



Idaho Healthcare Coalition

Meeting Agenda

October 10, 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>

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>Lisa Hettinger, IHC Co-Chair</i> – ACTION ITEM
2:10 p.m.	Beneficiary and Member Attribution Report – <i>Scott Banken, Mercer</i> – ACTION ITEM
2:20 p.m.	HTCI Charter Update – <i>Drs. Ted Epperly & David Pate, Co-Chairs</i> – ACTION ITEM
2:50 p.m.	HTCI Timeline Update – <i>Katie Falls, Mercer</i>
3:00 p.m.	SHIP Legacy Project Update – <i>Casey Moyer, SHIP Operations</i>
3:10 p.m.	Break
3:20 p.m.	RC Survey Finalization – <i>Madeline Russell, SHIP Operations</i>
3:30 p.m.	Medicaid Expansion Initiative Update – <i>Dr. Ted Epperly, Chair & Lisa Hettinger, Deputy Director IDHW</i>
3:45 p.m.	OHPI Overview – <i>Casey Moyer, SHIP Operations</i>
4:00 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 (IHC) October 10, 2018

Action Items

- Action Item 1 – September IHC Meeting Minutes

IHC members will be asked to adopt the minutes from the September 12, 2018 IHC meeting:

Motion: I, _____ move to accept the minutes of the September 12, 2018, Idaho Healthcare Coalition (IHC) meeting as prepared.

Second: _____

Motion Carried ____.

- Action Item 2 – Beneficiary and Member Attribution Report

IHC members will be asked to support and adopt the Beneficiary and Member Attribution Report as presented by Scott Banken from Mercer.

Motion: I, _____ move that the IHC support and adopt the Beneficiary and Member Attribution Report as presented.

Second: _____

Motion Carried ____.

- Action Item 3 – Amended HTCI Charter

IHC members will be asked to support and adopt amendments to the Healthcare Transformation Council of Idaho (HTCI) charter as presented by Drs. Ted Epperly and David Pate.

Motion: I, _____ move that the IHC support and adopt the amended HTCI charter as presented.

Second: _____

Motion Carried ____.



Idaho Healthcare Coalition

Meeting Minutes:

SUBJECT: IHC September Minutes

DATE: September 12, 2018

ATTENDEES: Russ Barron, Russell Duke, **LOCATION:** 700 W State Street, 1st Floor East Conference Room
Kym Schreiber as proxy for
Ross Edmunds, Ted Epperly,
MD, Janica Hardin, Lisa
Hettinger, Todd York as proxy
for Drew Hobby, Casey
Moyer, Tammy Perkins, Kevin
Rich, MD, Rhonda Robinson-
Beale, MD, Elke Shaw-
Tulloch, Dieuwke Dizney-
Spencer as proxy for Mary
Sheridan, Norm Varin, Jennifer
Wheeler, Beth Kriete as proxy
for Matt Wimmer, Nikole
Zogg

Teleconference: Michelle Anderson, Andrew
Baron, MD, Yvonne Ketchum-
Ward, Deena LaJoie, Maggie
Mann, Amy Mart, Susie
Pouliot, Geri Rackow, Neva
Santos

Members Absent: Richard Bell, MD, Melody
Bowyer, Kathy Brashear, Pam
Catt-Oliason, Melissa
Christian, Keith Davis, MD,
Scott Dunn, MD, Lee Heider,
Mark Horrocks, MD, Glenn
Jefferson, MD, Kelly McGrath,
MD, Nicole McKay, Casey
Meza, Carol Moehrle, Daniel
Ordyna, David Pate, MD,
David Peterman, MD, Boyd
Southwick, MD, Larry Tisdale,
Karen Vauk, Lora Whalen,
Fred Wood,

IDHW Staff Kevin Grant, Meagan Graves,
Burke Jensen, Madeline
Russell, Stacey St.Amand,
Sherie Thompson, Ann
Watkins

STATUS: Draft 9/13/2018

Summary of Motions/Decisions:

Motion:

Jennifer Wheeler moved that the IHC accept the August 8, 2018 IHC meeting minutes.
Nikole Zogg seconded the motion.

Outcome:

Passed

Kevin Rich moved that the IHC accept as presented the Healthcare Transformation Council of Idaho charter.
Russ Duke seconded the motion.

Passed

Agenda Topics:

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

- ◆ Dr. Epperly welcomed everyone to the meeting and took roll. He opened the meeting with a quote from John McCain, “Nothing in life is more liberating than to fight for a cause larger than yourself, something that encompasses you but is not defined by your existence alone.”
- ◆ Two new OHPI employees were introduced: Meagan Graves, Amin Support; and Kevin Grant, Program Specialist.

Transformation Sustainability Workgroup Charter Presentation & Discussion – Dr. Ted Epperly, IHC Co-Chair

- ◆ Six meetings of the Transformation Sustainability Workgroup were held over the last three months with support from Mercer and HMA. The workgroup was charged with developing a charter for a new multi-stakeholder advisory body which will be called the Healthcare Transformation Council of Idaho (HTCI).
- ◆ The charge of the council is to:
Promote the advancement of person-centered healthcare delivery system transformation efforts in Idaho to improve the health of Idahoans and align payments to achieve improved health, improved healthcare delivery, and lower costs.
- ◆ The full charter document can be found on the SHIP website. It includes information on the council’s functions, membership and composition, meetings, subcommittees/working groups, and staff resources.
- ◆ Among the council’s 11 functions are:
 - Promoting and supporting transformation by identifying opportunities for innovation that will help shape the future of healthcare.
 - Serving as a convener of a broad-based set of stakeholders.
 - Supporting the efforts in Idaho to provide a healthcare workforce that is sufficient in numbers and training to meet the demand.
- ◆ After discussion about the inclusion of nursing, legislators, and oral and behavioral health in the membership of the council, the charter was approved as presented by the IHC.

Next Steps & Business Case – Dr. Ted Epperly, IHC Co-Chair

- ◆ With the charter accepted, the workgroup will move on to create a business model and business case for the HTCI. They will likely be presented at the November IHC meeting.
- ◆ Key questions to be addressed include:
 - Why is the HTCI needed?
 - What is the HTCI?
 - Who is the HTCI for?
 - What does the HTCI do?
 - How does the HTCI carry out its work?
 - What is needed for the HTCI to carry out its work?

OHPI Sustainability – Lisa Hettinger, IHC Co-Chair

- ◆ Lisa Hettinger discussed the history of the OHPI and its mission to protect and promote the health of all Idahoans. The question being considered is what the right amount of funding and staffing is to enable the OHPI to continue its work.
- ◆ A decision has been made to request of the governor's office general funds for seven individuals. Four other positions will be based on external funding such as grants.
- ◆ She asked for assistance from IHC members for this effort in the form of letters of support to the governor's office.

CHW Report – Jennifer Wheeler, WRG Corporate Services

- ◆ After a year-long study that included researching states with a wide variety of CHW programs and interviewing 19 people who engage with CHW efforts in Idaho, WRG Corporate Services made the following recommendations at the CHW learning collaborative in August:
 - Form an incubator as a collaborative effort of entities to support the tactical growth of the profession in Idaho.
 - Form an alliance – an organized group of supporters including businesses, state divisions, non-profits, and others to work as champions of the industry.
 - Create a professional association – a group formed by CHWs for CHWs. This is where continuing education, networking, and nurturing of CHWs would happen.
- ◆ The stakeholder group adopted the above recommendations and continues to meet.
- ◆ Idaho State University, the Bureau of Community and Environmental Health, and OHPI are working in the incubator role. They are enhancing the online certificate of completion course and are looking for ways to expand the participant pool.
- ◆ A number of entities have met several times and are almost ready to finalize a charter for a CHW alliance.
- ◆ A professional association will likely need support from employers and champions. The Bureau for Community and Environmental Health, through the Diabetes, Heart Disease, and Stroke Prevention program is taking the lead on this.

Change Management Workshop Update – Torey Mates, Briljent

- ◆ Briljent, SHIP's technical assistance vendor, will be hosting an "Effectively Leading Change" workshop in four locations across the state in October:
 - Idaho Falls, October 9
 - Pocatello, October 11
 - Post Falls, October 16
 - Boise, October 18

- ◆ The full-day, interactive sessions will explore how to lead and manage change and help participants begin their own change management plans.

Mercer Project Management & Dashboard Update – *Katie Falls, Principal, Mercer*

- ◆ Katie Falls presented the SHIP project management dashboard for Award Year 4, Quarter 2 which covers the period May 1, 2018 – July 31, 2018. Highlights include:
 - Seventy-seven SHIP clinics have achieved national PCMH recognition/accreditation.
 - Seventy-six individuals have completed CHW training as of AY4 Q2.
 - Forty-six virtual PCMHs and 10 CHEMS programs have been established.

Community EMT Training Update – *Wayne Denny, EMS Bureau, Public Health*

- ◆ Nationally, there isn't a curriculum, so the EMS Bureau worked with Idaho State University (ISU) to create the product being used. It is a 48-hour, 13-week, live online course. The first cohort, which began in August, had nine students; the second cohort, which will begin in September, already has 20 students signed up.
- ◆ The course will allow EMTs to treat more than the acute conditions they treat now; it will allow more treatment of chronic conditions.

CHEMS Learning Collaborative Update – *Wayne Denny, EMS Bureau, Public Health*

- ◆ The EMS Bureau contracted with the Paramedic Foundation to measure an EMS's readiness, capture the impact on communities, and collect patient outcome and system data. They conducted 11 site visits across the state and measured 12 phases of system development.
- ◆ Survey findings were presented at the August 8 learning collaborative. Abbreviated results can be found in the IHC meeting packet.

SHIP Operations and Advisory Group Reports/Updates – *Casey Moyer, OHPI Administrator*

- ◆ Casey Moyer reminded the group that, as the grant winds down, the work of different entities (contractors and subgrantees) will be concluding; this is the case for District 5. They accomplished what they were supposed to and their subgrant has been closed out. The operations update section will continue to highlight these updates and changes.

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

- ◆ There being no further business, the meeting was adjourned at 4:25PM.

PAYER FINANCIAL AND ENROLLMENT METRICS FOR GOAL 6 THROUGH AWARD YEAR 3 (AY3)

September 6, 2018

INTRODUCTION

In calendar year (CY) 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) 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 measure the progress in moving from fee-for-service (FFS) to value-based payments.

STRATEGIES AND METHODS FOR VALUE-BASED PAYMENTS

The State's multi-payer approach shifting from FFS payments to value-based payment strategies is expected to achieve a long-term, sustainable impact on the State's healthcare system. In AY3, payers continued to move away from FFS and towards value-based payment through several methods, including:

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

In addition to the Patient-Centered Medical Home (PCMH) model of care, payers are testing alternative models including accountable care organizations (ACOs) with many of the State's acute care hospitals.

Payers also support total-cost-of-care programs with shared savings payments for improving and managing patients with chronic conditions to reduce avoidable emergency room visits.

The multi-payer approach includes:

- Understanding each payer's need to design and implement payment models that they believe fit their organization's goals and are most effective for their beneficiaries and provider partners.
- Recognizing that system wide transformation to value-based purchasing will only occur across Idaho payers if payers are participating as leaders of the change rather than responding to mandates.
- Acknowledging that payment transformation may not occur quickly in the State but, through partnership with payers, new reimbursement models will emerge that have a positive impact on the system statewide. Implementation of new reimbursement models representing at least 80% of the beneficiary population is the goal for the State and is underway.

To collect payer data for tracking the State's progress in shifting to value-based payments, an Idaho alternative payment model framework was developed by the Multi-Payer Workgroup. The model follows the Health Care Payment Learning and Action Network model and reflects the different payment methodologies in the Idaho marketplace.

BASELINE FOR IMPROVEMENT COMPARED TO AWARD YEAR 3

The overarching aim of the State's integrated multi-payer PCMH model is to improve quality outcomes and beneficiary experience, which is expected to lower the cost of healthcare. Transforming from a FFS reimbursement model to payment models that incentivize quality outcomes and improved beneficiary experience is a key goal to achieve this aim. Evidence of the transformation from paying for volume to paying for value will be shown by comparing the enrollment and payment metrics from commercial, Medicare and Medicaid payers throughout the State for each award year.

Data Requests

To measure progress, the baseline of CY 2015 data was compared to CY 2016 and CY 2017 data. Payers were asked for both years to provide percentages of beneficiaries and percentages of payments in the following categories:

- Category 1: FFS — no link to quality and value. Example is FFS payments.
- Category 2: FFS — link to quality and value. Examples include a) foundational payments for infrastructure and operations, b) pay for reporting, c) rewards for performance, and d) rewards and penalties for performance.
- Category 3: Value methodologies built on FFS architecture. Examples include a) methodologies with upside gainsharing and b) methodologies with upside gainsharing/downside risk.

- Category 4: Population-based payment. Examples include a) condition-specific population-based payments and b) comprehensive population-based payments.

To assist in compilation, the data request also asked for total dollars paid for medical services in both years. The data request forms did not change from year to year.

Mercer’s Client Confidentiality Agreement was signed by commercial payers and Mercer to ensure their data was protected and kept private. The agreement covers all four award years. It was agreed that the data would be aggregated across payers so no individual payer data would be discernable.

Data Compilation

Upon receiving data from five of the State’s largest payers, including Medicare and Medicaid, Mercer collected comparison data from public documentation, including KFF.org and statutory filings in the National Association of Insurance Commissioners format. Data was weighted for both enrollment and payment information by payers to combine the data and protect the privacy of commercial respondents.

TABLE 1: PERCENTAGE OF BENEFICIARIES PER CATEGORY FOR CY 2015, CY 2016 AND CY 2017

CALENDAR YEAR	MEDICAID			COMMERCIAL & MEDICARE ADV.			MEDICARE			TOTAL		
	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
Category 1: FFS without quality	100%	13%	13%	21%	22%	23%	8%	7%	6%	42%	15%	15%
Category 2: FFS with quality and value	0%	87%	87%	73%	71%	59%	72%	75%	78%	51%	77%	73%
Category 3: Methodologies built on FFS architecture	0%	0%	0%	4%	4%	13%	20%	18%	16%	6%	8%	11%
Category 4: Population-based payment	0%	0%	0%	2%	2%	4%	0%	0%	0%	1%	1%	2%

TABLE 2: PERCENTAGE OF PAYMENTS (PAID OR ACCRUED) PER CATEGORY FOR CY 2015, CY 2016 AND CY 2017

CALENDAR YEAR	MEDICAID			COMMERCIAL & MEDICARE ADV.			MEDICARE			TOTAL		
	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
Category 1: FFS without quality	100%	99%	99%	71%	67%	61%	43%	45%	45%	76%	75%	71%
Category 2: FFS with quality and value	0%	1%	1%	19%	20%	18%	37%	37%	39%	16%	16%	17%
Category 3: Methodologies built on FFS architecture.	0%	0%	0%	7%	9%	12%	20%	18%	16%	7%	8%	8%
Category 4: Population-based payment.	0%	0%	0%	3%	4%	9%	0%	0%	0%	2%	2%	4%

Analysis

In CY 2017, all payer types remained consistent in their assignment of beneficiaries to value-based payment arrangements with incentives for providers based on quality and value. Gain-sharing, risk-sharing and population-based payments were completing their second year in the Medicare and commercial settings and additional assignments were relatively consistent for new membership. While membership attribution remains strong, payments were still primarily FFS. However, the CY 2017 data improved slightly with gains in categories 2, 3 and 4 compared to CY 2016 and CY 2015, driven by commercial and Medicare.

Anecdotal evidence suggests that payers and providers are limited in their ability to accept quality-based payments due to system limitation and increased risk due to the lack of beneficiaries assigned to each provider or were waiting to see the outcomes of initial assignments. Some payers required minimum levels of beneficiaries, such as 1,000 beneficiaries, before quality or risk-based payment arrangements replaced FFS.

Medicaid continued the Health Connections PCMH program in CY 2017, although the design phase of the program was extended. The program includes four tiers with PMPM payments ranging from \$2.50 to \$10.00. While Medicaid members were attributed to primary care clinics, payments remained primarily FFS in CY 2017. At the request of providers, however, beginning July 1, 2019, Idaho Medicaid will expand Healthy Connections program to include shared savings for primary care practices and ACOs through direct contracts and through participation with regional care organizations. Medicaid is implementing several programs that cover a broad range of healthcare transformation activities and population-based care management initiatives. All Medicaid beneficiaries will be attributed to primary care, either through beneficiary choice or, if no choice is made, prior claims history or proximity to providers. In designing its payment program options, Idaho Medicaid is proposing a financial risk structure consistent with the Advanced APM standard of “more than nominal financial risk”, allowing participating clinicians to pursue the APM with Medicare, as allowed under the Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015. Medicaid expects to make the first shared savings payment in CY 2020.



Healthcare Transformation Council of Idaho Charter

Presented to the IHC, September 2018

Charge

Charge	Promote the advancement of person-centered healthcare delivery system transformation efforts in Idaho to improve the health of Idahoans and align payment to achieve improved health, improved healthcare delivery, and lower costs.
Functions	<ul style="list-style-type: none">• Promote and support transformation by identifying opportunities for innovation that will help shape the future of healthcare.• Serve as a trusted source and a credible voice to strategically drive improvements in the healthcare delivery system.• Serve as a convener of a broad-based set of stakeholders.• Identify delivery system barriers that are preventing healthcare transformation and prioritize and recommend solutions.• Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation.• Recommend and promote strategies to reduce overall health care costs.• Utilize accurate and timely data to identify strategies and drive decision making for healthcare transformation.• Promote improved population health through policies and best practices that improve access, quality, and the health of all Idahoans.• Promote whole person integrated care, health equity, and recognize the impact of social determinants of health.• Support the efforts in Idaho to provide a healthcare workforce that is sufficient in numbers and training to meet the demand.• Promote efficiencies in the collection, measuring, and reporting of quality metrics.

Membership and Composition

<p>General Information</p>	<p>The membership composition will consist of representatives from the following stakeholder groups:</p> <ul style="list-style-type: none"> • 3 private payers, Medicaid and Self-funded 5 payers (Medicaid, Pacific Source, Blue Cross, Regence, Self-funded) • 4 primary care clinicians • 3 hospital representatives <ul style="list-style-type: none"> ○ 1 from a hospital system ○ 1 from a non-Critical Access hospital ○ 1 from a Critical Access Hospital • 1 Medical/Surgical Sub-Specialist • <u>1 Behavioral Health representative</u> • 1 Consumer representative • 1 representative from one of Idaho's Public Health Districts • 1 representative from each of the following organizations: <ul style="list-style-type: none"> ○ Idaho Department of Health and Welfare ○ Idaho Hospital Association ○ Idaho Medical Association ○ Idaho Primary Care Association ○ <u>Idaho Academy of Family Physicians</u> ○ <u>Nursing Leaders of Idaho</u> • Up to 3 At-Large members
<p>Member Selection</p>	<p>The Governor will appoint the members and two<u>one</u> chair and co-chairs<u>co-chairs</u>. The chair and<u>chair</u> co-chairs<u>co-chairs</u> will convene and preside over the HTCI meetings.</p>
<p>Terms</p>	<ul style="list-style-type: none"> • For initial appointment: <ul style="list-style-type: none"> ○ One-third would have three-year term ○ One-third would have four-year term ○ One-third would have five-year term • Ongoing appointments are three year terms, with one-third of members turning over each year. • Individuals' terms can be renewed for up to two three-year terms. • Individuals serving on the HTCI for the following organizations will not be subject to term limits: <ul style="list-style-type: none"> ○ Idaho Department of Health and Welfare ○ Idaho Hospital Association ○ Idaho Medical Association ○ Idaho Primary Care Association ○ <u>Idaho Academy of Family Physicians</u> ○ <u>Nursing Leaders of Idaho</u> • If there is a vacancy for any cause, a new member will be appointed to become immediately effective for the unexpired term
<p>Expectations of Members</p>	<ul style="list-style-type: none"> • Representatives from organizations must be in a senior leadership position. If the representative is not the CEO/President from the organization, the individual must be a subject matter expert, on the entities' senior leadership team, and in a decision-making position. • Members must participate in 75% of all meetings scheduled within the calendar year. • Members' designee may participate in up to 25% of the meetings scheduled within the calendar year. • Members are encouraged to send the same designee to the meetings instead of different individuals.
<p>Sponsor</p>	<p>Idaho Department of Health and Welfare (IDHW)</p>

Idaho Department of Health and Welfare
State Health Innovation Plan
Regional Collaborative (RC) Survey



**THE
LANGDON
GROUP**

qualtrics

Survey Objectives

The Idaho Department of Health and Welfare conducted a survey for the Regional Collaborative (RC) to provide a neutral forum for feedback regarding the functionality of the RCs since the onset of the State Health Innovation Plan (SHIP). The function of the RC is to provide local leadership and support for healthcare transformation, strengthening of the Medical Health Neighborhood, and improving population health to achieve the Triple Aim. The Langdon Group refined and finalized the survey and participated in developing, distributing, gathering, and tabulating the results. The Langdon Group prepared a report to highlight some of the findings from the survey.

Administering the Survey

The survey was completed online by RC participants and contained questions on roles in each individual RC, length of member participation with the RC, RC performance, difficulties, accomplishments, challenges and obstacles, RC technical and administrative support, and future plans.

Survey Implementation

The Public Health District SHIP managers identified their RC members. The survey was distributed via email, July 2, to 165 RC members. The Langdon Group received 35 survey responses (21% response rate).

RC Participation and Roles

Through the SHIP, there have been a total of seven operational RC's in Idaho. RC-4 and RC-6 had the most survey respondents at seven, while RC-5 had the least survey respondents at three. Every RC had at least one survey respondent that fell into the role of PHD SHIP staff. RC-2 and RC-7 did not have any survey responses from RC Executive Team members, and only RC-5 did not provide any survey responses from an RC member. Only three respondents had participated for less than a year with their RC; 11 respondents had one-to-two years of participation experience; and, 20 respondents had three-to-four years of participation with their RC.

Survey Barriers and Assumptions

- Many Cohort 3 clinics have little to no experience with RC's;
- Schedule and time-frame for responses: the survey was administered over the 4th of July holiday and respondents were given a limited time to respond; and,
- Unknown sender: the survey was meant to be anonymous and was provided by a third-party; this could have reduced the number of RC members that saw the email (sent to spam) or were reluctant to respond to an email with a link.

Survey Results (Highlights)

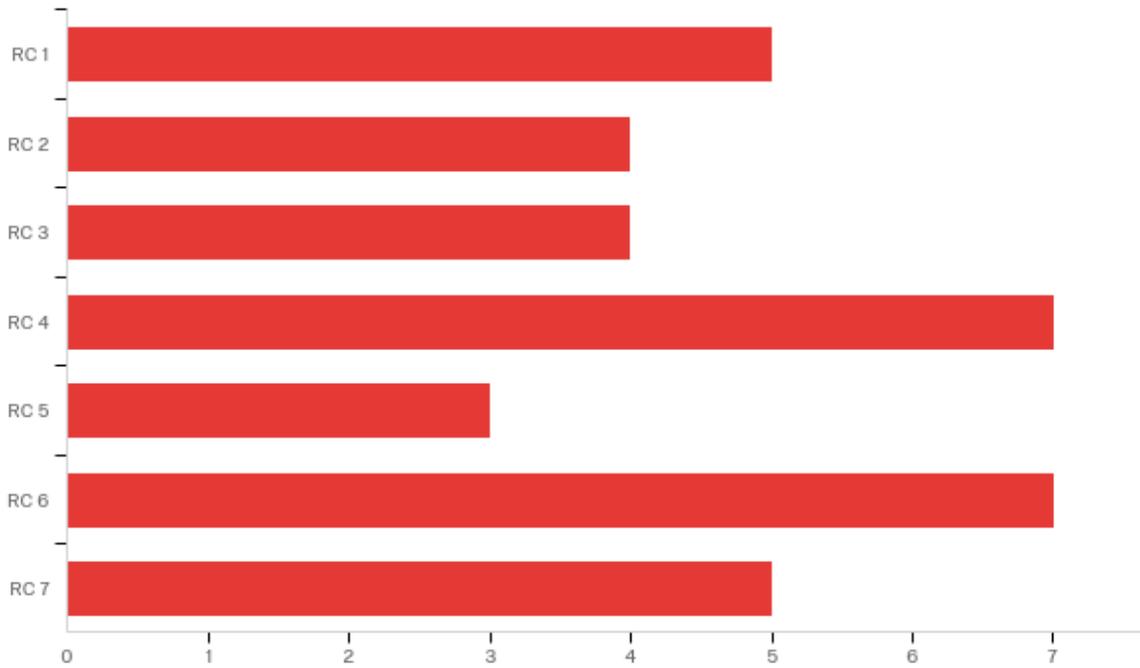
- 29 of 35 respondents (83%) indicated that their RC was very successful (10) or successful (19) in providing local leadership and support for healthcare transformation.
- 23 of 35 respondents (66%) indicated that their RC was very successful (5) or successful (18) in the development of the medical-health 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.
- 26 of 35 respondents (74%) indicated that the level of difficulty in fulfilling their function was challenging (20) or very challenging (6).
- Of those that responded that the level of difficulty was very challenging:
 - 2 are RC Executive Team, 2 are PHD SHIP Staff, and 2 are RC Members;
 - 3 (50%) indicated that their RC was very successful (1) or successful (2) in providing local leadership and support for healthcare transformation;
 - 2 (33%) indicated that their RC was very successful or successful in the development of the medical-health neighborhood (2 indicated that their RC was unsuccessful);
 - 2 (33%) indicated that their RC was very successful or successful in improving population health to achieve the Triple Aim (2 indicated that their RC was unsuccessful); and,
 - 5 (83%) indicated that the technical assistance and administrative support their RC received in achieving their goals was very helpful (3) or helpful (2).
- 26 of 35 respondents (74%) indicated that the technical assistance and administrative support their RC received in achieving their goals was very helpful (11) or helpful (15).
- 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).

• **Survey Results (data)**

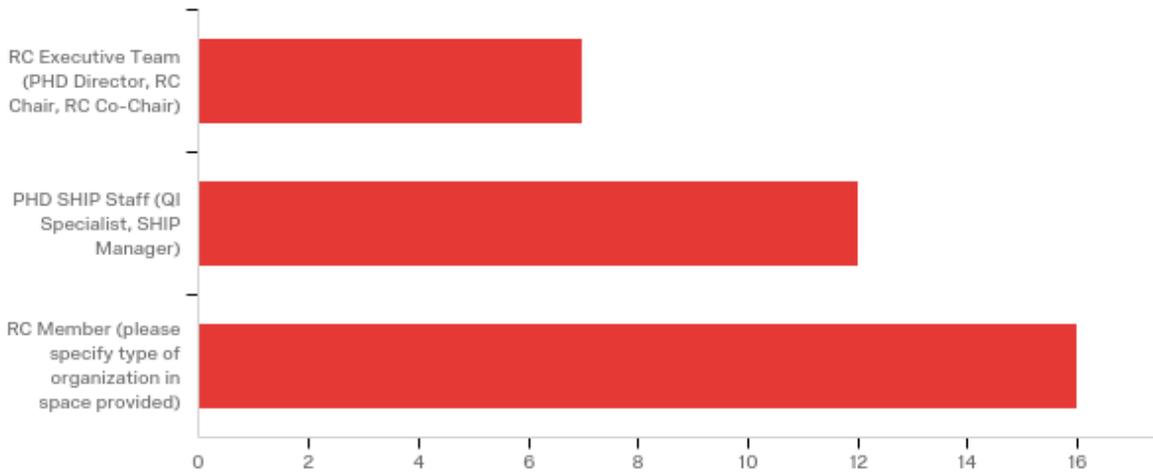
		1. With which RC do you participate?								
		RC 1	RC 2	RC 3	RC 4	RC 5	RC 6	RC 7	Total	Percent of Total
2. Please select the group that best reflects your role in the RC.	RC Executive Team (PHD Director, RC Chair, RC Co-Chair)	1	0	2	1	2	1	0	7	20%
	PHD SHIP Staff (QI Specialist, SHIP Manager)	1	1	1	3	1	2	3	12	34%
	RC Member (please specify type of organization in space provided)	3	3	1	3	0	4	2	16	46%
	Total	5	4	4	7	3	7	5	35	100%
3. How long have you been participating with your RC?	Less than 1 year	1	0	0	0	0	1	1	3	9%
	1-2 Years	2	2	1	3	1	1	1	11	31%
	3-4 Years	2	2	3	4	2	5	3	21	60%
	Not currently active	0	0	0	0	0	0	0	0	0%
	Total	5	4	4	7	3	7	5	35	100%
4. How would you measure the performance of your RC in providing local leadership and support?	Very successful	1	1	2	0	0	4	2	10	29%
	Successful	4	2	2	5	0	3	3	19	54%
	Neutral	0	0	0	2	3	0	0	5	14%
	Unsuccessful	0	1	0	0	0	0	0	1	3%
	Very unsuccessful	0	0	0	0	0	0	0	0	0%
	Total	5	4	4	7	3	7	5	35	100%
5. How would you measure the performance of your RC in the development of the medical-health neighborhood?	Very successful	1	0	1	1	0	1	1	5	14%
	Successful	2	3	2	3	0	4	4	18	51%
	Neutral	1	1	1	2	2	2	0	9	26%
	Unsuccessful	1	0	0	1	1	0	0	3	9%
	Very unsuccessful	0	0	0	0	0	0	0	0	0%
	Total	5	4	4	7	3	7	5	35	100%
6. How would you measure the performance of your RC in improving population health to achieve the Triple Aim?	Very successful	1	0	1	0	0	2	1	5	14%
	Successful	3	2	1	4	1	5	3	19	54%
	Neutral	1	1	2	2	1	0	1	8	23%
	Unsuccessful	0	1	0	1	1	0	0	3	9%
	Very Unsuccessful	0	0	0	0	0	0	0	0	0%
	Total	5	4	4	7	3	7	5	35	100%
7. What was the level of difficulty for your RC in fulfilling their function as described above?	Very challenging	1	0	0	2	2	0	1	6	17%

		1. With which RC do you participate?									
		RC 1	RC 2	RC 3	RC 4	RC 5	RC 6	RC 7	Total	Percent of Total	
		Challenging	3	3	4	4	1	4	1	20	57%
		Neutral	1	1	0	1	0	2	2	7	20%
		Not very challenging	0	0	0	0	0	0	0	0	0%
		Not challenging at all	0	0	0	0	0	1	1	2	6%
		Total	5	4	4	7	3	7	5	35	100%
10. How helpful was the technical assistance and administrative support your RC received in achieving their goals?		Very helpful	1	0	1	3	2	1	3	11	31%
		Helpful	3	2	2	3	0	3	2	15	43%
		Neutral	1	2	1	1	1	2	0	8	23%
		Not very helpful	0	0	0	0	0	1	0	1	3%
		Not helpful at all	0	0	0	0	0	0	0	0	0%
		Total	5	4	4	7	3	7	5	35	100%
13. How likely is it that your RC or an RC-like group continue after the SHIP grant ends?		Very likely	0	0	1	1	0	2	1	5	14%
		Likely	2	2	2	4	0	1	2	13	37%
		Neutral	3	1	1	2	0	4	0	11	31%
		Unlikely	0	1	0	0	1	0	2	4	11%
		Not likely at all	0	0	0	0	2	0	0	2	6%
		Total	5	4	4	7	3	7	5	35	100%

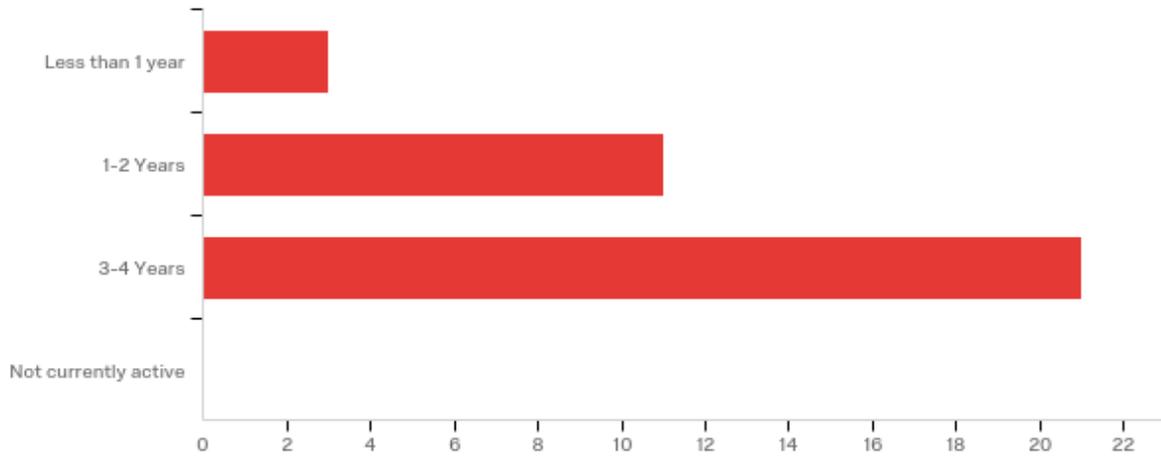
1. With which RC do you participate?



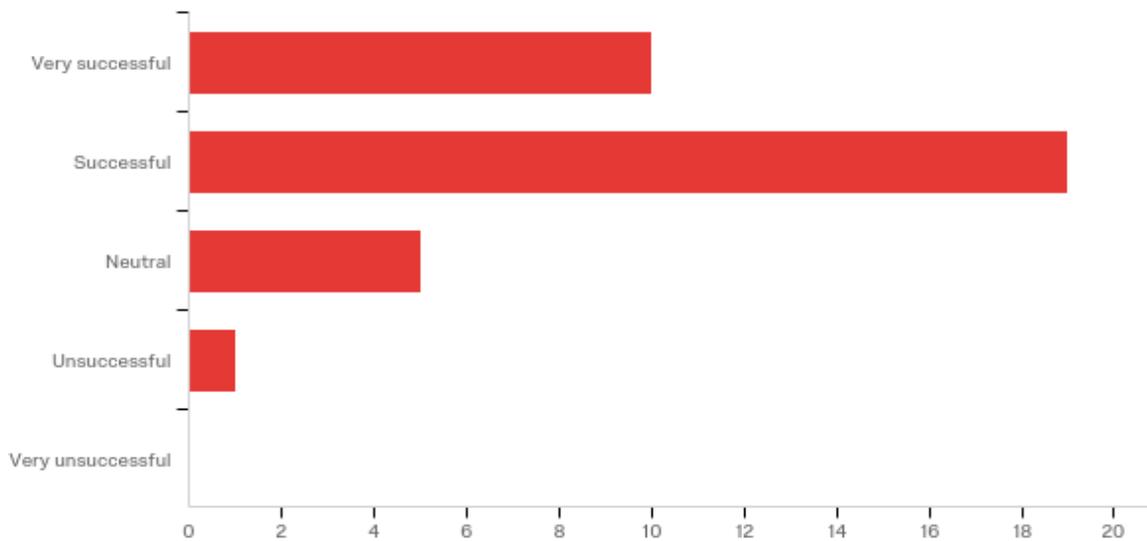
2. Please select the group that best reflects your role in the RC.



3. How long have you been participating with your RC?

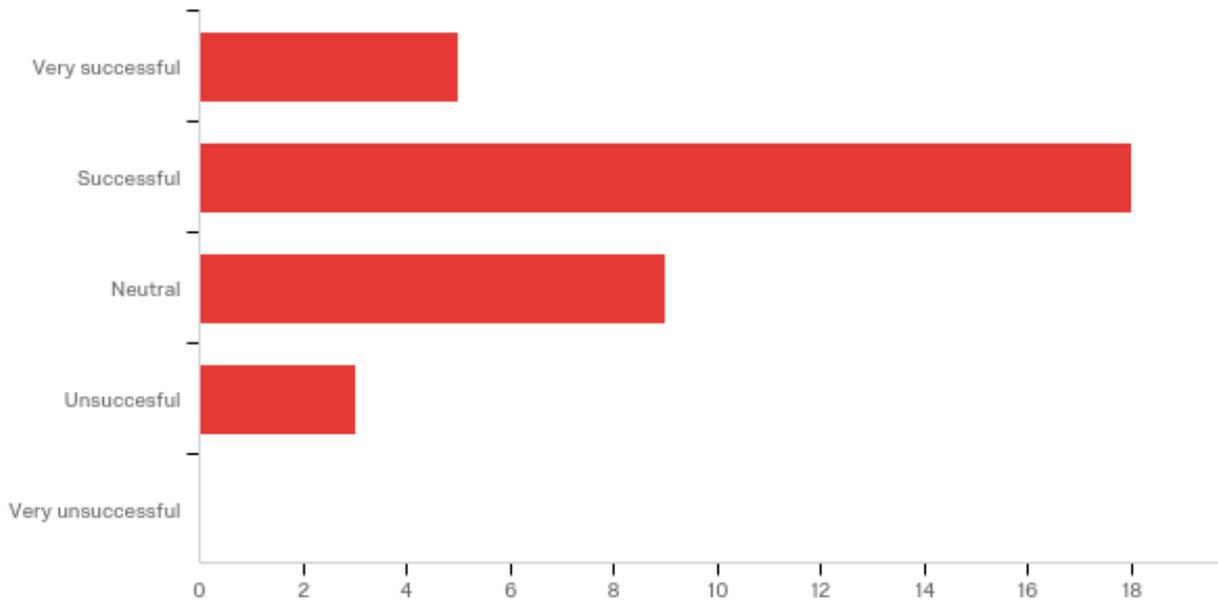


4. How would you measure the performance of your RC in providing local leadership and support for healthcare transformation?

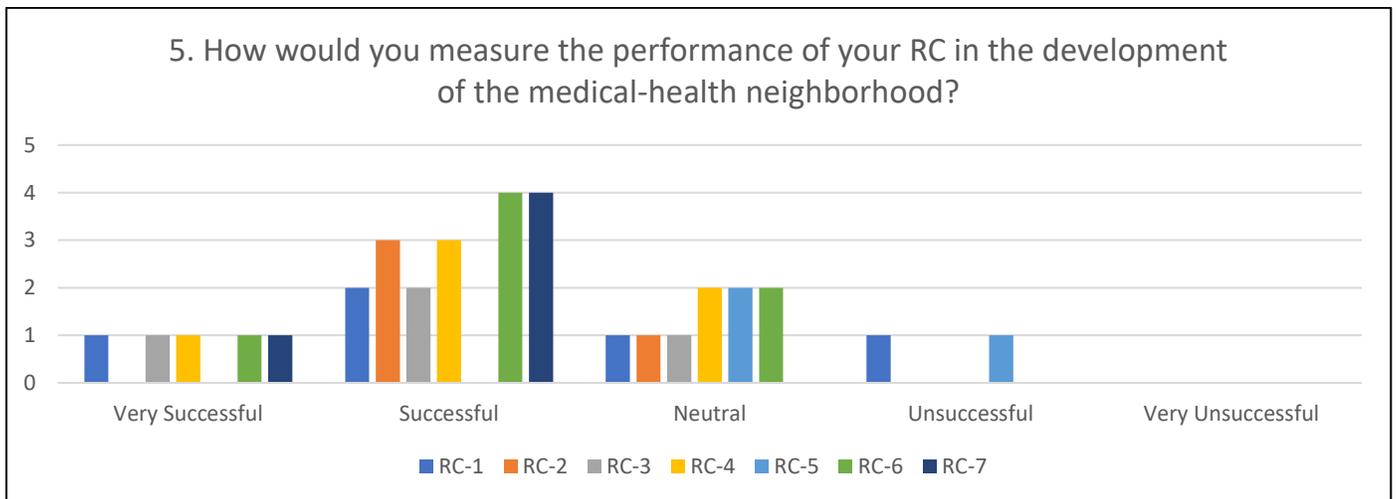


#	Answer	%	Count
1	Very successful	28.57%	10
2	Successful	54.29%	19
3	Neutral	14.29%	5
4	Unsuccessful	2.86%	1
5	Very unsuccessful	0.00%	0
	Total	100%	35

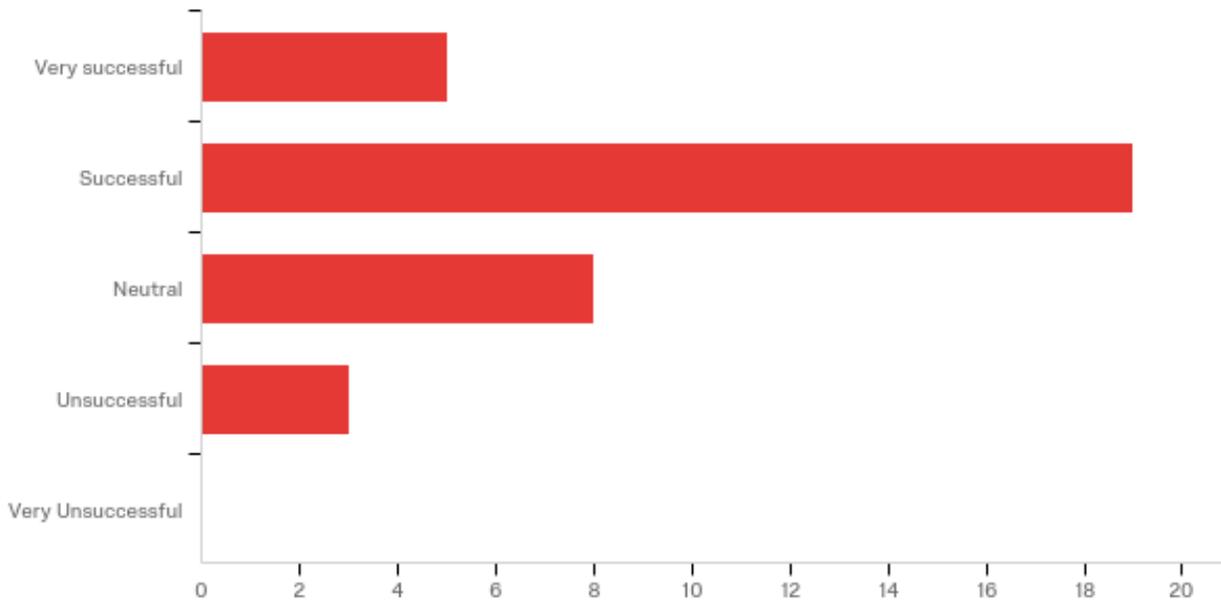
5. How would you measure the performance of your RC in the development of the medical-health neighborhood?



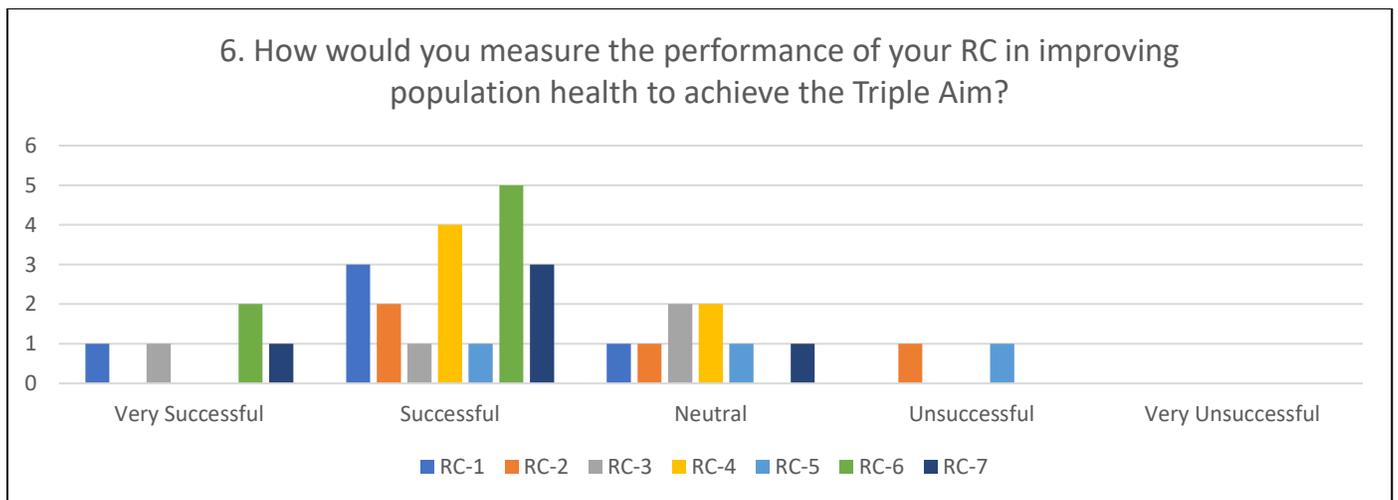
#	Answer	%	Count
1	Very successful	14.29%	5
2	Successful	51.43%	18
3	Neutral	25.71%	9
4	Unsuccessful	8.57%	3
5	Very unsuccessful	0.00%	0
	Total	100%	35



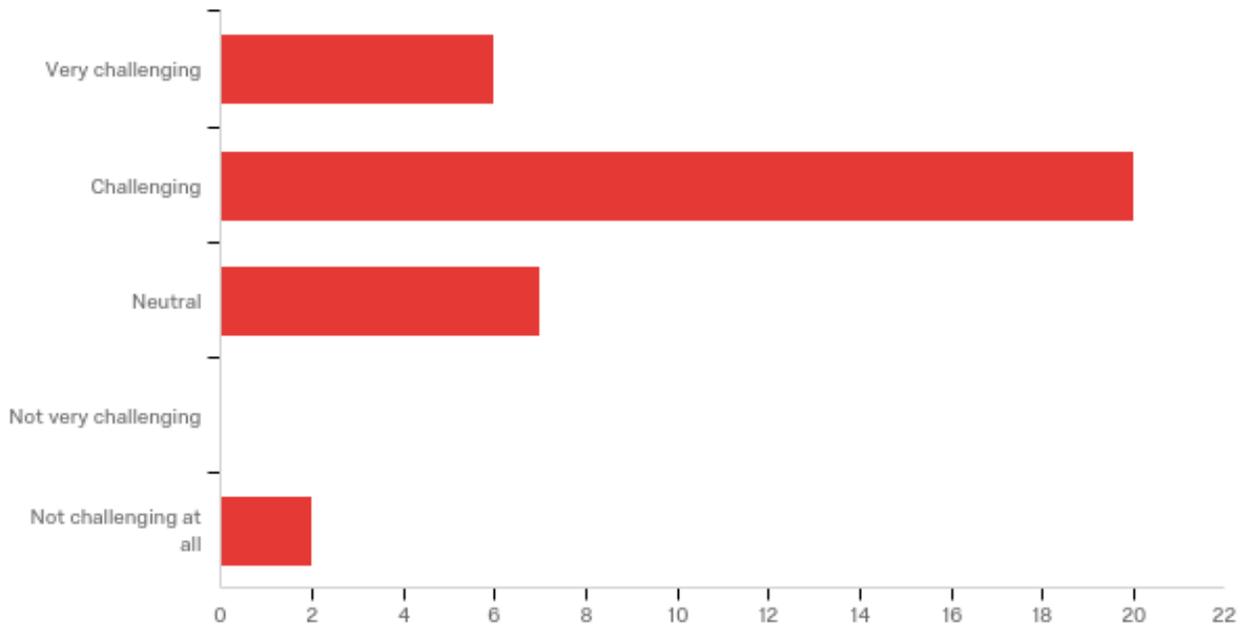
6. How would you measure the performance of your RC in improving population health to achieve the Triple Aim?



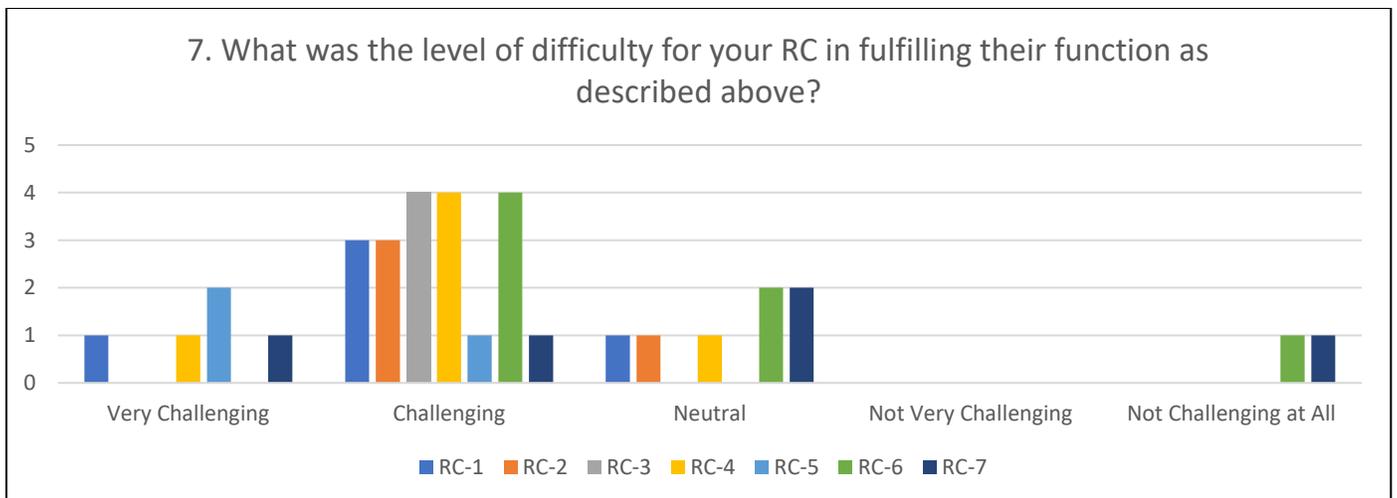
#	Answer	%	Count
6	Very successful	14.29%	5
7	Successful	54.29%	19
8	Neutral	22.86%	8
9	Unsuccessful	8.57%	3
10	Very Unsuccessful	0.00%	0
	Total	100%	35



7. What was the level of difficulty for your RC in fulfilling their function as described above?



#	Answer	%	Count
1	Very challenging	17.14%	6
2	Challenging	57.14%	20
3	Neutral	20.00%	7
4	Not very challenging	0.00%	0
5	Not challenging at all	5.71%	2
	Total	100%	35



8. What do you consider to be your RC's most notable accomplishment(s)?

8. What do you consider to be your RC's most notable accomplishment(s)?
Supporting the cohorts in integrating Behavioral Health
Greater awareness of community resources to support the health needs of our citizens beyond the traditional health care setting. A collective desire among active RC members to meaningfully connect people to community health supports.
Establishing strong community support
Collaborations in community resources and population tracking
Bringing in knowledgeable community partners to present to RC members
Caregiver Integration Project, MHN meetings for Diabetes, Collaboration, PCMH Support, etc.
Our organization has gained local knowledge and shared local resources. Finding out how other clinics are serving patients helps us learn and grow.
Bringing partners together
Their expertise on the concepts and what is needed to meet the requirements.
Getting multiple clinics to achieve PCMH designations who had not completed PCMH prior to this time.
Regional QI project
Offering education on regular basis
SHIP Clinic Collaboration with relevant topics and experts available to present as well as platform to link new with mature clinics; and Mentoring, Telehealth & CHW's
The staff has been very responsive to all my questions. I really like when the RC brings in outside resources.
The collaborative efforts with community partners
Mental health
Workgroups that were formed, and the work they completed
MIPS score of 100
Education for all members
Our chairperson networked with clinics in an effort to recruit for SHIP and RC membership. We also developed a Community Resources Guide for anyone to use when seeking or referring services.
Diabetes improvement project
transformation of clinics to PCMH
Addressing unmet behavioral health needs in our primary schools.
Bringing our clinics together for specific meetings geared towards their PCMH needs to support one another, care coordination job shadowing and mentoring, educating the medical health neighborhood on PCMH, educating ISU health care programs (Nursing, Nurse Practitioners, Pharmacy, Medical Assistants, Health Care Administration) on the PCMH model to foster sustainability, facilitating a regional suicide prevention training, facilitating a PCMH Training for our Cohort 3 Clinics where both the PHD staff and Physician Champions/RC Chair and Co-Chair presented.
Gathering representatives from so many primary care clinics across the region to meet together to discuss problems, solutions, and resources.

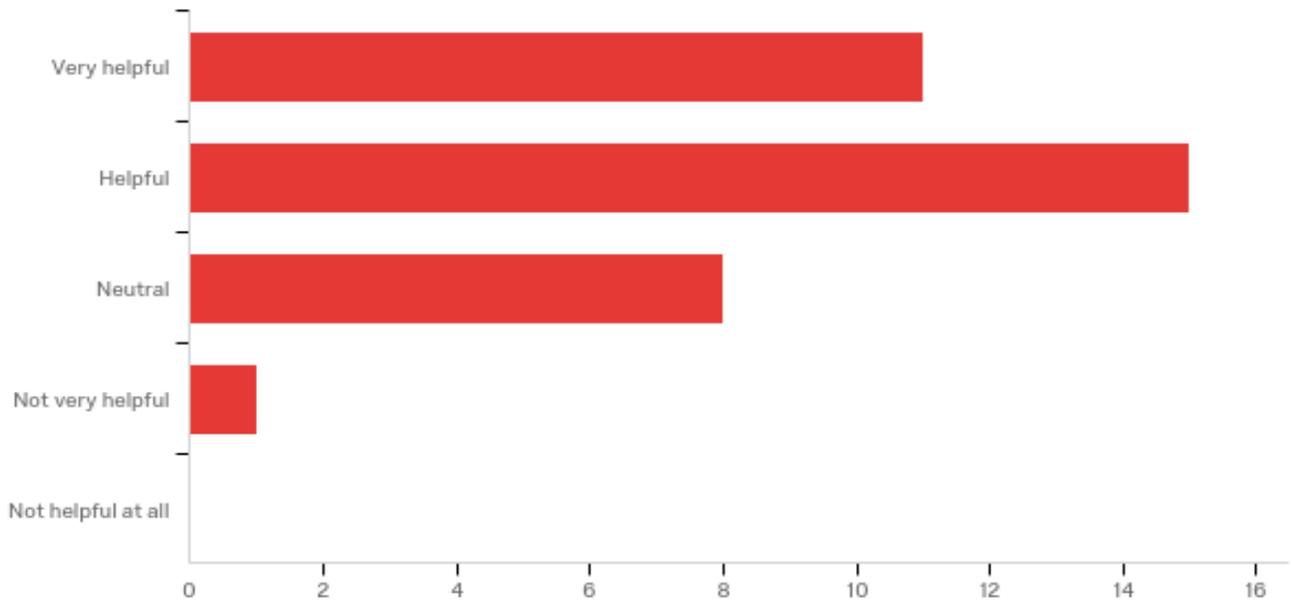
8. What do you consider to be your RC's most notable accomplishment(s)?
Establishing PCMH across N Idaho. Promoting collaboration
Bring clinic staff together to network and share learning about local resources and PCMH transformation
Their knowledge and understanding to help our clinic achieve our goals.
PCMH Clinic transformation, suicide prevention work, connections made between clinics and organizations that address social determinants of health.
Safe space for clinics to share best practices and glean ideas from each other.
Assistance with providing education and support to medical practices
Behavioral health portfolio (Healthy Minds Partnership, IIBHN, Let's Talk series)
Suicide symposium, crossed regions
Reaching out to the other clinics and getting them either PCMH (NCQA) certified or on the road to it.

9. What was the biggest challenge or obstacle your RC faced?

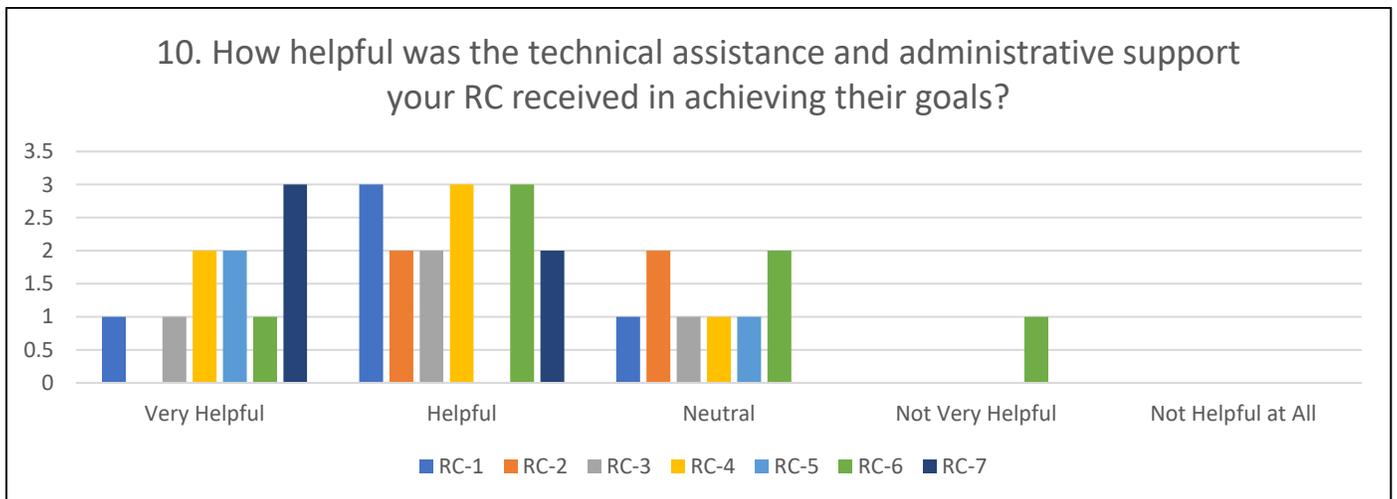
9. What was the biggest challenge or obstacle your RC faced?
Data
Determining a method by which people can be meaningfully connected to community health resources that can track the referrals, document that there is follow through, and measure outcomes.
too much debate, not enough action
The massive needs of the community
Bringing together and aligning large healthcare systems and other organizations with competing interests
Available data to make informed decisions
At first, the most difficult part was ensuring that the involved clinics were using data in the same way and able to compare appropriately.
Getting everyone to participate
NCQA
No data from the IHDE from which to set goals and work on the population through a medical neighborhood.
The medical health neighborhood was challenging to tackle. We started, but it will take more time.
Time available to participate in calls. It may have been helpful to record sessions for later playback
Lack of anticipated data to drive Regional Population Health Management efforts
All the different EMRs the health centers are on
Keeping needed members at the table and engaged
Sustainability

9. What was the biggest challenge or obstacle your RC faced?
Not having the data needed to start measuring changes
PCMH recognition
Fully implementing all goals
membership/participation/motivation
Getting physician leadership and buy in at each practice
lack of member participation
The lack of claims/encounter data to make planning decisions and monitor outcomes/impact.
Our biggest challenge was overcoming the barriers of competing interests that organizations experience. There were multiple clinics that were not necessarily ready to participate in SHIP. We had difficulty in engaging some individuals/organizations but this could be due to the fact that they were truly not ready to implement PCMH transformation. However, despite the difficulties, this did not stop us in reaching out to engage them.
Scheduling and taking staff out of the clinic to meet, especially those located at a farther geographical location.
Access to care
Finding topics that apply to all clinics in attendance and staff members from the clinic, example: something that isn't just Ped specific or only applies to office managers and not the providers
Understanding regulations and policies to better our patient care.
Competing quality improvement demands placed on clinics, sustainability post-SHIP,
Scheduling with RC Chair's to find time in their working schedule.
Creating sustainable programs that impact change
Data
membership
I didn't feel like the Medical Neighborhood was something that worked out well.

10. How helpful was the technical assistance and administrative support your RC received in achieving their goals?



#	Answer	%	Count
1	Very helpful	31.43%	11
2	Helpful	42.86%	15
3	Neutral	22.86%	8
4	Not very helpful	2.86%	1
5	Not helpful at all	0.00%	0
	Total	100%	35



11. What type of technical assistance and administrative support that your RC received did you find the most helpful in achieving their goals?

11. What type of technical assistance and administrative support that your RC received did you find the most helpful in achieving their goals?
The CDHD staff and the coaches that assisted the clinics.
Having leadership and guidance from the district SHIP manager and staff to set agendas for the leadership team and the RC meetings. The SHIP staff organization presentations about community health resources and performing research between meetings needed to advance the work of the RC.
not sure
Having staff
public health district support
PHD staff convening, facilitating meetings, QI Specialist reporting and dissemination of information.
I'm unaware
Public health team coordinating meetings was very valuable
The State patient surveys.
The in-person support of helping clinic achieve PCMH designation.
CDE educational support for QI project
Not sure about what assistance was received.
Very organized, meaningful and relevant agenda items for both RC and PCMH clinic meetings
NCQA is a very helpful resource
NA
Rachel has been incredible! Without her we would be dead in the water
Rachel did a great job in seeking support and resources for the RC
Help with NCQA
Presenters and external resources who provided education
I do not believe we asked for or received any TA or admin support.
Admin support at PHD.
convening meetings, finding speakers
I'm not sure what this questions is asking. The district SHIP staff were awesome. Our RC received little technical assistance or administrative support from SHIP Central or other sources.
Our RC Leadership, specifically our Physician Champions brought expertise and extensive experience in PCMH. Their experience and willingness to help others through the process built trusting relationships between clinics so they could share their experiences, barriers, and successes. Our leadership spent time with those new to PCMH by meeting with their practices in person to talk about PCMH and gain buy-in to the model.
The behind the scenes work of the QI Specialists and bringing needed resources into our RC meetings to provide information to the primary care clinics.

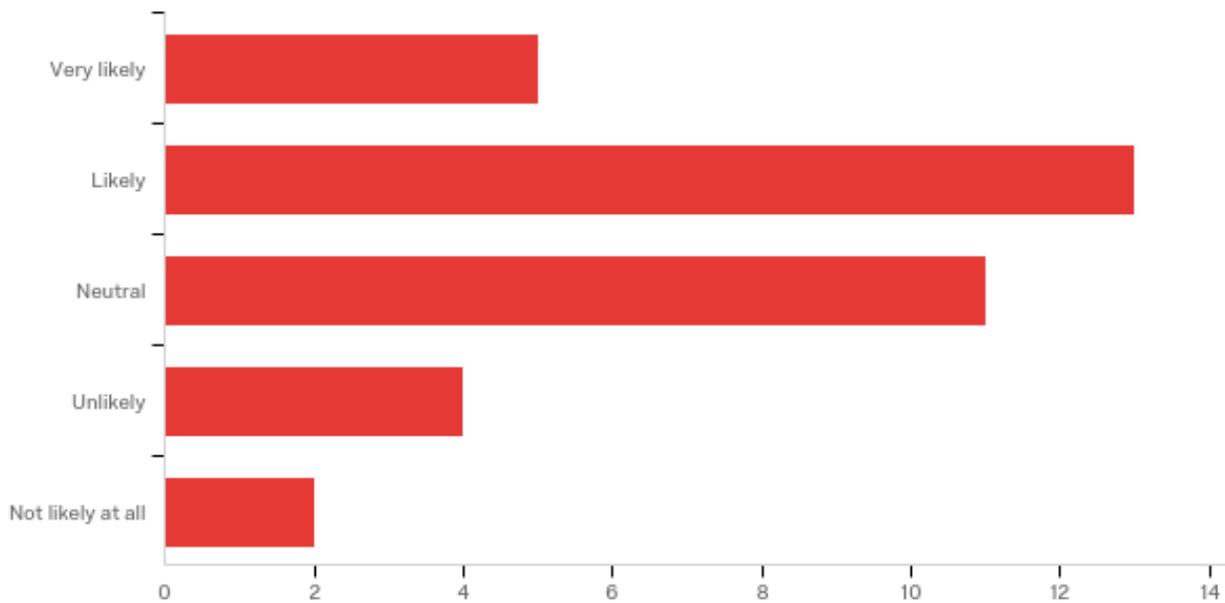
11. What type of technical assistance and administrative support that your RC received did you find the most helpful in achieving their goals?
Program info
Learned how to pull certain reports on different EHRs, also connected clinics with similar EHRs so that they could help one another. Shared different examples and tools that other clinics have used
They did a SHIP crash course at the beginning that helped with overview of program.
Enthusiasm and knowledge of RC Chairs and Co-chairs was critical to the function of the RC. The QI Specialist's unique knowledge of the transformation status, challenges, and successes of each of the SHIP clinics was very helpful in providing the RC leadership team a big picture perspective of PCMH growth and development in our region.
n/a
Didn't really receive technical support (from our vantage point), but some support thru education.
Scheduling and facilitation
n/a
The support from the Public Health Department was awesome. The support from Brilljent (is that how you spell it) and their advisor phone calls was not very helpful.

12. In the future, what could be done differently to help your RC to better achieve their goals?

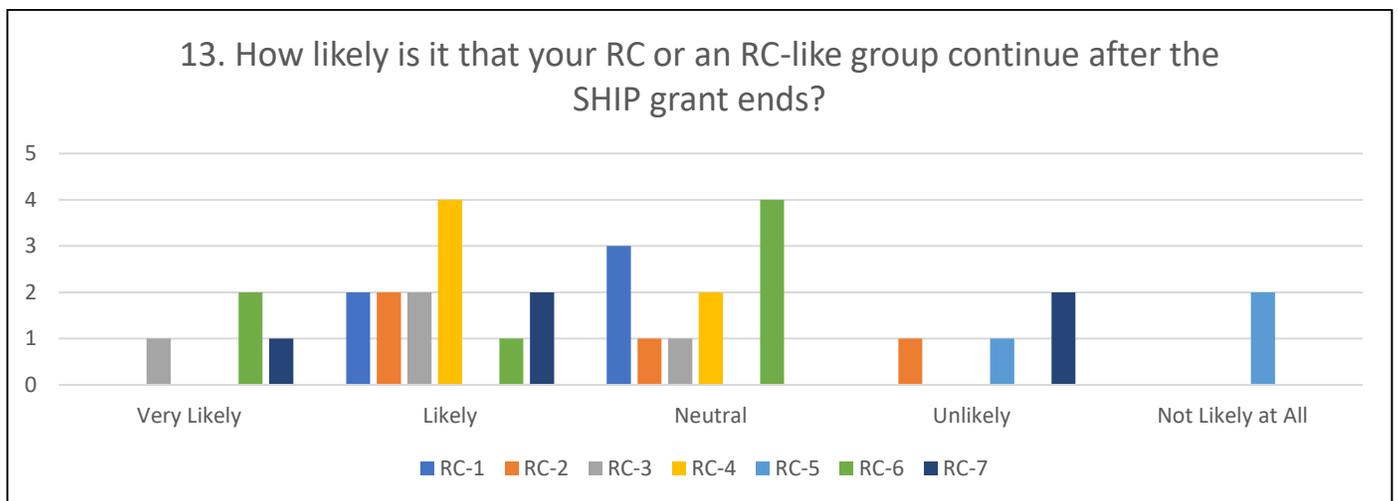
12. In the future, what could be done differently to help your RC to better achieve their goals?
more action oriented goals
As noted earlier, we are challenged with identifying processes that could be integrated into our health care and social services systems to ensure that people who need help are actually connected to resources and improve their situation. Our group has been working on this for more than year, but we have not outside support to know what options we might have other than those brought forward by the SHIP team or members of the RC.
a clear and defined goal. We spent too much time trying to figure out what we could or should do and entertaining every reason why the idea wouldn't work, and then we'd start again with a new idea.
More help with data management and staff
access to data
Data, ongoing support for operations/administrative support
I'm unaware
Nothing differently I don't think, but we just need to keep up with meeting and pursuing goals.
Better training from NCQA
Find differential funding from insurers/payors for PCMH designation in order to incent clinics to maintain PCMH and get the IHDE functional
Involve more community stakeholders committed to health care transformation
recording sessions for future listening.
The SHIP staff was presented with challenges in bringing all the RC members up to speed specific to understanding the RC's function and goals
Collaboration with local specialists on referrals
NA
More time 3yrs is inadequate to make changes we are hoping for
Access to data, if possible
Better it support to coordinate IHDE and EMRs
Ongoing meetings after SHIP "expires"
I do not believe we could have done anything differently. Clinics had the QI for transformation help. And lack of motivation/participation is not something you can force.
Marketing the projects and resources to the physicians and other providers beyond the admin staff
1) Access to data, 2) Sustainable funding, and 3) 2-3 shared statewide goals/measures that all RC could influence
To help us better achieve our goals, it would have been beneficial to have better access to data. Some of our clinics didn't have great accessibility to data through their own EMR and experienced many barriers and had to create separate systems to get the data (for some clinics this process took over a year alone to achieve). Setting realistic goals would have been helpful for our clinics as well. PCMH Transformation is expected to take 12 months for a clinics according to NCQA experts, however when they are required to participate in other activities along the way (webinars, collaboratives, coaching calls, QI specialist interaction, Healthy Connection visits, IHDE communications etc.), the time frame should have extended to allow for these activities as well. I believe it would have helped reduce

12. In the future, what could be done differently to help your RC to better achieve their goals?
staff frustration and burnout with transforming to the PCMH model. If we aligned better with organizations from the very beginning it may have made the transition or "warm hand off" to other entities, such as Medicaid smoother.
Financial resources would be helpful.
Maintain permanent staff
I'm not sure
Help with initial organization of our clinic. We were given a lot of information and paperwork at the beginning that needed organized.
Improved reimbursement opportunities that support PCMH transformation activities (care coordination, patient outreach, patient education, etc.) would be helpful. Improved alignment between payors, regulatory agencies, and PCMH accrediting bodies is critical for sustaining the work.
n/a
Creating programs with lasting change instead of just convening every quarter to discuss issues and topics.
More focus at the beginning
sustainability, and including all medical provider types
Focus on clinics getting their certifications via the quality specialists at the public health departments

13. How likely is it that your RC or an RC-like group continue after the SHIP grant ends?



#	Answer	%	Count
1	Very likely	14.29%	5
2	Likely	37.14%	13
3	Neutral	31.43%	11
4	Unlikely	11.43%	4
5	Not likely at all	5.71%	2
	Total	100%	35



14. How do you envision your RC evolving in the future?

14. How do you envision your RC evolving in the future?
we are talking about a future project supporting the community schools in our region
We hoped to have support from the Medicaid Value Care program in regard to funding from shared savings or front end loaded by Medicaid (so we didn't have to wait for shared savings) and take over the function of the CHOICE advisory boards. This is uncertain and the dates have been pushed back for implementation of the Value Care program. I could see the concept of the CHOICE groups fitting well with the RC structure, but the lack of funding to continue having administrative support for the RC will make it very difficult to continue after the grant.
I would like to see the MHN concept come to life. I think we're still trying to figure out what the MHN really is.
Don't know
Focus more on the MHN
Alignment with Medicaid ACO Transformation and potentially using shared savings funding for community projects.
We have really enjoyed the collaboration the RC provides and hope that continues.
More partners joining so our group is more inclusive and can be a stronger collaborative and voice for health care and patients
Support for sustainability of NCQA recognition.
I envision this area evolving into and RCO model to contract with Medicaid on a capitated model of care
Not sure. It depends if someone is facilitating the group, members' time, and financial support.
I am not sure
Possibly more involved in assessing provider/community needs to achieve triple aim and serving as a great resource to seek funding to support transformation
I would like to see additional care management training and it would be helpful as an RC to work with local specialists on referrals and getting reports back.
Continuing with emphasis on population health and to offer a distinct role in our community for the promotion of better health for all ages
Combine with region 4
To provide support to communities
Continue collaborating
Hopefully we continue to meet.
I do not believe our RC can be sustained. Monthly meetings were reduced to every other month. The bi-monthly meetings were reduced to quarterly meetings. The next step is bi-annual meetings and, in my opinion, The RC does not have a purpose.
The health district relationship matures, the visibility to the community grows, the regional QI improves
if RCO is available, this will be the place for RC activities
I see it becoming a part of CHOICE and continuing to identify top priorities that can help move Idaho closer to achieving the triple aim.
Since we have identified that for our region the RC will likely not be sustainable, we hope to continue to develop connections between the RC members so they can reach out to each other for continued transformation support.

14. How do you envision your RC evolving in the future?
Additionally, we will continue as a PHD to help foster healthcare transformation through the implementation of our other grants that focus on working with clinics in the areas of chronic disease, comprehensive cancer, etc.
The RC needs a neutral organization leading it and getting all of the clinics together. Public health is useful because they know about so many resources and can act as the connector for the clinics. They know which clinics could mentor the others, etc. I don't see the RC evolving in the future if there isn't an organization like public health who is willing to lead it.
Continue to promote system integration
Clinics working together with already existing relationships and networking to work together and answer questions
Monthly check-ins to see how we are doing and if we are still on track with the program
We have two major healthcare systems in our region, one of which has a quality improvement organization that includes several SHIP clinics. Those clinics will likely continue to collaborate with PQA. The other system is not likely to join this quality improvement organization. Public health has several contracts that include the convening of health coalitions. These public health programs can/will encourage participation by SHIP clinics and will continue to work toward specific clinical improvement goals.
The RC will likely be absorbed by other existing coalition and workgroups.
Our CIN intends to move forward with our pop health initiatives using some of the connections gained thru the medical health neighborhood.
Combining with RC3 and aligning with major public and private payers
Adding more provider type/specialties, to include all for greater impact. Discuss issues pertaining to our area, including all aspects of care.
Focusing on having the quality specialists help clinics who are interested with PCMH/NCQA certification. And having the quality specialists know that she can call on other members of the present collaborative to help give presentations or touch base with those who are trying to progress. I don't see anything happening with the Medical Neighborhood other than what the Public Health Department already does.

15. What is the type of support you would need in the future to sustain your regional activities?

15. What is the type of support you would need in the future to sustain your regional activities?
admin and project management support
I believe the current members of our RC would continue to volunteer their time as well as our leadership team beyond the grant period. The main issue is funding needed to provide ongoing administrative and technical support and guidance so that the RC has a clear purpose and the ability to identify resources to achieve goals.
we need the support of the clinics that are transforming...we need to know what they need and what they would find most helpful. We had a few clinics represented but mostly health systems.
Staff, data management, meeting organization
Funding for operational support and data
Administrative/operations support, a neutral space to convening multiple partners.
Unsure
The coordinating of the group by public health is invaluable. If left in private practice hands it won't happen. Time to make it grow and develop is always a challenge as well, but it's pretty hard to create more of that.
Quarterly meetings to keep clinics up to date on changes in NCQA requirements.
See above, there needs to be a way to pay for doing care differently (i.e., non-RVU based pay for maintaining the health of populations of people).
Convening organization and financial support
More input on topics to be discussed.
Administrative support as well as convener to support RC and create the ongoing link and relationship to the Statewide effort
Not sure
Money/funds to support/sustain this important effort
\$ and administrative support
Having a facilitator to convene meetings, create a vision for the group and workplan
It support for integration of data exchange
Someone to continue to organize.
Motivation. Guidance. Leadership.
Need admin support at the PHD regional level.
.
Funding and some form of structure or leadership at the state or regional level
In order to sustain the depth of work that has been done through our RC we would need a funding mechanism. We can continue to foster transformation through other grants as I described above, but we cannot solely focus on PCMH transformation and MHN development in the same capacity as we have over the past 3 years. It takes dedicated staff time towards this effort to meet with clinics, help them identify resources and strategies for transformation. It also takes dedicated staff time to convene the collaborative and develop relationships between the clinics and medical health neighborhood partners to work towards population health goals as a region.

15. What is the type of support you would need in the future to sustain your regional activities?
The QI Specialist offered the most benefit because of their work with all of the clinics and ability to share resources that clinics may or may not have known they needed.
Continue to remote collaboration
Financial, some kind of common goal as clinic learn more about PCMH and become recognized they don't need as much support plus they have already networked they need less help from the RC
Tracking progress
An organizational framework, continued state leadership, continued provider champion support, a regional QI specialist/community liaison
n/a
Continued educational resources and grant funding for financial assistance if available.
admin support to help convene
leadership
Funding to keep the Quality Specialists going.

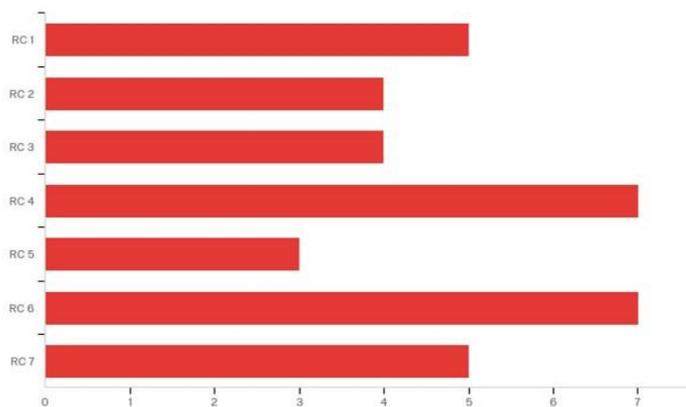
REGIONAL COLLABORATIVE SURVEY

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

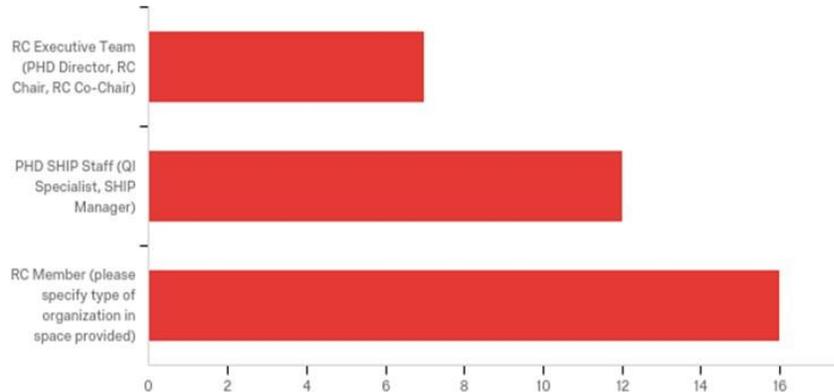
The survey was distributed via email to 165 RC members in July 2018. The team received 35 survey responses (21% response rate).



SURVEY RESULTS: RESPONDENT PARTICIPATION IN RCs



SURVEY RESULTS: RESPONDENT ROLES IN THE RCs

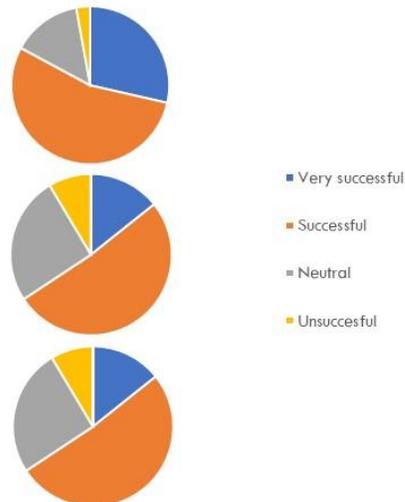


SURVEY RESULTS: SUCCESS IN ACCOMPLISHING GOALS

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.

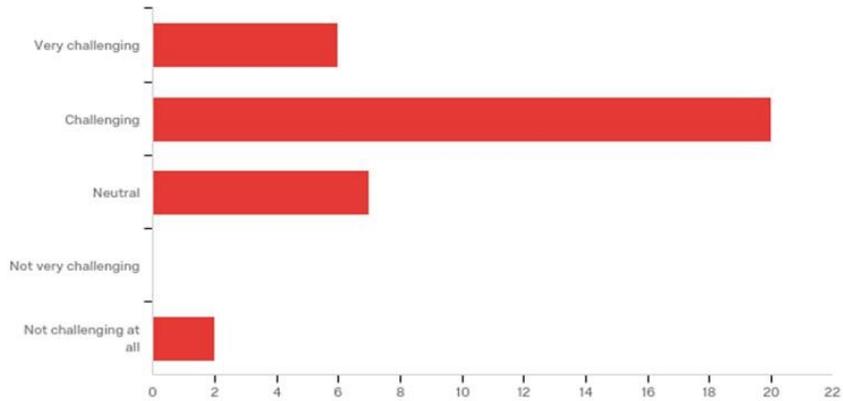
23 of 35 respondents (66%) indicated that their RC was very successful (5) or successful (18) in the development of the medical-health neighborhood.

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.



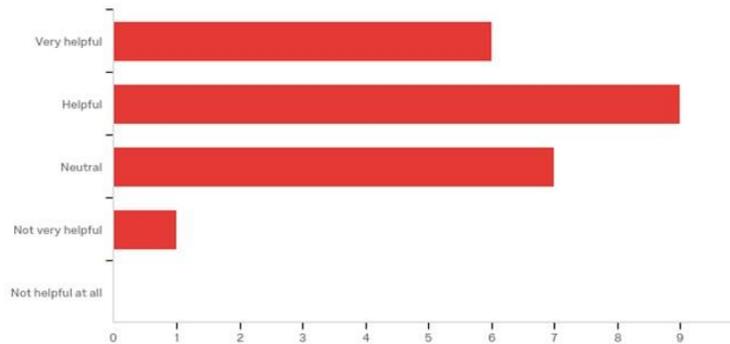
SURVEY RESULTS: LEVEL OF DIFFICULTY

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?

Regional Collaborative Post-SHIP Transition Plan Focus Areas

October 2018

Regional Collaborative	District SHIP Manager	1. Focus Area	2. Focus Area	3. Focus Area
District 1 Panhandle Health District	Steve Holloway sholloway@phd1.idaho.gov	Organizing and Holding Regional PCMH Meetings	Facilitate Regional QI Project's	Promoting PCMH Model of Care
District 2 North Central Health District	Kayla Sprenger ksprenger@phd2.idaho.gov	Continue to convene clinics and support ongoing mentoring between clinics		
District 3 Southwest Health District	Rachel Blanton rachel.blanton@phd3.idaho.gov	Care Coordination	Medicaid and ACO alignment	Behavioral Health Integration
District 4 Central Health District	Melissa Dilley mdilley@cdhd.idaho.gov	Care Coordination	Medicaid and ACO alignment	Behavioral Health Integration
District 5 South Central Health District		Resource Directory		
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Financial Impacts from Medicaid Expansion in Idaho

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July 19, 2018

This report assumes that the reader is familiar with the state of Idaho's Medicaid program and federal healthcare reform. The report was prepared solely to provide assistance to DHW to model the financial impact of federal healthcare reform provisions. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

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EXHIBITS

Exhibit 1: Impact of Expansion on Idaho Including State and Local Cost Offsets with Projected Offsets

Exhibit 2: 2020 Projections of PMPM Cost and Membership Distributions by Age/Gender

I. EXECUTIVE SUMMARY

At the request of the Idaho Department of Health and Welfare (DHW), we prepared this report to analyze the cost impact of expanding Medicaid coverage under the Patient Protection and Affordable Care Act (ACA) as a possible result of a voter-initiated ballot measure. The ballot measure proposes expanding Medicaid coverage to the population of adults with income up to 133% of the Federal Poverty Level (FPL), with the standard Medicaid income rules allowing those with up to 138% of FPL to enroll. Throughout this report, we refer to state and local offsets.

The nature of this forecast is based upon the data and information available at this time. Actual enrollment levels and costs will vary from these estimates as the actual results are observed relative to the assumptions contained within this report.

Actual results could be higher or lower than our estimates. This can be due to changes in the number of persons eligible, enrollment take-up rates, per member costs, cost offsets, or federal funding. State funds will be needed to pay the state share of a potential Medicaid expansion. We have assumed a 90% federal medical assistance percentage (FMAP) for the duration of the projection period.

The total ten year cost estimate from SFY2020 to SFY2030 in state and local funds is \$105.1 million net of projected offsets for currently authorized programs. The total state and federal ten year net cost (reflecting savings from existing state and local funds) is \$4,796.3 million. Please see Table 1 for details.

Note that we have included ten complete fiscal years as well as the initial partial year given a January 1, 2020 implementation date.

Table 1 Idaho Department of Health and Welfare Total Projected Additional State, Local, and Federal Costs <Savings> (Values in Millions)						
Expansion with Projected Offsets						
	Formula	SFY 2020**	SFY 2021	...	SFY 2030	Cumulative Total
Total Gross Cost Expansion	(a) = (b) + (c)	\$199.6	\$412.0		\$586.2	\$5,220.8
Federal Funds - Expansion	(b)	\$179.0	\$370.1		\$526.9	\$4,691.2
State Funds - Expansion	(c)	\$20.6	\$41.9		\$59.3	\$529.6
Projected State Offsets	(d)	(\$10.2)	(\$20.4)		(\$35.0)	(\$327.2)
State Funds - Expansion, Net State Offsets	(e) = (c) + (d)	\$10.4	\$21.5		\$24.3	\$202.4
Projected Local Offsets	(f)	\$0.0	\$0.0		(\$12.6)	(\$97.3)
State Funds - Expansion, Net State & Local Offsets	(g) = (e) + (f)	\$10.4	\$21.5		\$11.7	\$105.1
Federal Funds - Expansion	(h)	\$179.0	\$370.1		\$526.9	\$4,691.2
Total Net Cost Expansion:	(i) = (g) + (h)	\$189.4	\$391.6		\$538.6	\$4,796.3

**Only includes six months of claims cost for SFY 2020. Six months of cost was considered for SFY 2020 as the program effective date is to coincide with the annual open-enrollment process for non-group health insurance coverage available through Your Health Idaho (YHI).

Our estimates are based on the following key assumptions:

Medicaid expansion enrollment:

The SFY 2020 Medicaid enrollment growth forecast as a result of the initiative is approximately 91,000 adults. This estimate is based on Idaho's current economic landscape and Medicaid expansion enrollment experience in other states relative to non-elderly adult Supplemental Nutrition Assistance Program (SNAP) enrollment. Actual enrollment may be lower or higher than our estimates due to variances in Medicaid enrollment take-up rates relative to other states, population changes, and fluctuations in unemployment rates and household income. For reference, Idaho's unemployment rate in April 2018 was 2.90%.¹ An increase in the unemployment rate would likely increase projected Medicaid expansion enrollment.

Medicaid expansion benefit expense:

Estimate per member per month (PMPM) benefit expense costs are based on an actual expansion Medicaid medical and pharmacy benefit costs from several states, adjusted for assumed Idaho age and gender mix and healthcare cost assumptions. Based on Idaho's Medicaid cost experience for existing populations, we assumed an annual PMPM trend of 2.50% for the projection period. For the second and third years (2021 to 2022), we also increased the annual PMPM trend to account for the duration of enrollment from the program start (please see the methodology section for further details). As stated previously, we have assumed a 90% FMAP for the duration of the projection period, resulting in the federal government funding 90% of direct Medicaid expansion benefit expenses.

Medicaid administrative expense changes:

The state of Idaho will incur additional administrative expenditures related to Medicaid expansion. DHW provided us with estimates for the one-time and ongoing administrative costs for SFY2020. DHW indicated a 0% trend of the ongoing expansion administrative load is a reasonable assumption.

Projected state and local offsets:

The State of Idaho has several state and local programs (not funded by federal dollars) that assist the medical needs of those not eligible for other form of health insurance in the state. Based on discussions with DHW, we assumed that Medicaid expansion would reduce the costs for these programs. This report includes assumptions for savings (offsets) from the following state and local programs due to Medicaid expansion:

- Local and State Catastrophic Health Care Cost (CAT) fund offsets
- Reduced hospitalizations for the Idaho Department of Corrections (IDOC)
- Offsets from services from DHW – Division of Behavioral Health (DBH) Mental Health Services.

The projected state and local offsets are summarized in Table 2 below. No cost offsets for the CAT fund and Local Medically Indigent claims are recognized until SFY 2022 because it is assumed to take approximately two years to phase down these programs after expansion. .

¹ <https://www.bls.gov/eag/eag.id.htm>

Table 2
Idaho Department of Health and Welfare
Total Projected State and Local Programs Offsets and Savings (Values in Millions)

	SFY 2020	SFY 2021	SFY 2022	...	SFY 2030	Total
<u>Projected State and Local Programs Offsets and Savings</u>						
<u>State Programs:</u>						
CAT Program (State)	\$0.0	\$0.0	(\$10.7)		(\$14.6)	(\$113.1)
Substance Use Disorder Services (IDOC)	(\$2.4)	(\$4.9)	(\$4.9)		(\$4.9)	(\$51.0)
Behavioral Health (DHW)	(\$4.1)	(\$8.1)	(\$8.1)		(\$8.1)	(\$85.2)
Hospitalizations (IDOC)	(\$1.4)	(\$2.8)	(\$2.8)		(\$2.8)	(\$29.0)
DHW - DBH - Mental Health Services	(\$2.3)	(\$4.7)	(\$4.7)		(\$4.7)	(\$48.9)
Total State Offsets	(\$10.2)	(\$20.4)	(\$31.1)		(\$35.0)	(\$327.2)
<u>Local Programs:</u>						
Medical Indigent (Local)	\$0.0	\$0.0	(\$9.2)		(\$12.6)	(\$97.3)
Medical Ind (Local Admin)	\$0.0	\$0.0	\$0.0		\$0.0	\$0.0
Total Local Offsets	\$0.0	\$0.0	(\$9.2)		(\$12.6)	(\$97.3)

Other issues not modeled: The issues highlighted below ***have not*** been included in the financial projections shown in our analysis.

- > Changes to Medicaid eligibility levels for certain eligibility categories
- > Reductions in DSH allotments
- > Impact on other state agencies
- > Economic ripple effect or multiplier
- > Maintenance of effort
- > Recidivism

The scope of our report is limited to a projection of the estimated financial impact of the voter initiated Medicaid expansion on the Idaho state budget with consideration to other state and local cost offsets. DHW can use the results of this report in its determination of the potential costs and benefits of expanding Medicaid coverage.

II. DETAILED FINANCIAL PROJECTIONS

In its June 28, 2012 decision, the Supreme Court of the United States upheld most of the ACA, but gave States the flexibility to decide whether to expand Medicaid program eligibility for adults to 138% of FPL. In the fall of 2018, there will be a voter-initiated program on the ballot, which proposes to expand the Medicaid program eligibility. If approved this program is scheduled to go live on January 1, 2020. This report evaluates the financial impact of this voter-initiated program to expand Medicaid coverage.

Medicaid programs are funded jointly by state and federal governments. The Federal Medical Assistance Percentage (FMAP) will vary based upon the type of program and the year.² For the ten year estimate of costs for Medicaid expansion, a 90% FMAP was assumed (10% state share of total costs).

Table 3 on the following page summarizes total costs by SFY providing the breakdown for Idaho's direct expansion costs, state cost offsets, local cost offsets, and the federal costs for expansion. Federal costs do not include offsets for individuals qualifying for federal premium assistance in YHI who would become Medicaid eligible under expansion. Subtotals are provided for the impact of state funds, the impact of state and local funds and the total Net Cost for expansion as well as the total Gross Cost for expansion without consideration of the state and local offsets. As the program is modeled to start on January 1, 2020 the SFY 2020 only includes six months of cost and enrollment. In the development of our estimates, we have not assumed any ramp-up period for the Medicaid expansion population to reach steady-state enrollment. It is possible that enrollment and associated costs for SFY 2020 may be less than the values shown in Table 3 to the extent program enrollment occurs in a gradual manner.

The costs shown below are only those costs associated with program changes due to the expansion of Medicaid eligibility. We have not included current historical Medicaid costs in these tables. We are not estimating any impacts on the existing Medicaid population.

² Please read <https://fas.org/sqp/crs/misc/R43847.pdf> for additional information.

Table 3
Idaho Department of Health and Welfare
Total Projected Additional State, Local, and Federal Costs <Savings> (Values in Millions)

Expansion with Projected Offsets													Cumulative
	Formula	SFY 2020**	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	SFY 2026	SFY 2027	SFY 2028	SFY 2029	SFY 2030	Total
Total Gross Cost Expansion	(a) = (b) + (c)	\$199.6	\$412.0	\$439.5	\$460.5	\$476.7	\$493.4	\$510.7	\$528.6	\$547.2	\$566.4	\$586.2	\$5,220.8
Federal Funds - Expansion	(b)	\$179.0	\$370.1	\$394.9	\$413.8	\$428.3	\$443.4	\$459.0	\$475.1	\$491.8	\$509.0	\$526.9	\$4,691.2
State Funds - Expansion	(c)	\$20.6	\$41.9	\$44.6	\$46.7	\$48.4	\$50.0	\$51.8	\$53.5	\$55.4	\$57.3	\$59.3	\$529.6
Projected State Offsets	(d)	(\$10.2)	(\$20.4)	(\$31.1)	(\$31.5)	(\$32.0)	(\$32.4)	(\$32.9)	(\$33.4)	(\$33.9)	(\$34.5)	(\$35.0)	(\$327.2)
State Funds - Expansion, Net State Offsets	(e) = (c) + (d)	\$10.4	\$21.5	\$13.6	\$15.2	\$16.4	\$17.6	\$18.9	\$20.2	\$21.5	\$22.9	\$24.3	\$202.4
Projected Local Offsets	(f)	\$0.0	\$0.0	(\$9.2)	(\$9.6)	(\$9.9)	(\$10.3)	(\$10.8)	(\$11.2)	(\$11.6)	(\$12.1)	(\$12.6)	(\$97.3)
State Funds - Expansion, Net State & Local Offsets	(g) = (e) + (f)	\$10.4	\$21.5	\$4.4	\$5.7	\$6.5	\$7.3	\$8.1	\$9.0	\$9.9	\$10.8	\$11.7	\$105.1
Federal Funds - Expansion	(h)	\$179.0	\$370.1	\$394.9	\$413.8	\$428.3	\$443.4	\$459.0	\$475.1	\$491.8	\$509.0	\$526.9	\$4,691.2
Total Net Cost Expansion:	(i) = (g) + (h)	\$189.4	\$391.6	\$399.2	\$419.5	\$434.8	\$450.6	\$467.1	\$484.0	\$501.6	\$519.8	\$538.6	\$4,796.3

**Only includes six months of claims cost for state fiscal year 2020.
 Assums 90% FMAP for benefits for Expansion population.

We estimate the total net financial impact of Medicaid expansion on the state of Idaho, after consideration of Medicaid expansion program costs and the projected state and local cost offsets from other programs for state fiscal years 2020 through 2030 to be an approximate cost of \$105.1 million ('State Funds – Expansion' less 'Projected State Offsets' and 'Projected Local Offsets'). Note our estimates include the costs and impacts for only 6 months of SFY 2020 assuming a January 1, 2020 effective date of expansion.

Table 4 shows the enrollment projections by FPL categories.

Table 4
Idaho Department of Health and Welfare
Estimated Impact on Projected 1/1/2020 Enrollment

Expansion (138% FPL)	<u><=100%</u>	<u>101-138%</u>	<u>Total</u>
Total	59,000	32,000	91,000

Note that these enrollment projections assume the full impact of expansion in all years. After 2020, population growth factors are applied to the enrollment estimate over the horizon of the projection.

For individuals with income at or above 100% FPL, federal premium assistance to purchase non-group coverage offered on YHI is available (dependent upon other qualifying conditions being met) in the absence of Medicaid expansion. Additional take-up of Medicaid coverage (relative to non-group coverage) for this income cohort is assumed due to no assumed premium requirements for Medicaid coverage, very limited cost sharing, and lack of enrollment restrictions for individuals eligible for affordable employer-sponsored insurance³.

The population with income below 100% FPL represents the “gap” population, individuals not eligible for Medicaid or federal premium assistance through YHI in the absence of Medicaid expansion. The estimated 2020 projected gap population enrolling under Medicaid expansion is approximately 59,000, reflective of adults in the <=100% FPL category. DHW’s current Medicaid eligibility extends to caregiver adults with low incomes. This population will be considered maintenance of effort and not part of expansion (regular state FMAP will still apply).

Note that we provided point estimates for both costs and enrollment changes. Actual results will vary from our projections for many reasons, including differences from assumptions regarding eligibility and take up rates, projected members by FPL levels, cost trends, enrollment trends, future FMAP rates, and state and local cost offsets, as well as other random and non-random factors such as economic conditions. Our estimates are based on the current federal reimbursement policy and does not consider changes to the FMAP. Please note that the FMAP assumption is a significant driver and slight changes to the FMAP will change results materially. Experience should continue to be monitored on a regular basis, with modifications to projections as necessary.

³ Individuals eligible for affordable employer-sponsored insurance are not eligible for federal premium assistance through YHI.

The estimate could result in higher and lower results if cost and enrollment assumptions differ. The following is a summary of a high-level sensitivity analysis testing the cost and enrollment assumptions:

- A 5% increase in either the baseline per capita cost *or* enrollment estimate increases the state funds expansion cost (net of state and local offsets) by approximately 25%.
- A 5% increase to both the baseline per capita cost *and* enrollment estimate increases the state funds expansion cost (net of state and local offsets) by approximately 50%.

Conversely, to the extent enrollment and/or per capita cost was less than our baseline assumptions, decreases in state funds expansion cost (net of state and local offsets) of a similar magnitude are estimated to occur.

The attached Exhibits 1 – 2 present the results of our projections in more detail:

- > **Exhibit 1:** Impact of Expansion on Idaho Including State and Local Cost Offsets with Projected Offsets
- > **Exhibit 2:** 2020 Projections of Cost and Membership Distributions by Age/Gender

The remaining sections of this report document our methodology and assumptions in more detail.

III. METHODOLOGY AND KEY ASSUMPTIONS

In the development of these financial impact estimates, we created a model that projects enrollment and healthcare expenditures for the expansion population. The following summarizes the methods and key assumptions:

- > We based our assumptions on a composite expansion experience over multiple years for multiple states adjusted to be consistent with the Idaho demographics, costs and covered services anticipated to be in effect on January 1, 2020. Please see the next section titled “Development of Medicaid Cost Estimates” for details of the development of the cost assumptions for Idaho.
- > Key assumptions for this forecast are:
 - Projected state program offsets from DHW and Idaho Department of Corrections projected offsets for probationers, parolees, and hospital inpatient payments.
 - The Catastrophic Health Care Cost Program (CAT) and Local Medically Indigent Program offsets are trended 4.00% annually. All other state and local program offsets are trended at 0% annually. No cost offsets for these two programs are recognized until SFY 2022 because it is assumed to take approximately two years to phase down these programs after expansion.
 - 2018 SNAP enrollment data for Idaho
 - 2016 SNAP enrollment data and 2016 Medicaid Expansion enrollment data for Idaho and other states
 - Annual enrollment growth rate is 1.00%.
 - Medicaid Cost Estimates per member per month (PMPM) are trended 2.50% annually

DEVELOPMENT OF MEDICAID COST ESTIMATES

The starting SFY 2020 PMPMs are based on an actual expansion Medicaid medical and pharmacy benefit costs from several states adjusted for assumed Idaho age and gender mix and healthcare cost assumptions. Based on Idaho’s Medicaid cost experience for existing populations, we assumed an annual PMPM trend of 2.50% for the projection period. For the second and third years (2021 to 2022), we also increased the annual PMPM trend to account for the duration of enrollment from the program start. The rest of this section further explains the duration adjustment.

Prior to expansion a general assumption in Medicaid rate setting is that new enrollees have a period of pent-up demand and increase in cost followed by a lower steady state cost level. In practice for expansion populations, we have observed that for the first three years there is an increase in costs beyond normal trend. In the third year, costs have stabilized in the experience observed from other states. We have applied a factor based on the duration of enrollment for the population. For the purpose of the modeling exercise, we assume that all eligible members will be enrolled on January 1, 2020 and do not increase the cost for future new enrollee growth. We have observed in other state expansion populations a selection bias where the most acute members enroll first and healthier members follow. This is an additional consideration to the duration adjustment. For this modeling, we have not assumed any additional cost patterns for the phasing of the enrollment. If there were a ramp up in enrollment then the selection bias and duration of enrollment would vary by phase. Under the assumption of full enrollment in January 2020 all members, including population growth, are assumed to have the same average duration at any time.

To develop the durational adjustment factors we adjusted expansion data from multiple states to be consistent with a scenario where all eligibles enrolled in the first month. The experience is also normalized to a consistent age/gender mix and trended to the same program starting date. This process allowed us to observe changes year over year for a population new to coverage. Based on this analysis we observed a second year increase of 5.63% and an additional increase of 3.92% going into the third year before stabilizing for future years. These increases are outside of normal utilization and cost trends assumed for these Medicaid populations. We assume further that the durational adjustments do not apply to the portion of population over 100% FPL since these members are likely getting care through YHI with limited pent up demand. The resulting increases applied to the aggregated expansion base experience are 3.67% in the second year and 2.55% in the third year. Table 5 shows the calculation of the duration factors:

Table 5
Idaho Department of Health and Welfare
Duration Factor

	0-100%	100-138%	Total*
2016 Expansion Enrollment Distribution	65%	35%	100%
Second Year Adjustment	1.0563	1.0000	1.0367
Third Year Adjustment	1.0392	1.0000	1.0255
Years 4+	1.0000	1.0000	1.0000

*The final duration factor used in the projection is a weighted average of the duration factors by FPL.

Exhibit 2 summarizes the estimated SFY 2020 cost PMPMs. These PMPM costs are based on the multi-state experience adjusted for Idaho demographics, services, and costs. After adjusting for enrollment duration for the first three years, the forecast PMPM cost trend for years 2023 to 2030 is a 2.50% annual PMPM rate. This annual PMPM rate increase is based on Idaho’s Medicaid experience.

Table 6 summarizes the adjustments used to project costs in expansion:

Table 6 – Composite Adjustment for Duration

Year	Annual Trend Factor	Duration Factor	Composite Adjustment
	(A)	(B)	(C)=(A)x(B)
CY 2020	1.0000	1.0000	1.0000
CY 2021	1.0250	1.0367	1.0626
CY 2022	1.0250	1.0255	1.0512
CY 2023+	1.0250	1.0000	1.0250

These adjustment factors reflect both the trend and duration adjustment applied to the cost from the prior year.

MEDICAID EXPANSION ENROLLMENT

The fiscal impact associated with the Medicaid expansion includes currently insured and uninsured adults who are not currently enrolled or eligible in Medicaid.

We relied on 2016 through 2018 SNAP data Idaho as a starting point to estimate the Medicaid expansion population. In order to project the total enrolled expansion population, we calculated and applied a SNAP non-elderly adult population to ultimate Medicaid expansion enrollment factor based on 2016 data from the following states: Arkansas, Indiana, Kentucky, Louisiana, and Montana. These states were selected based on similar eligibility criteria for Idaho's currently eligible Medicaid populations. The following steps through the calculation for 2020 projected expansion enrollment:

1. DHW reported approximately 63,000 non-elderly adults receiving SNAP in 2018.
2. Based on a collection of other states' 2016 non-elderly adult SNAP and Medicaid expansion enrollment data, we calculated the SNAP population to ultimate Medicaid expansion enrollment factor and adjusted the starting known Idaho SNAP enrollment by 139%.
3. The 2018 projected enrollment is calculated by multiplying the starting known adults by the SNAP to Ultimate Medicaid expansion factor = $63,000 \times (139\%) = 88,000$ (rounded)
4. We apply a 1.0% annual population growth increase for 4 years and the 2020 projected enrollment is approximately 91,000 .

The projected estimate is based on Idaho's current economic environment and assumes current economic conditions will be the same for the projection period. Changes in the economy (e.g. unemployment rates) could significantly impact the projected expansion enrollment estimate.

DHW provided a list of 73,000 known individuals that would qualify for Medicaid expansion and met one of the following criteria:

- Individuals currently receiving SNAP;
- Individuals with income below 100% FPL that were denied federal premium assistance and did not qualify for SNAP; and,
- Individuals enrolled in YHI with income between 100% and 138% FPL receiving federal premium assistance.

For the purposes of estimating the mix of individuals qualifying for Medicaid expansion (age/gender, income), we assumed the demographics of expansion enrollees would be consistent with the collective demographics of the above population cohorts.

Idaho's current Medicaid income eligibility standards for healthy adults are summarized below:

- > Parents (Caregiver): ~26% of FPL
- > Childless adults (Non-caregiver): not covered

Implementation of the expansion program would increase all of the FPL limits listed above to at least 138% of FPL.

INCREASED ADMINISTRATIVE EXPENDITURES

In addition to the expenditures associated with providing medical services to the expansion population, the state of Idaho will incur additional administrative expenditures related to expansion. DHW provided us with estimates for the one-time and ongoing administrative costs for SFY2020. We assumed that the one-time administrative costs would be incurred in SFY2020.

DHW indicated a 0.00% trend of the ongoing expansion administrative load is a reasonable assumption.

OTHER ASSUMPTIONS

We used the following key assumptions in our analysis:

FMAP Rates by State Fiscal Year (SFY):

We assumed expansion FMAP benefits to be 90% in SFY2020 – SFY2030.

Projected State and Local Cost Offsets:

The state of Idaho has several state and local programs (not funded by federal dollars) that assist the medical needs of those not eligible for other form of health insurance in the state. The DHW provided us with the assumptions for how Medicaid expansion would reduce the cost for these programs as well as providing the projected cost for all state and local programs. The largest cost offset or savings with the Medicaid expansion are from the Local Medically Indigent and Catastrophic Health Care Cost (CAT) programs. Based on information provided by DHW, we assumed that the projected costs for Local Medically Indigent programs and the State CAT program would be reduced for these populations under Medicaid expansion.

We reflected the costs for CAT as a State offset separately from the local offset of the Local Medically Indigent programs. The CAT offset assumption is a 50% reduction in claims and administrative costs. The Local Medically Indigent offset assumption is a 50% reduction in claims. Based on discussions with DHW, the Local Medically Indigent and CAT program offsets are assumed to begin in SFY 2022. because it is assumed to take approximately two years to phase down these programs after expansion. It is important that the budgets for these programs be monitored.

DHW has indicated that the Local Medically Indigent and CAT programs are not going to be eliminated because in order for these programs to be eliminated, changes will need to be made at the state level.

In addition to these primary offsets, DHW identified other programs that could generate savings under the scenario of Medicaid expansion. We assumed that all of these savings opportunities for IDHW Department Behavioral Health (DBH) Behavioral Health and Mental Health Services as well as Department of Corrections (IDOC) would be achieved.

The estimate could result in higher and lower results if state and local offsets assumptions differ. The following is a summary of a high-level sensitivity analysis testing these assumptions:

- No state and local offsets relating to the CAT and Local Medically Indigent program increases the state funded expansion costs (net of all other state and local offsets) by approximately 200%.
- Assuming the full phase down of the CAT and Local Medically Indigent program for SFY 2022 and beyond will create enough in state and local savings to cover the state costs relating to Medicaid expansion to generate an estimated savings to the state of approximately \$150M.

Division of Behavioral Health Projected Offsets:

The Division of Behavioral Health (DBH) will also experience direct savings and cost offsets under an expanded Medicaid benefit. Based on a recent review, which is consistent with earlier findings by the Leavitt Partners estimates, approximately 93% the population served by DBH would be newly Medicaid eligible under an expanded program. Therefore, 93% of those served in DBH with largely general funds would have the opportunity to receive services funded through Medicaid. Additionally, DBH's base appropriation contains \$2.3 million (six month cost offset) in state general funds for the 2020 fiscal year and \$4.7M (twelve month cost offset) for each fiscal year from 2021 to 2030 for treatment services to the felony probation and parole population in Idaho under the Justice Reinvestment Initiative. This general fund appropriation would be largely offset with expansion as nearly all of the probation and parole population would qualify under an expanded Medicaid benefit.

IV. OTHER IMPACTS NOT MODELED

The following outlines additional financial impacts under the current provisions of the federal legislation. The issues highlighted below ***have not*** been included in the financial projections shown in our analysis.

- > **Changes to Medicaid Eligibility Levels for Certain Eligibility Categories:** Several states evaluated whether to reduce eligibility levels for certain Medicaid beneficiaries starting on January 1, 2014, such as pregnant women and breast and cervical cancer program enrollees, due to the availability of subsidized coverage through the insurance marketplace (YHI in Idaho). We assumed that DHW would maintain its current 138% of FPL eligibility level for pregnant women and continue to operate the breast and cervical cancer program.
- > **Reductions in DSH Allotments:** Legislation delayed Medicaid Disproportionate Share (DSH) funding reductions until 2020. Changes to DSH funding are not part of our analysis.
- > **Impact on Other State Agencies:** We did not consider the impact of the ACA on any other Idaho state agencies other than DHW, except for the limited considerations on the Catastrophic Health Care Program and the Department of Correction. We did not analyze the impact of recidivism on the Department of Corrections.
- > **Economic Ripple Effect or Multiplier:** We did not consider the multiplied impact of the additional state and federal dollars spent in the state.
- > **Maintenance of Effort:** We did not consider the impact of Maintenance of Effort (MOE) requirements. Our model assumes the federal government will modify or waive current MOE requirements in place for the Department's Behavioral Health programs.

V. CAVEATS AND LIMITATIONS

This report is intended for the internal use of the Idaho Department of Health and Welfare (DHW) in accordance with its statutory and regulatory requirements. Milliman recognizes that the materials may be public records subject to disclosure to third parties; however, Milliman does not intend to benefit, and assumes no duty or liability to, any third parties who receive this report and related materials. The materials should only be reviewed in their entirety. Any user of this report should possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

In the development of the data and information presented in this report, Milliman relied upon certain data from the state of Idaho and its vendors. In addition, we placed significant reliance on SNAP and Medicaid expansion data made publicly available by the federal government. To the extent that the data was not complete or accurate, the values presented in the report will need to be reviewed for consistency and revised to meet any revised data. Although we performed several reasonableness checks we have not audited these data sources. The data and information included in this report was developed to assist in the analysis of the financial impact of Medicaid expansion on state of Idaho. The data and information presented may not be appropriate for any other purpose. It should be emphasized that the results presented in this correspondence are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

While we believe our estimates are reasonable, actual costs for the Medicaid expansion are dependent upon numerous factors and are certain to vary from the estimates provided in this report.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are all members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

This analysis – the assumptions, methodology, and calculations – has been thoroughly peer reviewed by qualified actuaries as of July 19, 2018. The terms of Milliman’s contract with Boise State University and Boise State University’s contract with the Idaho DHW, dated July 1, 2015 both apply to this report and its use.

Exhibit 1

Impact of Expansion on Idaho Including State and Local Cost Offsets with Projected Offsets

Idaho Department of Health and Welfare
Financial Impact of the Medicaid Expansion
On the Idaho Medicaid Budget Including State and Local Cost Offsets

July 19, 2018

This report assumes that the reader is familiar with the state of Idaho's Medicaid program and federal healthcare reform. The report was prepared solely to provide assistance to DHW to model the financial impact of federal healthcare reform provisions. It may not be appropriate for other purposes. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This material should only be reviewed in its entirety.

Exhibit 1
STATE OF IDAHO
Idaho Department of Health and Welfare
Expansion Projection
Total Projected State, Local, and Federal Costs <Savings>
State, Local, and Federal Dollars Only (Values in Millions)

Expansion	SFY 2020**	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	SFY 2026	SFY 2027	SFY 2028	SFY 2029	SFY 2030	Total
<u>Expansion State Spending:</u>												
Optional Expansion Claim State Costs:	\$19.7	\$40.9	\$43.7	\$45.8	\$47.4	\$49.1	\$50.8	\$52.6	\$54.5	\$56.4	\$58.4	\$519.3
Administration (DHW) State Costs*:	\$1.0	\$0.9	\$0.9	\$0.9	\$0.9	\$0.9	\$0.9	\$0.9	\$0.9	\$0.9	\$0.9	\$10.3
Total Additional Expansion State Costs	\$20.6	\$41.9	\$44.6	\$46.7	\$48.4	\$50.0	\$51.8	\$53.5	\$55.4	\$57.3	\$59.3	\$529.6
<u>Projected State and Local Programs Offsets and Savings</u>												
CAT Program (State)	\$0.0	\$0.0	(\$10.7)	(\$11.1)	(\$11.6)	(\$12.0)	(\$12.5)	(\$13.0)	(\$13.5)	(\$14.1)	(\$14.6)	(\$113.1)
Medical Indigent (Local)	\$0.0	\$0.0	(\$9.2)	(\$9.6)	(\$9.9)	(\$10.3)	(\$10.8)	(\$11.2)	(\$11.6)	(\$12.1)	(\$12.6)	(\$97.3)
Medical Indigent (Local Admin)	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Substance Use Disorder Services (IDOC)	(\$2.4)	(\$4.9)	(\$4.9)	(\$4.9)	(\$4.9)	(\$4.9)	(\$4.9)	(\$4.9)	(\$4.9)	(\$4.9)	(\$4.9)	(\$51.0)
Behavioral Health (DHW)	(\$4.1)	(\$8.1)	(\$8.1)	(\$8.1)	(\$8.1)	(\$8.1)	(\$8.1)	(\$8.1)	(\$8.1)	(\$8.1)	(\$8.1)	(\$85.2)
Hospitalizations (IDOC)	(\$1.4)	(\$2.8)	(\$2.8)	(\$2.8)	(\$2.8)	(\$2.8)	(\$2.8)	(\$2.8)	(\$2.8)	(\$2.8)	(\$2.8)	(\$29.0)
DHW - DBH - Mental Health Services	(\$2.3)	(\$4.7)	(\$4.7)	(\$4.7)	(\$4.7)	(\$4.7)	(\$4.7)	(\$4.7)	(\$4.7)	(\$4.7)	(\$4.7)	(\$48.9)
Total State and Local Offsets:	(\$10.2)	(\$20.4)	(\$40.3)	(\$41.1)	(\$41.9)	(\$42.8)	(\$43.7)	(\$44.6)	(\$45.5)	(\$46.6)	(\$47.6)	(\$424.5)
Grand Total - Net State & Local (Total Costs) Spending <Savings>	\$10.4	\$21.5	\$4.4	\$5.7	\$6.5	\$7.3	\$8.1	\$9.0	\$9.9	\$10.8	\$11.7	\$105.1
<u>Expansion Federal Spending:</u>												
Optional Expansion Claim Federal Costs:	\$176.9	\$368.5	\$393.3	\$412.2	\$426.8	\$441.8	\$457.4	\$473.5	\$490.2	\$507.5	\$525.4	\$4,673.4
Administration (DHW) Federal Costs*:	\$2.1	\$1.6	\$1.6	\$1.6	\$1.6	\$1.6	\$1.6	\$1.6	\$1.6	\$1.6	\$1.6	\$17.9
Total Additional Expansion Federal Costs	\$179.0	\$370.1	\$394.9	\$413.8	\$428.3	\$443.4	\$459.0	\$475.1	\$491.8	\$509.0	\$526.9	\$4,691.2
Grand Total - Net State, Local, and Federal (Total Costs) Spending <Savings>	\$189.4	\$391.6	\$399.2	\$419.5	\$434.8	\$450.6	\$467.1	\$484.0	\$501.6	\$519.8	\$538.6	\$4,796.3

**Assumes one-time administration costs are all incurred in state fiscal year 2020. Medical Indigent is a local offset. DHW indicated the administrative loads are reasonable assumptions. For the purpose of this forecast they have assumed these additional administrative costs would have a blend FMAP rate of 68% in SFY 2020 and 63% for SFY 2021-2030. CMS has issued communications that certain administrative costs associated with the expansion population are eligible for an enhanced FMAP rate of 75%.*

***Only includes six months of claims cost for state fiscal year 2020.*

Exhibit 2

2020 Projections of PMPM Cost and Membership Distributions by Age/Gender

Idaho Department of Health and Welfare
Financial Impact of the Medicaid Expansion
On the Idaho Medicaid Budget Including State and Local Cost Offsets

July 19, 2018

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Exhibit 2
Idaho Department of Health and Welfare
Projected SFY2020 PMPM Costs by
Age/Gender Band

Medicaid Benefit PMPM

Age Band	Male	Female
19 to 34	\$212.83	\$231.37
35 to 64	\$469.42	\$483.14

Membership Distribution (Up to 138% FPL)

Age Band	Male	Female
19 to 34	22%	24%
35 to 64	26%	28%



SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition October 10, 2018

SHIP OPERATIONS:

SHIP Contracting/Request for Proposal (RFP) Status:

- **Report Items:**
 - A request for release of Award Year 3 carryover funds was submitted for funds for telehealth technical assistance on September 20, 2018.
 - A request for release of Award Year 3 carryover funds was submitted for funds for the Boise State Learning Resource System on September 19, 2018.
 - A request for release of Award Year 4 funds was submitted for in-state travel by OHPI staff on September 21, 2018.

SHIP Administrative Reporting:

- **Report Items:**
 - The Idaho Healthcare Coalition Transformation Sustainability Workgroup (TSW) met on September 20, 2018 and on October 4, 2018.
 - The Goal 1 PCMH Cohort Three webinar on Patient and Provider Engagement was held on September 19, 2018.
 - YouTube videos for the State Evaluator Goal 4 Panel Discussion video series have been posted to the SHIP website www.ship.idaho.gov. Interviews were conducted with Community Health Workers (CHWs) and Community Health Emergency Medical Services (CHEMS).

Regional Collaboratives (RCs):

- **Report Items:**
 - **District 1:** August 16 PCMH meeting: shared Medical-Health Neighborhood (MHN) resources.
 - **District 2:** August 9 meeting: discussions on transition planning, CHW training, Project ECHO, rural crisis response, CHNA, potential projects for partnering with clinics. Meeting agenda and minutes can be found at <http://idahopublichealth.com/community/ship>
 - **District 3:** August 7 meeting: discussed sustainability plan and PCMH update; Oral Health Workgroup. 8/2: discussed care coordination demonstration; Behavioral Health Workgroup 8/27: discussed alignment with behavioral health integration projects in the region and progress of the Healthy Minds Partnership.
 - **District 4:** August 7 meeting: Russ Duke, Dr. Rich, and Melissa Dilley were in attendance. Executive Leadership meeting - held on 08/15. Russ Duke, Dr. Rich and Melissa Dilley attended.
 - **District 6:** August 29 executive committee meeting: direct PCMH and RC activities in Region 6. Details are provided in the agenda and draft minutes.
 - **District 7:** No meeting held in August. Continue to meet on SHIP transition plan as needed.

- **Issues and topics discussed:**

- **District 1:** The PCMH meeting on August 16th included: 1.announcements on upcoming events, PrEP & PEP update on September 6, North Idaho Rx Solution Symposium on September 12, SPAN Walk on September 22, Alzheimer's Walk on September 29, and Diabetes Quality Improvement Project Patient Interview Opportunity; 2. Community Resources - DSME program, DDP program, Fit and Fall Proof classes; 3. a presentation on services provided by Community Action Partnership; and 4. presentation on telehealth programs by Coeur d'Alene Pediatrics and Sandpoint Family Health Center.
- **District 2:** None
- **District 3:** At the SWHC meeting on 8/7, Amber Aberasturi shared a detailed update on Cohort Three clinic progress and the RC discussed potential support and connection opportunities for the clinics. The group highlighted the need for ongoing access to support beyond January 2019. In addition, the SWHC discussed opportunities to merge with the CHC, pending funding requests, and CHOICe alignment. The consensus was that additional funding should be pursued and that it was beneficial to pursue merger with the CHC in advance of the January 2019 funding close.
- **District 4:** CHC executive leadership meeting on 08/15 - discussed the feasibility of the Pathways Community Hub model in the Treasure Valley and whether the state has the value-based payment structures in place to truly support the implementation of this model. The Care Coordination Systems software platform demonstration was very eye-opening to all CHC members and various questions/concerns came up regarding the feasibility of implementation, specifically given the current timeline of the SHIP grant. Additional outstanding discussion items included Medicaid transformation, status of the SW Payment Reform Workgroup and IDHW feedback on the RC Transition Plan for CHC.
- **District 6:** See meeting minutes.
- **District 7:** No meetings in August.

- **Action Items:**

- **District 6:** No action requested but a discussion about clinic readiness to participate in SHIP/PCMH transformation was held. The Executive Committee recommends that if other states have a selection process for PCMH transformation support, that the written application is followed-up with a required PCMH transformation team interview to assure/support clinic-wide engagement in the transformation effort. The committee noted that some applications were submitted without the knowledge and support of others necessary to the process, and that those clinics with less team buy-in and cohesiveness experience greater challenges in creating a true PCMH culture. This is not a criticism of the SHIP selection process but is recognition that an added step (transformation team interview) would be helpful in assessing PCMH transformation readiness.

ADVISORY GROUP REPORTS:

TeleC

Telehealth SHIP Subcommittee:

- **Report Items:**

- Health Management Associates (HMA), telehealth technical assistance contractor, held a learning collaborative webinar on September 11, 2018. The topic for this webinar was Part II tele-behavioral health with presentations by Dr. Marc Avery, and “stories from the field” from SHIP grantee, Terry Reilly Health Center. Webinar recordings from this and past webinars, can be found on the [SHIP website](#).
- ECHO Idaho will host a free medication-assisted treatment (MAT) DATA waiver training for physicians, nurse practitioners, and physician assistants to support service expansion, particularly in rural, frontier, and underserved areas of Idaho to significantly build capacity. The training, led by Dr. Magni Hamso and Dr. Todd Palmer, will be offered in a blended format which includes the initial live four-hour seminar which participants will be able to access using ECHO video conferencing technology. The second portion of the training is delivered via online modules that participants complete on their own within a given time frame following the seminar. Both portions of the training are free and approved for eight CME credits. Physicians, nurse practitioners and physician assistants who complete the training will qualify for the waiver to prescribe and dispense buprenorphine; nurse practitioners and physician’s assistants will also qualify for the waiver after an additional 16 hours of training. Participants can join in-person at the University of Idaho Water Center in Boise or via Zoom video conferencing from around the state. Participants must be able to join using a webcam. Get more information at www.uidaho.edu/echo.

- **Next Steps:**

- Continue to work with HMA to compile case study reports of the telehealth clinics with summaries of lessons learned and key “how-tos.”

CHW

Community Health Workers:

- **Report Items:**

- Idaho State University (ISU) will be taking five existing CHW Health Specific Modules (HSMs) curriculum and translating them into Spanish, to be offered asynchronously online. Based on needs and health disparities, the following HSM modules will be translated into Spanish: 1) Behavioral Health, Suicide Prevention, and Substance Abuse, 2) Opioid Use, 3) Diabetes, 4) Colorectal Health and Cancer Screening, 5) Cervical Health and Cancer Screening.
- A Medication Adherence three-part webinar series will be delivered by subject matter expert, Linda Mikitish, on October 10th, 17th, and 24th from 12:00-1:00pm (MST). Learning objectives for this series include: identifying causes of medication non-adherence, discovering tools to assess medication adherence, and developing strategies to help patients/clients improve their knowledge about their medications.

- **Next Steps:**
 - Working closely with ISU and the Division of Public Health for post-SHIP CHW training sustainability.

WORKGROUP REPORTS:



Community Health EMS (CHEMS):

- **Report Items:**
 - The last statewide CHEMS Workgroup meeting was held September 26, 2018, 10:00-11:00am (MST).
 - **Idaho Healthcare Coalition (IHC) Transition**
 - Casey Moyer from the OHPI provided an IHC update. Even though SHIP is winding down, he stressed that healthcare transformation is not ending. Moving forward, the 25-member, Healthcare Transformation Council of Idaho (HTCI) will help coordinate and facilitate healthcare transformation efforts in Idaho.
 - **CEMT Training Program**
 - Travis Spencer is instructing the first cohort, which is comprised of eight students and is seven weeks underway. The students have covered the following subjects: Cultural Competency, Chronic Disease Management, Patient Centered Medical Home, and Social Determinants.
 - The second cohort is being taught by Eric Day and Renee Miller and is comprised of 23 students. These students represent 14 EMS agencies throughout Idaho. The cohort began September 19th. The training structure will resemble the first cohort, will be delivered live and online over 13 weeks, and includes 39 hours of online learning plus an additional nine hours of asynchronous Health Specific Modules (HSMs), totaling 48 hours of coursework.
 - **Medication Adherence Webinar – 3-part series**
 - A save-the-date has been sent out. The webinar will be presented by Linda Mikitish on October 10, 17, and 24 from 12:00-1:00pm (MST). Topics will include: tools, strategies, and a general overview; patient assistance in navigating insurance and Medicaid/Medicare, strategies to manage patient cost; and strategies and tools to improve medication adherence.
 - The webinar will be recorded, and registration is required.
 - **The Paramedic Foundation**
 - Two members of the Paramedic Foundation along with Bureau representatives visited 11 EMS agencies throughout the state to conduct a CHEMS program evaluation. A report will be developed for each agency with the information collected and resources to aid in program development and sustainability moving forward. Overall, the site visits showed that CHEMS readiness in the state is about 36%.
 - The internal CHEMS Workgroup continues to meet every other Monday.
 - Collective CHEMS Workgroup activities include:
 - ISU Community Paramedic Certificate program third and final cohort is underway.

- Community Paramedic Program Evaluation Pilot Project is developing toolkits to meet the needs of providers throughout the State of Idaho.
 - Statewide CHEMS Workgroup:
 - Discussions have begun to evolve this workgroup into a “working” collaborative workgroup to utilize our stakeholders and partners in future CHEMS efforts.
 - ImageTrend Community Health Module Pilot Project: an addendum contract is being pursued and routed accordingly. Once the proper documentation is in place, the pilot will commence.
 - Project Charter, Deliverable 6 – develop and implement learning collaborative – **completed**
 - The second in-person learning collaborative took place in August 2018.
- **Next Steps:**
 - Project Charter, Deliverable 3 – Develop and implement training program for EMTs (ILS and BLS) – **in progress**
 - First and second cohorts to be completed by January 2019
 - Project Charter, Deliverable 4 – Establish CHEMS peer mentoring and/or technical assistance programs – **in progress.**
 - Continue to define, develop, and implement peer mentorship throughout the state.
 - The next statewide CHEMS Workgroup meeting is scheduled for October 24, 2018, 10:00-11:00am (MST).



Idaho Medical Home Collaborative:

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



Data Governance:

- **Report Item:**
- The Data Governance Workgroup (DGW) met on September 10, 2018.
 - Meg Hall updated members on the progress and challenges Medicaid has faced with releasing its provider portal, where Medicaid providers will be able to login and see their performance on several CQMs. Medicaid hopes the portal will be ready for launch by November 1, 2018. Prior to November, they will be offering additional WebEx trainings to providers.
 - Casey Moyer provided a preview of the proposed charter for the Healthcare Transition Council of Idaho (HTCI).
 - Workgroup members discussed how the DGW might fit under the HTCI and agreed to revise its workgroup charter in the coming months.
 - IHDE provided a connection-building update and expects to have 147 of the SHIP clinics connected by the end of the SHIP grant. The remaining 13 will be unable to connect due to EMR challenges, clinics not being able to pay the ongoing maintenance fees, or other extenuating circumstances.
 - IHDE has visited 160 different clinics and hospitals over the last nine months. During these visits, clinics provide IHDE with valuable perspective about their use of the data exchange. In addition, IHDE can provide onsite training and share best practices from other clinics.

• Report Item:

- Scott Banken, Principal at Mercer, provided highlights and facilitated a discussion of the Payer Financial and Enrollment Metrics Report for Goal 6 - SHIP Award Year 3. A synopsis of the analysis showed that in CY2017, all payer types remained consistent in their assignment of beneficiaries to value-based payment arrangements with incentives for providers based on quality and value. Gain-sharing, risk-sharing and population-based payments were completing their second year in the Medicare and commercial settings and additional assignments were relatively consistent for new membership. While membership attribution remains strong, payments were still primarily Fee-For-Service (FFS). However, the CY2017 data improved slightly with gains in categories 2, 3 and 4 compared to CY2016 and CY2015, driven by commercial and Medicare.

The report suggested that payers and providers are still “hesitant” to accept quality-based payments due to system limitations and increased risk due to the lack of beneficiaries assigned to each provider or because they were waiting to see the outcomes of initial assignments. The workgroup members felt that it would be more accurate to state that payers and providers are limited in their ability to accept quality-based payments due to system limitations and increased risk due to the lack of beneficiaries assigned to each provider or because they were waiting to see the outcomes of initial assignments. This change was made, and the workgroup voted to accept the report with the above change. The report will be presented to the IHC at the October meeting.

- Katie Falls, Principal at Mercer, presented the charge and charter for the Healthcare Transformation Council of Idaho (HTCI). The importance of the MPW having a role in the HTCI was discussed. The members, DHW staff and contractors all agreed that the continued work on measure alignment, identification of delivery system barriers, and providers and payers working together to identify and address these issues is critical to promoting alignment of the delivery system payment models to drive sustainable healthcare transformation that will help reduce overall health care costs.
- Casey Moyer, Administrator of OHPI, presented the Idaho Core Quality Metrics Set initial draft proposal. This whitepaper captures the importance of provider and payer agreement on a core metrics set to reduce some of the burden to providers in the move to value-based reimbursement. It provides a recommendation to establish an Idaho 2020 core metric set of measures agreed upon by both providers and payers. An initial proposed core measure set was identified from the HEDIS measures survey completed by Idaho payers. Suggested next steps include each payer evaluating the proposed core metrics set for fit with value-based contracts and alignment with strategic organization initiatives. Additionally, all members of the MPW will evaluate the proposed core metrics set and the process to compile and adopt the set for use in 2020. The MPW agreed that a good strategy is for the OHPI to compile individual participant feedback and provide the results to the MPW.

- **Next Steps:**
 - Casey Moyer and Cynthia York will be meeting with individual providers and payers over the next few months to discuss the core set of metrics, the commitment to the process and to assess the ability of providers and payers to provide data.
 - The next meeting is set for Tuesday, October 2, 2018 from 3:00 to 4:30 PM.

BHI **Behavioral Health:**

- **Report Item:**
 - The BHI Sub-Committee met Tuesday, September 4th.
 - Gina provided an update on the activities of the BHI Sub-Committee Action Plan. The BHI Sub-Committee will focus on goals and tasks for the next three months from the Farley Health Policy Center Report for Behavioral Health, Organizing the Movement, Workforce, Finance and Care Delivery.
 - The IIBHN is currently working on the 2nd Annual BHI Conference to be held in April 2019.
 - The SHIP team provided the BHI Sub-Committee with an extensive update on the SHIP next steps, CHW/CHEMS, telehealth and the Data Governance Workgroup.
- **Next Steps:**
 - The next BHI Sub-Committee meeting will be held Tuesday, November 6, 9:00-11:00 at the PTC Building, 7th Floor conference room.

PHW **Population Health:**

- **Report Item:**
 - The PHW met September 5, 2018 from 3:00 – 4:30. This was their 28th meeting.
 - Dieuwke Disney-Spencer gave a presentation on the Division of Public Health's Health Equity Framework. Addressing health equity is a requirement of the Division's accreditation and best practice. The framework will be integrated into the daily work of the Division and provide the key questions we need to address to ensure we are moving toward cultural competency, health equity and empowerment.
 - Gina Westcott, Division of Behavioral Health, provided an update on the Behavioral Health Integration Workgroup. A detailed overview of this group's work can be found in their workgroup report to the IHC.
 - The group received an update on all components of the virtual PCMH: CHEMS, CHW, and Telehealth. These specific updates will be provided to the IHC by their respective workgroup reports.
 - Workgroup members provided reports of activities.
- **Next Steps:**
 - The next meeting of the PHW October 3, 2018 from 3:00 – 4:30.