytics feedback

Sustainability Analysis

- Functionality of Data Governance Workgroup is evolving
- Verifiable data sources have resulted in better alignment of quality measures

Roadmap

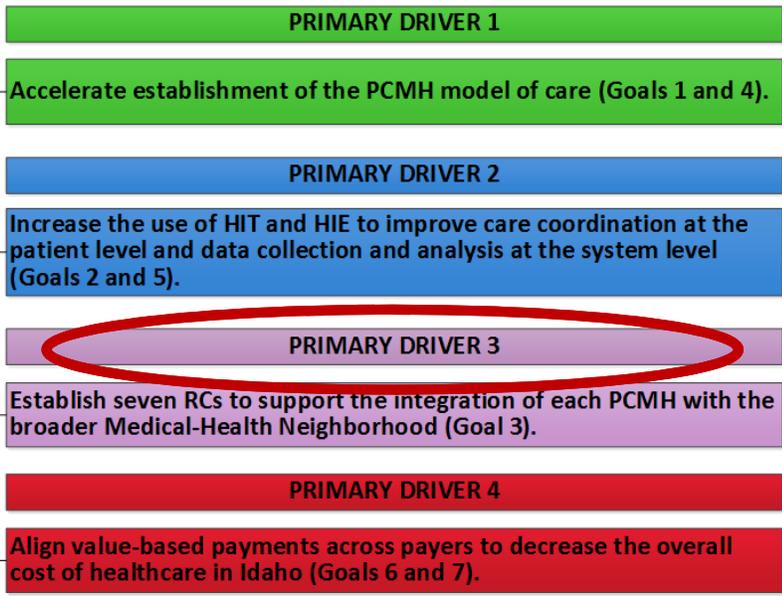
- OHPI could be the support body for the development and implementation of comprehensive Statewide HIT Plan
- Clinics will receive clinical quality measure (CQM) reporting from Medicaid data analytic portal and Public Health
- Efforts to align measures across payers will continue to be a goal



AIM

By 2019, Idaho will:

1. Improve health outcomes.
2. Improve quality and patient experience of care.
3. Reduce healthcare costs by \$89 million.





Establish seven RCs to support the integration of each PCMH with the broader Medical Health Neighborhood (MHN)

SIM Investment

- RC development and implementation

Sustainability Analysis

- No state funding is allowed to be requested to continue support for RC activities beyond the SHIP project
- Some RCs will continue, but uncertain whether all seven RCs will continue
- Lack of data needs to be addressed to support the role of the RCs

Roadmap

- Role of some RCs may change with the implementation of the Medicaid Regional Care Coalition (RCC) model



Establish seven RCs to support the integration of each PCMH with the broader MHN

SIM Investment

- PCMH support
- MHN development, implementation and expansion
- RC-specific focus areas

Sustainability Analysis

- No state funding is allowed to be requested to continue support for development of the MHN and specific RC SHIP activities

Roadmap

- Components of RCs are looking for resources to stay active post-SHIP
- Some resources will still be available, including through clinic to clinic mentorship
- Exploring other avenues to obtain resources to continue PCMH support and MHN development at the local level

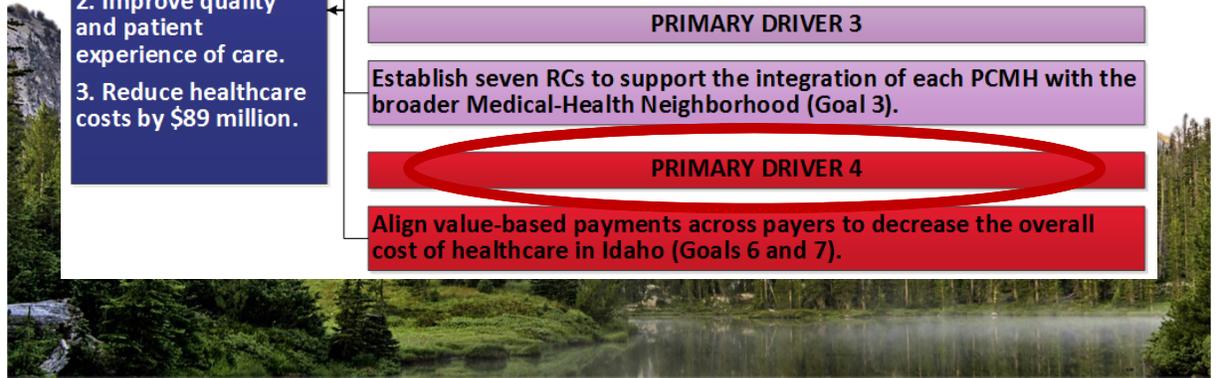
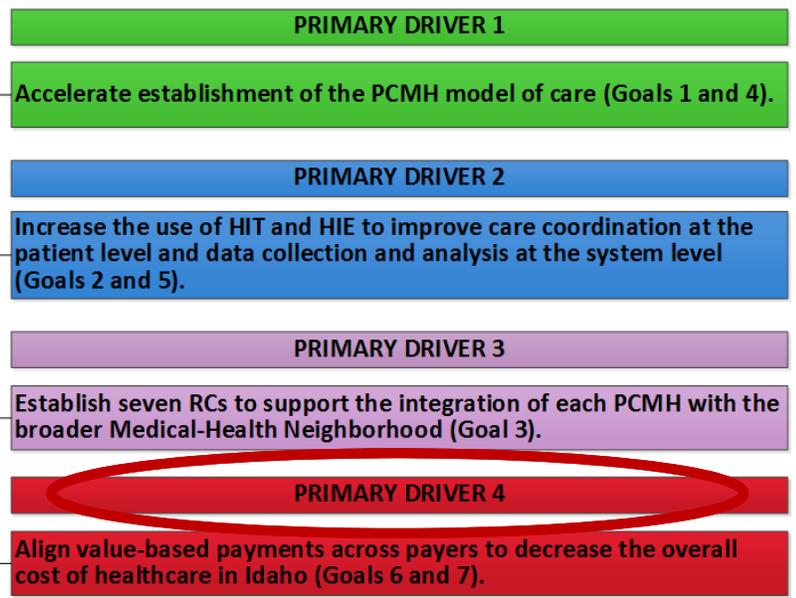




AIM

By 2019, Idaho will:

1. Improve health outcomes.
2. Improve quality and patient experience of care.
3. Reduce healthcare costs by \$89 million.



Align value-based payment across payers to decrease the overall healthcare costs in Idaho

SIM Investment

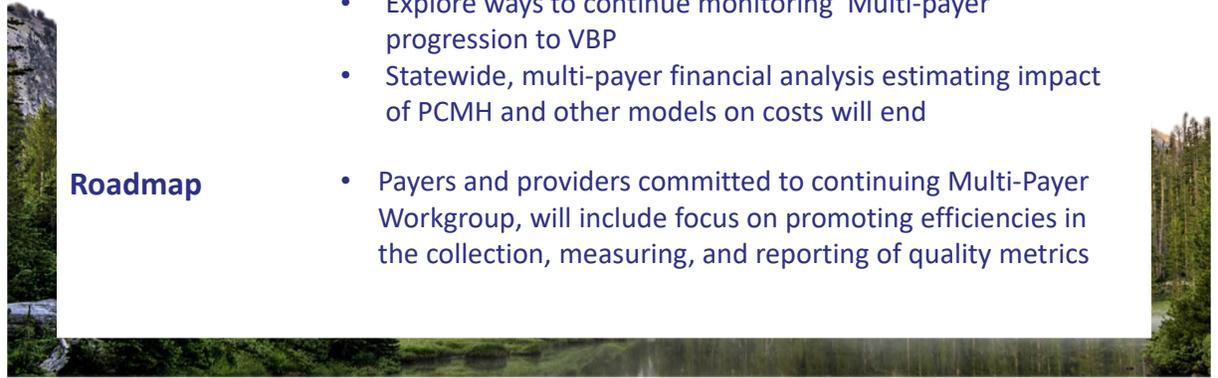
- Support for the Multi-Payer Workgroup
- Financial analysis to monitor Idaho’s progress in moving toward value based payment (VBP)
- Financial analysis to estimate impact of PCMH and other delivery models on Idaho’s healthcare system costs

Sustainability Analysis

- No definitive state funds for OHPI’s support to convene and staff Multi-Payer Workgroup
- Explore ways to continue monitoring Multi-payer progression to VBP
- Statewide, multi-payer financial analysis estimating impact of PCMH and other models on costs will end

Roadmap

- Payers and providers committed to continuing Multi-Payer Workgroup, will include focus on promoting efficiencies in the collection, measuring, and reporting of quality metrics





Idaho's Post-SHIP Governance and Stakeholder Engagement Plan to Further Health System Transformation



Post- SHIP Governance and Stakeholder Engagement

- IHC Transformation Sustainability Workgroup
 - Charter
 - Business Case
- IHC will review draft charter and business case and approve, possibly with modifications
- New advisory body will begin in January 2019
- Advisory body will develop an action plan that includes identifying initiatives to carry out their functions





Infrastructure and Operational Capacity

- DHW/OHPI will continue to support Idaho healthcare system transformation
- DHW is working to obtain funding for OHPI positions starting February 1, 2019
- OHPI will:
 - Provide support for the next iteration of the IHC
 - Assess the state’s healthcare performance, identify programmatic and policy gaps and develop recommendations for improvements
 - Support expanded healthcare transformation projects



Next Steps

- Draft document will be finalized and submitted to CMMI on August 30, 2018
- Questions from and discussions with CMMI regarding the plan are expected
- DHW/OHPI will conduct grant close out activities





Questions and Discussion



IHDE - SHIP Update - July 2018

SHIP Cohorts

151 of 165 clinics

connected or projected by

Jan 31, 2019

78 Fully Bi-Directional Now

Quality Visits

139 Clinics

27 Hospitals

100% goal met 5 months early

Driving Connectivity

Training

3 New Training Modules

“User Settings”

“Subscriptions and Notifications”

“Send to EMR”

Hospital Connections

Critical Access Hospitals

Madison, Bingham, Valor

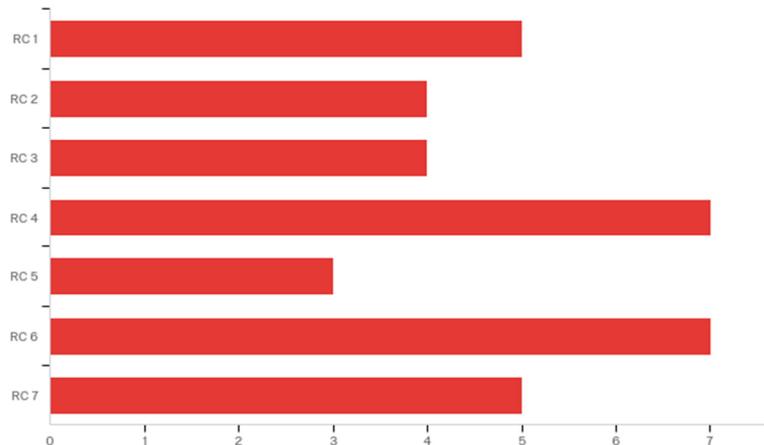
REGIONAL COLLABORATIVE SURVEY

IDHW conducted an online survey for the Regional Collaborative (RC) in July 2018

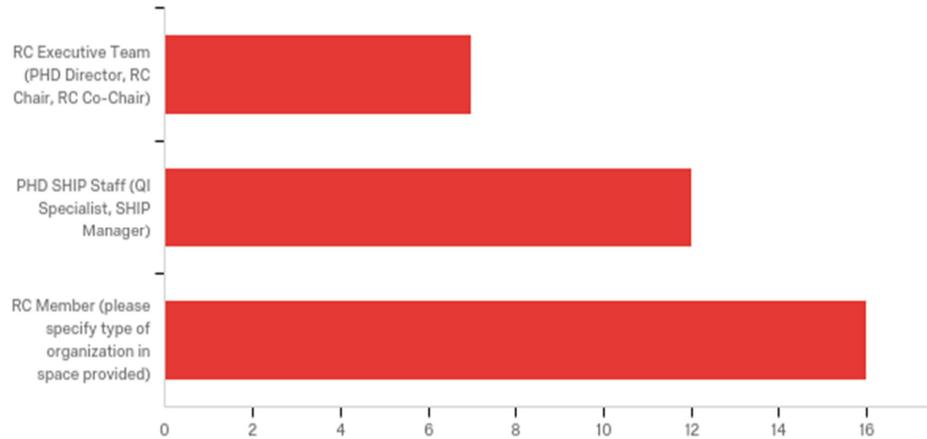
The survey was distributed via email to 165 RC members in July 2018. The team received 35 survey responses (21% response rate).



SURVEY RESULTS: RESPONDENT PARTICIPATION IN RCs

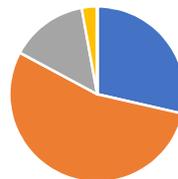


SURVEY RESULTS: RESPONDENT ROLES IN THE RCs

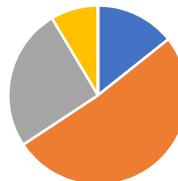


SURVEY RESULTS: SUCCESS IN ACCOMPLISHING GOALS

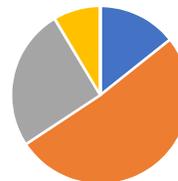
29 of 35 respondents (83%) indicated that their RC was very successful (10) or successful (19) in providing local leadership and support for healthcare transformation.



23 of 35 respondents (66%) indicated that their RC was very successful (5) or successful (18) in the development of the medical-health neighborhood.



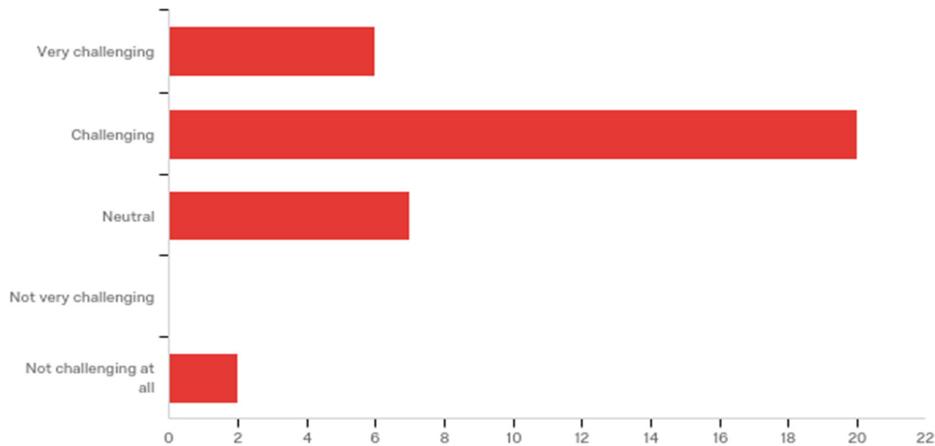
24 of 35 respondents (68.5%) indicated that their RC was very successful (5) or successful (19) in improving population health to achieve the Triple Aim.



- Very successful
- Successful
- Neutral
- Unsuccessful

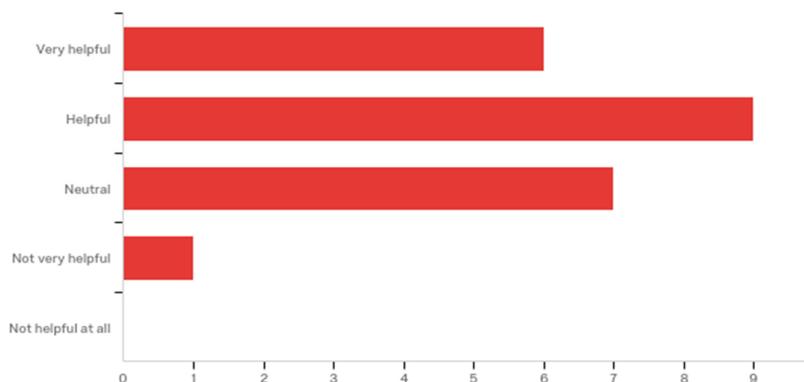
SURVEY RESULTS: LEVEL OF DIFFICULTY

26 of 35 respondents (74%) indicated that the level of difficulty in fulfilling their function was challenging (20) or very challenging (6).



SURVEY RESULTS: TECHNICAL ASSISTANCE AND ADMIN. SUPPORT

15 of 23 of non-PHD staff respondents (65%) indicated that the technical assistance and administrative support their RC received in achieving their goals was very helpful (6) or helpful (9).



OTHER SURVEY RESULTS (HIGHLIGHTS)

18 of 35 respondents (51%) indicated that it is very likely (5) or likely (13) that their RC or an RC-like group will continue after the SHIP grant ends (6 indicated it is unlikely or not likely at all).

Other

QUESTIONS?

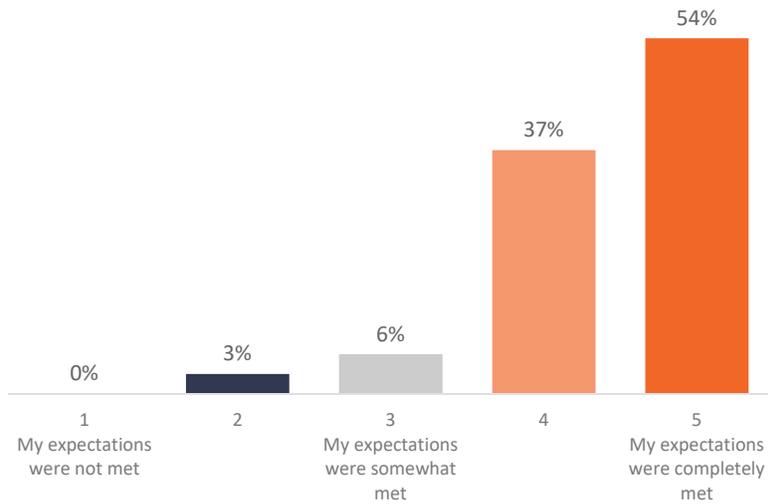
**2018 Community Health Worker
Learning Collaborative
Evaluation Results**

August 3, 2018

**91 Registered Attendees
42 Total Responses**

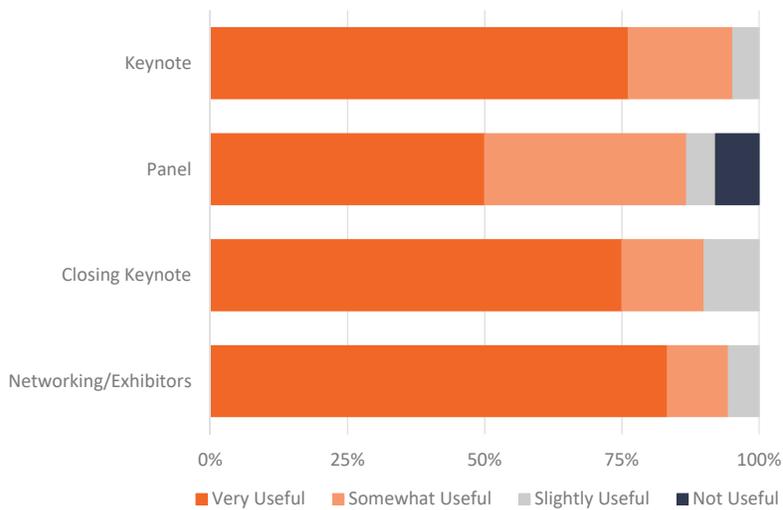
46% Response Rate

91% of attendees said the Learning Collaborative met their expectations.



Answered: 35 Skipped: 7

Most attendees found the conference useful.



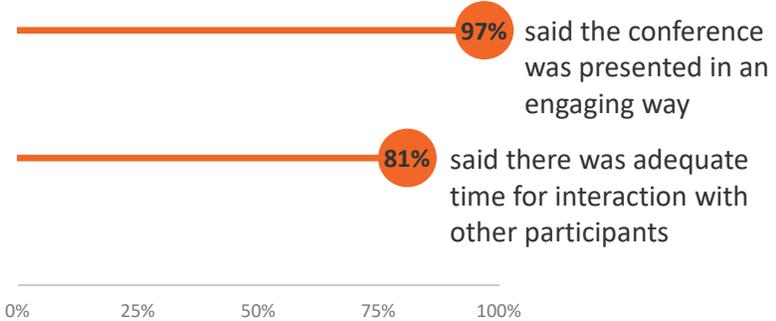
“This was a very good conference. Good balance between presentations/ general and break-out sessions”

- conference attendee

Answered: 42 Skipped: 0

Most attendees had a positive experience at the conference.

“I liked having the different resources and having the opportunity to talk w/ people from these programs. It was a really good conference for someone who is a new CHW or is wanting CHWs”
- conference attendee



Answered: 42 Skipped: 0

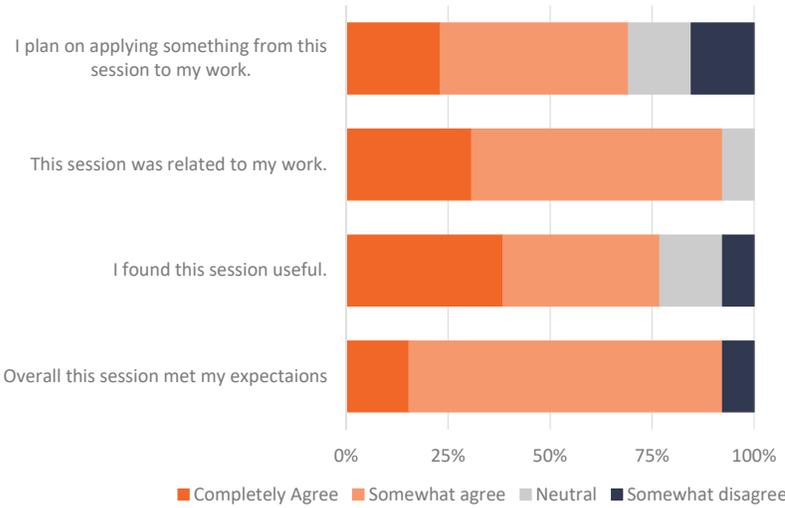
Breakout Sessions

91 Registered Attendees

45 Total Responses

49% Response Rate

The Provider and CHW Relationship – Todd Roseborough and Michelle Dix

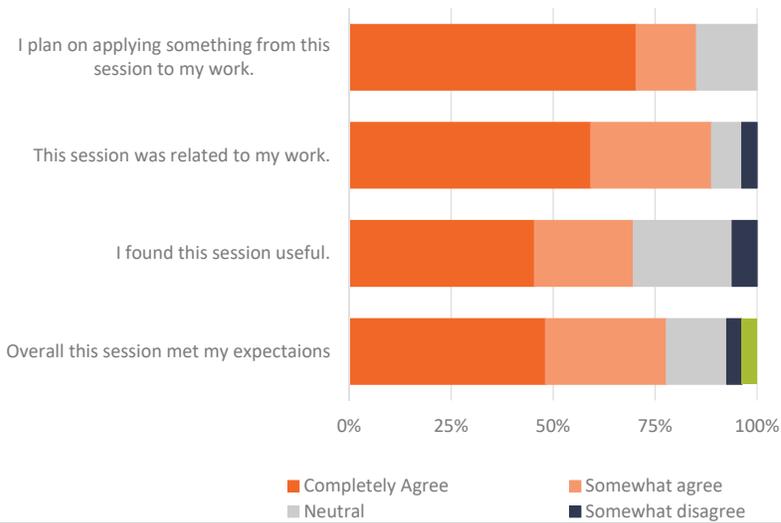


“This session was very valuable to me. It informed me that my next recertification requires an oral health educational component necessary to complete for recertification in Oregon.”

- session attendee

Answered: 13 Skipped: 0

Addressing Social Determinants through Care Coordination – Elizabeth Barber

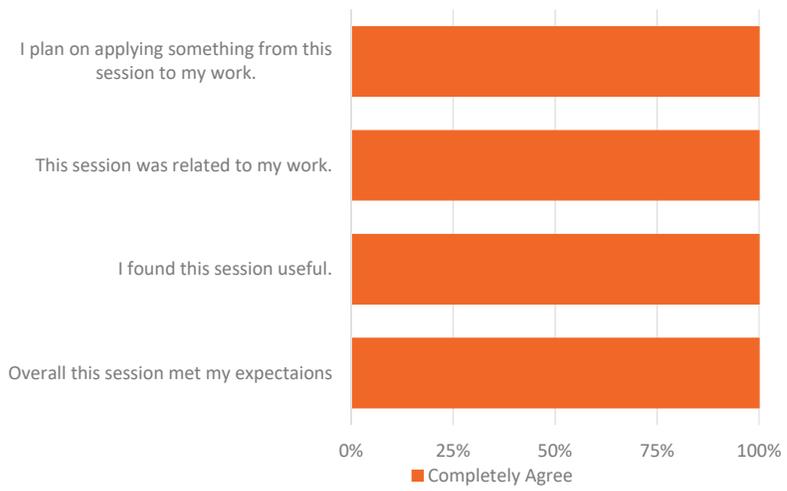


“The CHW program at St. Alphonsus explained very clearly. Challenges and recommendations very valuable”

- session attendee

Answered: 27 Skipped: 0

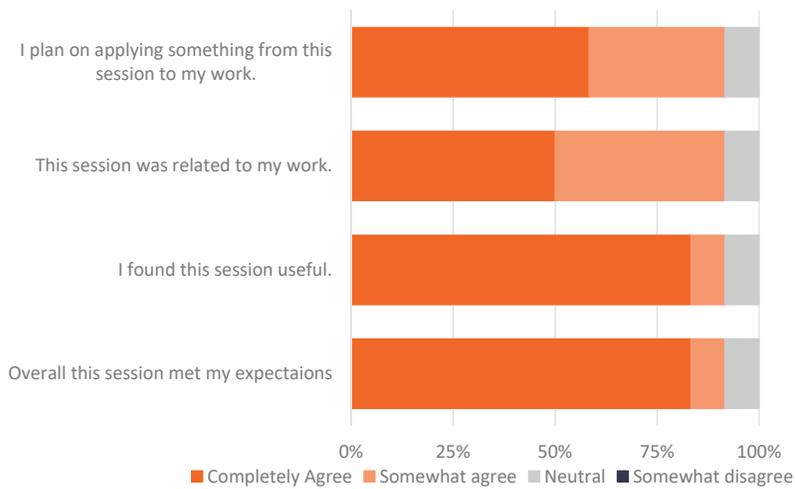
Oral Health – Samantha Kenney



“Learned about how dental health impacts medical. HPV effects oral cancer. Very helpful resources given to us.”
- session attendee

Answered: 3 Skipped: 0

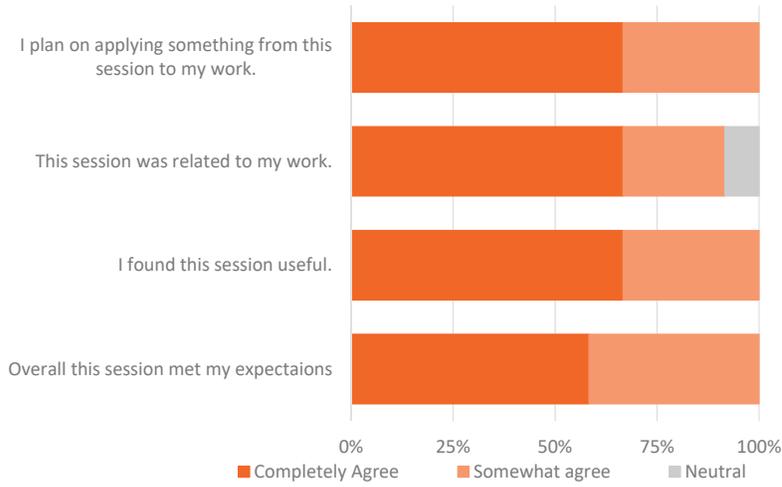
Pain Management and Opioid Addiction and Treatment – Dr. Kathy Eroschenko



“This was so impactful to me personally and professionally. Overwhelmed with knowledge. Everyone should take this.”
- session attendee

Answered: 12 Skipped: 0

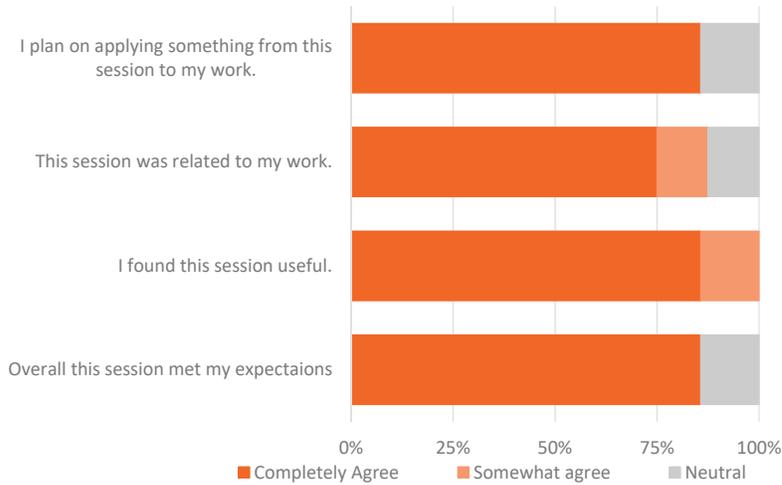
Motivational Interviewing – Jayne Josephsen



“The role-play was nice to do and critical in helping me realize how it takes time and it's a learning process.”
- session attendee

Answered: 12 Skipped: 0

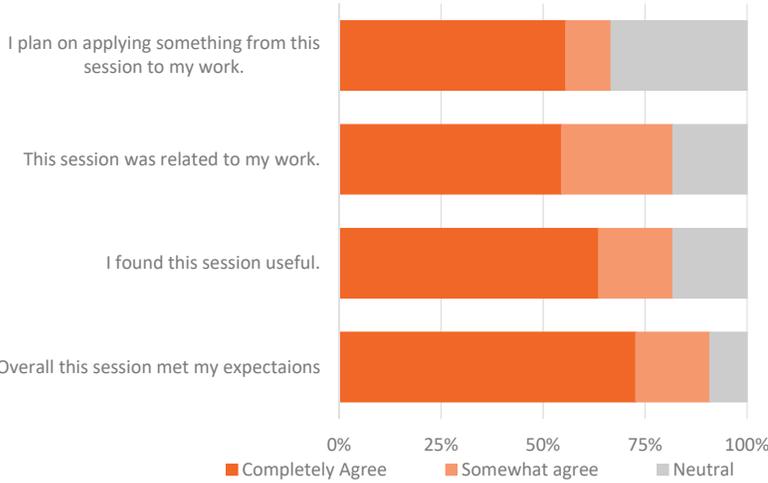
Diabetes Management Education – Laura Hollingshead



“Excellent presenter and answered all questions and then some on the topic of diabetes”
- session attendee

Answered: 7 Skipped: 0

Medication Adherence – Linda Mikitish



“Even relevant information to topics outside of medication adherence. Great info!”
- session attendee

Answered: 11 Skipped: 0



SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition August 8, 2018

SHIP OPERATIONS:

SHIP Contracting/Request for Proposal (RFP) Status:

- **Report Items:**
 - A CMMI Award Year 4 and Award Year 3 carryover funds request for release of funds was submitted for the Idaho Health Data Exchange (IHDE).
 - A request for release of Award Year 3 carryover funds was submitted for the PCMH Portal sustainability project.
 - A request for release of funds for Award Year 3 carryover funds was submitted and approved to hire an OHPI Program Specialist position.
 - A request for release of funds for Award Year 3 carryover funds was submitted for the CHEMs Learning Collaborative to be held August 8, 2018.
 - A CMMI Award Year 4 and Award Year 3 supplemental carryover request for release of funds was submitted and approved for the Community Health Worker (CHW) Learning Collaborative held July 25, 2018.
 - A CMMI Award Year 4 request for release of funds was submitted and approved for the transfer of funds to the travel category to fund promotion of Project ECHO by the University of Idaho (UI) WWAMI Program.

SHIP Administrative Reporting:

- **Report Items:**
 - A request for release of Award Year 4 funds for out of state travel was approved by CMMI on July 12, 2018 for Burke Jensen to attend the HHS Analytics Symposium for Action in Chicago.
 - A request for release of Award Year 4 funds for out of state travel was approved by CMMI on July 18, 2018 for Madeline Russell to attend the Northwest Regional Telehealth Center (NRTRC) conference in Salt Lake City, Utah in October 2018.
 - A CMMI Award Year 3 carryover request for release of funds was approved for personnel costs for the OHPI Program Administrator position.
 - CMMI revised the Notice of Award to reflect the appointment of Casey Moyer as the SIM Program Administrator for the Idaho SIM Cooperative Agreement as submitted on June 8, 2018.
 - The Idaho Healthcare Coalition Transformation Sustainability Workgroup met on July 12, 2018 and on July 26, 2018
 - The OHPI Administrative Assistant 2 and Program Specialist positions have closed and interviews for both positions will be conducted in August.

Regional Collaboratives (RC):

- **Report Items:**
 - **District 1:** RC meeting on 6/20/2018, regular monthly meeting.
 - **District 2:** None

- **District 3:** The Southwest Health Collaborative (SWHC) meeting on 6/5: regular bimonthly meeting; Oral Health Workgroup on 6/7: plan care coordination pilot; Executive Committee on 6/11: regular business; Behavioral Health Workgroup on 6/13: combined June/July meeting; IDCareNetwork meeting on 6/18: regular quarterly meeting.
- **District 4:** Central Health Collaborative (CHC) meeting - held on 06/05/18: Russ Duke, Dr. Rich, and Dr. Watts were all in attendance; Executive Leadership meeting - held on 06/20/18: Russ Duke and Melissa Dilley attended.
- **District 5:** 6/5/18 RC meeting to finalize information for the Transition Plan.
- **District 6:** June 28, 2018, Clinic Committee meeting.
- **District 7:** No RC meeting held in June. Continue to meet on SHIP transition plan as needed.

- **Issues and topics discussed:**

- **District 1:** Medical Health Neighborhood: Kasey Nixon, LPC, Senior Crisis Intervention Specialist - Northern Idaho Crisis Center, Program Overview. QI Specialist Update: Regional Diabetes QI project update, May PCMH meeting recap, HMA site visit recap.
- **District 2:** None
- **District 3:** Jeff Crouch provided an update on the Medicaid transformation activities and responded to questions from the SWHC and CHC. The SWHC also discussed CHC activities (focused primarily on Pathways) in anticipation of a combination of RCs in the upcoming months. Finally, the group discussed post-SHIP RC vision. Group members will reach out to private payer groups and will support the PHD legislative request.
- **District 4:** CHC Executive Leadership meeting - held on 06/05/18. The CHC meeting included an update on Medicaid transformation and the High Value Care Plan as well as an update on the Community Schools Initiative. The group also discussed the Pathways Community HUB model, brainstorming potential next steps and needs to move this project forward. The group also discussed potential funding opportunities. Next steps include inviting a representative from the Care Coordination System (CCS) software team to the next CHC meeting to provide a demo on the tool and how it may help track outcomes and reduce risk for elementary school aged children. Missy Goode also agreed to send CHC members a comprehensive contact list for all Boise School District Community Schools Coordinators. Melissa will work with Missy and other administrators to potentially schedule a Community Schools room tour at one of the local elementary schools for members of the CHC group.
- **District 5:** topics included: activities to be sustained, where these activities could find "homes" so that they could remain viable. St. Luke's Magic Valley Regional Medical Center medical meetings were offered by Dr. Kohtz as a way to replace RC meetings. Dr. Davis offered to be a resource on CHEMS.
- **District 6:** agenda items included: use case introduction by Janet Reis, introduction of Clinic Committee purpose, review of the Medical Health Neighborhood (MHN) concepts and upcoming meetings, pneumococcal vaccine initiative and other quality improvement support opportunities.
- **District 7:** No meetings in June

- **Action Items:**

- **District 5:** The RC recommended that the state SHIP staff leave PCMH resources with the IHC after the SHIP project ends. The IHC could distribute these to providers post SHIP.

ADVISORY GROUP REPORTS:



Telehealth SHIP Subcommittee:

- **Report Items:**
 - A Behavioral Health in Primary Care ECHO session will begin September 5, 2018. This ECHO session will run every other Wednesday from 12 – 1pm (MT). Registration is currently open.
 - The Opioid Addiction and Treatment ECHO session has extended their training into January 2018. The past recordings of this session will also be available online.
 - The letter of request from the IHC regarding telehealth in Idaho was sent to the Health Quality Planning Commission Chair (HQPC). The HQPC will put this on their agenda for their meeting in November. Attached is a copy of the letter.

- **Next Steps:**
 - Continue marketing and outreach efforts for ECHO.



Community Health Workers:

- **Report Items:**
 - The 2018 Idaho Community Health Worker Learning Collaborative was held July 25, 2018 at the Idaho State University, Meridian campus. Nearly 110 individuals registered, and 20 exhibitors provided resources and networking opportunities. Carl Rush, a research affiliate for the project on CHW policy and practice at the University of Texas's Institute of Health Policy provided the keynote address. A CHW panel was held and a multiple of breakout sessions were offered. For a review of the learning collaborative program and PowerPoint presentations, please visit the SHIP website at:
<http://www.ship.idaho.gov/Portals/93/Users/152/00/2200/CHW Program 20180720.pdf?ver=2018-07-23-162713-843>
 - The second Motivational Interviewing three-part webinar series ended July 31, 2018. Feedback for this series was positive. Recordings of the webinar series and resources provided can be found on the SHIP website.
 - Outreach for the fall 2018 CHW training is ongoing. This live-online training begins Tuesday, August 21, 2018 and runs for 13-weeks. The application and registration period is open.

- **Next Steps:**
 - Working closely with Idaho State University (ISU) for post-SHIP CHW training sustainability.
 - Considering another webinar series (on Medication Adherence), this series would start in September.
 - Opportunity for translating CHW training curriculum and Health Specific Modules (HSMs) into Spanish is being considered. There is potential to have a second Fall 2018 training for Spanish speaking individuals interested in the CHW course.

WORKGROUP REPORTS:



Community Health EMS (CHEMS):

- **Report Items:**
 - The CHEMS Workgroup did not meet in July.



Idaho Medical Home Collaborative:

- **Report Item:**
 - The Idaho Medical Home Collaborative did not meet in July.



Data Governance:

- **Report Item:**
 - The Data Governance Workgroup met on July 30, 2018.
 - Burke Jensen, SHIP Operations Health IT Project Manager, updated the workgroup on SHIP data analytics and reminded members of the data quality and data completeness challenges being experienced.
 - He also listed several operational constraints tied to SHIP data analytics including: 1) the grant end date of January 31, 2019; 2) there is no funding to continue the HealthTech Solutions (HTS) analytics solution beyond the grant period; 3) many health systems and payers have reported to SHIP that they have no intention of using the SHIP analytic solution; and 4) Idaho Medicaid is in the process of developing an analytic provider portal for Idaho Medicaid clinics and has multiple quality measures that overlap with SHIP measures.
 - Burke told the workgroup that based on these constraints and a complete analysis of available options and pros/cons, the SHIP Operations team made the following operational decisions to continue to meet grant requirements:
 - SHIP will be substituting the SHIP quality measures with these new measures: 11 Medicaid quality measures and three measures from the Division of Public Health's Behavioral Risk Factor Surveillance System (BRFSS) survey covering the obesity and tobacco topics.
 - In addition, SHIP will continue reporting: 1) the Childhood Immunization Status measure that is reported via Idaho's Immunization Reminder Information System (IRIS); and 2) the Access to Care measure that is reported by the SHIP State Evaluation Team (SET).
 - Burke reminded the workgroup that these operational decisions do not impact the clinic connection efforts with IHDE. The clinic EHR connection efforts will continue through the end of the grant.
 - The workgroup discussed the overall successes and challenges of the data analytics reporting effort to date.

- In addition, the workgroup discussed the role of data governance beyond the SHIP grant.
- There was consensus that the group put forward a motion to the IHC that it support a change in scope to Goal 5. The change in scope would allow Idaho to remain compliant with the time remaining in the grant.
- **Next Steps:**
 - The next SHIP Data Governance Workgroup meeting is scheduled for September 10, 2018.
 - The workgroup members would like an update from IHDE on establishing connections as well as the current state of the Medicaid analytics.
 - The workgroup will discuss the draft charter of the IHC Transformation Sustainability Workgroup (TSW) and the future role of data governance and health IT coordination beyond SHIP.



Multi-Payer:

- **Report Item:**
 - The MPW met Wednesday, July 31, 2018. The outcomes of the meeting include:
 - Review SHIP Financial Analysis Report – Scott Banken, CPA, Principal at Mercer, provided a summary of the updated SHIP financial analysis report for award year three. The grant requires the state to analyze financial metrics for the state’s population health in an effort to determine the impact of changes occurring through SHIP on the state’s healthcare costs. The report had been updated with the new / corrected data from Medicaid. The members discussed the updated findings and voted to recommend to the IHC that this report be approved for submission to CMMI as required by the grant.
 - Review of results from the HEDIS 2018 measures survey – Scott Banken presented findings from the payer survey on HEDIS measures. Many payers selected the same measures in areas such as Prevention & Screening, Respiratory, Cardiovascular, Diabetes, Musculoskeletal, Behavioral Health, and Utilization & Risk-Adjusted Utilization.
 - Discussion on next steps for Workgroup and Payer Survey - workgroup members discussed the survey results and next steps for this effort. It was decided that the Office of Healthcare Policy Initiatives (OHPI) will draft a white paper on the vision for establishing a common core set of measures among payers. The core set could be updated each year to allow for focus topics. The white paper would include a summary of the measure survey and articulate the vision for aligning on a common core set of measures that are: 1) clinically relevant and measurable, 2) not overly burdensome, and 3) measured by payers in a consistent format so providers do not need to report the same measure various ways for their payers. The concept paper will be discussed in the next workgroup meeting.
- **Next Steps:**
 - IHC members will be asked to support submission of the SHIP Financial Analysis, as presented by Mercer, to CMMI as required by the grant.
 - The OHPI staff will draft the concept paper on establishing a common core set of measures among payers prior to the next meeting and will circulate it to workgroup members for comments.
 - The next meeting is scheduled for September 4, 2018.

BHI**Behavioral Health:**

- **Report Item:**
 - The BHI Sub-Committee did not meet in July.
- **Next Steps:**
 - The next meeting will be held on Tuesday, September 4th, 9:00 am – 11:00 am at PTC building, 7th floor conference room.

PHW**Population Health:**

- **Report Item:**
 - The PHW did not meet in July.
- **Next Steps:**
 - The PHW met August 1 and report out at the September IHC meeting.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON – Director

CASEY MOYER – Program Administrator
OFFICE OF HEALTHCARE POLICY INITIATIVES
450 West State Street, 3rd Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-6997

July 27, 2018

Health Quality Planning Commission
c/o Idaho Department of Health and Welfare
450 West State Street
Boise, ID 83720

Dear Members,

Thirty five of Idaho's 44 counties are rural or frontier and many areas have limited access to specialty care. Telehealth and telemedicine can provide a wide variety of inpatient, outpatient and emergency services throughout the state. The Idaho Telehealth Council, created by House Concurrent Resolution No. 46¹ in 2014 has established standards and policies through promulgation of the Telehealth Access Act² which was signed into law in 2015 thus fulfilling their main mission.

After considerable discussion among the Telehealth Council and Idaho Healthcare Coalition, it was agreed that telehealth continues to be a key asset to Idaho in rural and underserved communities though its adoption and use remains slow. The Statewide Healthcare Innovation Plan (SHIP) has used portions of funding to support the adoption and expansion of telehealth however this grant project will be concluding in January 2019. Key barriers to adoption remain and include: a) complex reimbursement structures, b) lack of operational coordination, c) lack of training, d) limitations on managing prescriptions and technology requirements. An enclosure containing the executive summary from the telehealth strategic planning meeting has been included.

Given the current barriers to achieving broad adoption and use of telehealth in Idaho, the Idaho Healthcare Coalition is requesting the Health Quality Planning Commission consider taking this on as a health issue of focus in the coming year given HQPC's current interest in this endeavor. Further, I.C. § 56-1054(5)(b) empowers the commission to 'identify best practices in clinical quality assurance and patient safety standards and reporting'; to which telehealth in Idaho aligns with the legislative charge of this body.

If you have questions or need additional information, please contact Stacey Carson at scarson@teamiha.org or Mary Sheridan at Mary.Sheridan@dhw.idaho.gov.

Sincerely,

TED EPPERLY, MD
Chair, Idaho Healthcare Coalition

TE/cam

Idaho Telehealth Planning Meeting Executive Summary
Wednesday, May 23, 2018 9:00am – 4:30pm
JRW Building – Boise, ID

On May 23, 2018, the Idaho Department of Health and Welfare hosted a telehealth planning meeting in Boise. The purpose of the meeting was to convene a diverse set of telehealth subject matter experts to identify and discuss barriers, challenges, and opportunities for advancing telehealth in Idaho. Over 40 telehealth stakeholders from across the state representing hospitals, urban and rural health clinics, health systems, Community Health EMS (CHEMS), government, insurance, telehealth consulting experts, associations, and academia participated. Through the convening, attendees built consensus around the value and need for advancing telehealth services across Idaho. The group concluded that its best course of action is to seek the partnership of the Idaho Healthcare Coalition (IHC) to advocate on behalf of the future of telehealth in Idaho.

The meeting came near the conclusion of the multi-year Statewide Healthcare Innovation Plan (SHIP) which has been working to transform healthcare to a value-based system and transform primary care practices across the state into Patient-Centered Medical Homes (PCMHs). The SHIP initiative concludes January 31, 2019. As a part of the larger SHIP initiative, significant work has been done to nurture the use of telehealth strategies to increase access to quality healthcare throughout the state. The efforts have included the development of a telehealth toolkit, a series of webinars, and two rounds of grantmaking. These grants supported new or expanding telehealth programs resulting in twelve sub-grant awards to eight clinics and one CHEMS agency, a technical assistance program to all grantees across the state, and the May 23 planning meeting.

Stakeholders at the meeting identified the most pressing barrier as the existence of a complex reimbursement landscape that has resulted in the inconsistent, or overall lack of reimbursement for telehealth services beyond the recent progress made with Idaho Medicaid telehealth policies. The group also voiced a concern about the lack of an operational coordinating body with adequate capacity to meaningfully advance telehealth. Other barriers included a lack of training and workflow processes that address telehealth's impact, limitations on managing prescriptions, and addressing technology requirements. (For a full meeting summary, see the attached minutes).

As the group moved on to identifying opportunities, there was general agreement about the potential of telehealth to help overcome the specific challenges of provider shortages and rural and frontier community isolation which contribute to significant areas of underserved populations due to lack of access to care. They identified the models and applications for telehealth that can improve access to primary care and specialists, support patient and provider education, and share real time actionable data. Additionally, the group recognized that the complex issues surrounding telehealth must be addressed by stakeholder collaboration to thrive within a very complex healthcare system.

By the end of the day, there was emerging consensus that continued, coordinated growth of telehealth as a resource for addressing healthcare needs in the state is urgent. Participants considered it crucial that dialogue continue post-SHIP among stakeholders, particularly payers, and all were interested in continuing the dialogue.

Given the previously narrow scope of the now inactive Telehealth Council, its low membership, inactivity, and lack of resources, participants agreed that another coordinating body with adequate capacity is needed to advance telehealth. Stakeholders decided to ask the IHC to advocate on their behalf, by communicating the need for the continued prioritization of telehealth to the Health Quality Planning Commission and asking their help in continuing the momentum of the telehealth work that has begun and finding potential solutions to identified challenges.

