



Idaho Health Care Council

Coordination Meeting

*Celebrate Accomplishments. Share Information.
Achieve our Vision!*



Prepared for the Idaho Health Care Council by
Marsha Bracke, President
IAF Certified Professional Facilitator
Bracke and Associates, Inc.
702 W Idaho St Ste 1100
Boise, ID 83702
(208) 472-8841

Table of Contents

Introduction 4

Agenda 4

Welcoming Session 5

Setting the Stage 5

Panel 1: Access To Health Care – Health Insurance Expansion And Reform 6

Panel 2: Health Care Coverage - Medicaid and Idaho's Medicaid Program 10

Panel 3: Health Care Delivery System - Status Reports 11

Panel 4: Health Care Delivery System 14

Take Away Messages 17

List of Participants..... 19

CELEBRATE ACCOMPLISHMENTS, SHARE INFORMATION, ACHIEVE OUR VISION
- THE SECOND ANNUAL MEETING OF THE IDAHO HEALTH CARE COUNCIL
October 30, 2012

Introduction

The Idaho Health Care Council Executive Leadership Team (Leadership Team) hosted its second annual meeting on Tuesday, October 30 2012, at the St. Alphonsus Regional Medical Center McCleary Auditorium in Boise, Idaho. The meeting was designed to celebrate accomplishments achieved since the group's first forum in June 2011, share information about the many important efforts and initiatives underway to continue to develop Idaho's health care system, and establish a shared understanding among public and private partners in health care as they pursue Idaho's desired future for health care.

Seventy-three (73) individuals attended the meeting (listed on page 19 of this summary report).

Health Care Council Executive Leadership Team members include:

- Richard Armstrong, Director, Idaho Department of Health and Welfare, Co-Chair
- William Deal, Director, Idaho Department of Insurance, Co-Chair
- Tammy Perkins, Office of the Governor
- Denise Chuckovich, Deputy Director, Idaho Department of Health and Welfare
- Joe Morris, Private Representative
- Stephen Weeg, Private Representative

Facilitator Marsha Bracke, Bracke and Associates, Inc., worked with the Leadership Team to coordinate the event. The following material summarizes the process and the themes discussed. Where PowerPoint materials were presented, they are attached as referenced.

Agenda

The [Agenda](#) featured the following series of presentations and panel discussions:

- Welcome by Governor C.L. "Butch" Otter
- Presentations to "Set the Stage" in response to the Affordable Health Care Act (ACA) Supreme Court Decision and Essential Health Benefits
- Four panel discussions focusing on the following topics:
 - Access to Health Care – Health Insurance Access and Reform
 - Medicaid Coverage – Medicaid and Idaho's Medicaid Program
 - Health Care Delivery – Status Reports on Important Initiatives
 - Health Care Delivery – Hospital and Provider Initiatives

Welcoming Session

Director Richard Armstrong, Idaho Department of Health and Welfare and Health Care Council Executive Leadership Team Co-Chair, and Director William Deal, Idaho Department of Insurance, Health Care Council Executive Leadership Team Co-Chair welcomed the group. Director Deal introduced featured speaker Governor C.L. “Butch” Otter.

[Governor Otter’s presentation](#) focused specifically on: celebrating accomplishments, pursuing initiatives and achieving Idaho’s vision. Governor Otter reviewed a series of health care initiatives undertaken since 2005, summarized their outcomes, presented the Idaho vision, and complimented the group on their efforts. Governor Otter noted the establishment of the Idaho Health Care Council in Executive Order 2010-15, and specifically discussed success associated with Idaho’s Children’s Insurance Program. He pointed out that education, corrections and health care make up 90 percent of the state’s budget, and making sure Idahoans have access to health care is a challenge, particularly given Idaho’s rural demographic. Efforts undertaken by people in this meeting – technology to address rural access, securing more health care professionals throughout the state, the health data exchange, the expansion of health care homes, and the development of Idaho’s health insurance exchange will generate increased opportunities for Idahoans to access quality, effective and efficient health care in a coordinated delivery system with affordable and accessible health insurance options.

In moving to the next section of the agenda, Director Deal underscored the specific accomplishments of many of the same health care initiatives since the 2011 forum. He also announced a recommendation for the insurance exchange was just delivered to the Governor, which he will discuss in more detail during the Health Access panel to follow. He noted Idaho’s collective emphasis for people to become involved with their wellness. Regardless of what happens in the future with the ACA, Director Deal noted that many of these initiatives are good for Idaho and should continue. Director Deal expressed his appreciation for everyone’s efforts, and invited them to use this meeting to learn, share, and help propel us into a promising future.

Setting the Stage

Tom Perry, Legal Counsel to the Governor, provided an overview of the Supreme Court decision respective to the ACA, the outcome of which he expected everyone was already aware. The following challenges were addressed and the ACA was upheld:

1. Whether the ACA exceeds Congress’ power
2. Whether Congress can use taxing power to uphold the individual mandate
3. Medicaid expansion

Tom Donovan, Deputy Director, Idaho Department of Insurance, reviewed the details of the Essential Health Benefits provisions within the ACA (EHB), pointing out that health insurance must provide EHB minimum essential coverage in both small employer and individual markets, excluding coverage within the grandfather clause for coverage existing in March 2010. Mr. Donovan's PowerPoint presentation, Department of Insurance, [Key Issues in Meeting Requirements of Essential Health Benefits](#), provides the specific language of the points he reviewed.

The following are among the specific points Mr. Donovan made about EHB:

- In 2017, the small employer market will be under 100 employees.
- Plans must include at least the minimum ten categories of essential health benefits as identified in the Act.
- There are options for cost sharing of items not paid by insurance.
- Levels of coverage—bronze, silver, gold, platinum—increase by 10% at each level. Catastrophic plans basically will not be available to general market.
- The State of Idaho has not yet announced a benchmark plan, largely because expected regulation from HHS has not been forthcoming, but work continues toward making the designation and monitoring HHS' plans because the state did not make a designation.
- Preventative services including immunizations, maternity and screening are to be included without deductibles.
- Broad general ambulatory services are covered with no additional specific requirements, although federal government regulation may provide more detail.

Panel 1:

Access To Health Care – Health Insurance Expansion And Reform

Moderator: Joe Morris, Health Care Council Executive Leadership Team

Mr. Morris' panel featured a presentation by Director Deal, who provided a report on the status and nuances of developing the Idaho Health Insurance Exchange, and a panel discussion with Mr. Deal and the following three private insurance executives:

- Steve Tobiason, General Counsel and Senior Vice President of Governmental Affairs, Blue Cross of Idaho
- Scott Kreiling, President, Regence BlueShield of Idaho
- David Self, Senior Vice President/Regional Director, PacificSource Health Plans

Director Deal summarized the efforts of a team of public and private professionals working since July 2011 to prepare legislation they hoped would be acceptable to the Idaho legislature during the 2012 session. This legislation did not get a hearing. The group speculated that the level of legislative involvement in the process, the pending Supreme Court decision on the ACA, and the pending election might all have been factors. Noting good progress has been made over the last 2½ years implementing some parts of ACA in Idaho, Director Deal pointed out the Insurance Exchange specifically is appropriate. Regardless of what happens with the ACA, Director Deal said a distribution system that is an exchange will be good for Idaho. People will have a one-stop shop to compare rates and buy their policies. The effort is an important and challenging one, for both the Department of Insurance and private insurance companies, all of which are waiting for specific decisions in order to complete their plans, rates and systems.

Director Deal made several points regarding the significance of an insurance exchange in Idaho:

- There are approximately 275,000 uninsured individuals in Idaho, which is about 17%, compared to 15% across the US. 500,000 Idahoans are insured with employer groups—81,000 to 83,000 with individual coverage. Approximately 158,000 are to be insured within the insurance exchange.

- Some people compare the insurance exchange to Travelocity, which is inaccurate. An exchange involves determining eligibility for Medicaid or the insurance exchange as well as offering many plan choices and prices.
- Rates will increase substantially for younger persons and decrease for older people.
- While prices will be as competitive as possible, with the expansion of benefits, rates will probably increase, as will the number of companies offering insurance in Idaho.
- The exchange panel recommends a state-based exchange using a not-for-profit model.
- The exchange has to be ready to go by October 2013, including the compliance, support, and an implementation guidelines procedure from the legislature.
- Idaho will need to apply for federal grants to operate the exchange.
- Fourteen states have decided to do state-based exchange, about half of which -- Washington, Oregon, Nevada, Utah and Colorado – are well on the way to certification.

Panel Discussion:

Mr. Morris asked the panel to respond to the following three questions, with each panelist taking the lead response for a different question as indicated. Meeting participants were invited to submit questions on index cards, which were collected and posed by Mr. Morris in a manner integral to the discussion underway.

Question #1:

What is the insurance company view of an insurance exchange and what is your reaction to the approach being taken by Idaho? How has your company prepared to work under an exchange and would an exchange have a place with health reform?

Regarding Question #1, Mr. Tobiason pointed out when this act was signed into law, the entire market fundamentally changed, specifically how insurance companies design, rate, and sell products. A lot of resources are required to redefine the marketplace. Mr. Tobiason noted the idea of the exchange is to provide a level of transparency and simplicity for people to see what exists and what coverage they can get. That transparency does not exclude the need for brokers. As people age, the role of coverage becomes more complicated. Fundamentally, Mr. Tobiason said, we see an advantage for consumers.

Mr. Tobiason pointed out that health care exchanges have been politicized. Historically, exchanges were a Republican concept generated to find a way to simplify the marketplace. In 2010 this became a Democrat idea, and so now they are polarized over the concept. Mr. Tobiason said we need to push politics out from analysis and determine whether this *is* or *is not* a good idea for Idaho. The exchange should be developed, and structured in Idaho by Idahoans.

There are three primary insurance companies in the Idaho market. With an exchange, that number will probably double. From a company point of view, maybe we don't like it, but from an individual point of view, it will be good.

Mr. Kreiling discussed the exchange specific to its intent to make health care insurance more affordable and accessible, noting there is a lot of work to do. He said larger national insurance companies chose not to offer coverage in smaller markets. Employees of the companies represented here today live and work in this community and care that people have affordable health care. Mr. Kreiling says there will be more carriers, and he hopes the insurance companies will be able to start moving forward soon. There

are many challenges across the state, and he appreciates those trying to solve these problems. He pointed out the state-based exchange offers opportunity for more control.

Mr. Self expressed concern about the complexity of the exchange for the consumer. The exchange structure in Oregon could offer more than 60 plans per tier, if all carriers offered the maximum numbers allowed. Oregon has eleven (to Idaho's three) primary carriers. There is an opportunity to do something in Idaho that is uniquely Idaho. He noted the expense is not going to go down; that problem isn't solved. However, the process must determine how to bring those people to the exchange who will benefit from it.

At this point, Mr. Morris brought forward the following questions from participants, with responses by the panelists as indicated¹:

Q: What is the risk to Idaho that pursuit of a state-based exchange at this late date could fail federal approval and Idaho would then not be able to be considered for the federal facilitated partnership? Do you have to wait for legislative approval before moving forward with the non-profit exchange? Would that make meeting the timeline very difficult?

A: Director Deal: The fallback is a hybrid, which is a partnership arrangement with the federal government, although the state's participation in the exchange would be subject to regulatory authority. The federal government would do the rest of the work with information technology—the engine that drives this whole thing. It is possible in November of each year that the state can make a change in how it wants to do business with the exchange, including going to the state-based model. If we go to a partnership exchange now, then we can decide to do a state-based exchange in 2014. We can say we'll be ready in 2015, or whatever, and then change to that plan then, although I do not favor that option.

A: Mr. Tobiason: As we look at insurance, it is about being able to balance risk, buy coverage, and cover cost. Having more people in the pool helps spread risk and ameliorate cost. The mandate was about making sure that will work. The focus is on premium subsidies in the individual market. For a family of four with an income of somewhere around \$88,000, there will be subsidized coverage. That's pretty good. When only unhealthy people buy insurance coverage, it puts insurance companies in a death spiral. We've got to have that base.

A: Mr. Kreiling: Look at hurricane Sandy. Those who have not paid premiums have no coverage. Property, casualty, etc. are not as expensive as health care. You want to take care of the community you serve. People coming in and going right back out of the system make it difficult for companies, but this is what happens with a lot of the population and results in less affordable insurance for all of us. With a state exchange, the risk is somewhat mitigated.

Q: Do you have to wait for State approval before going ahead with state-based exchange?

¹ Please note that the question and answer section of this summary seeks to capture the essence of the discussion as maintained by the notetaker during the meeting. Remarks may be but are not necessarily direct quotes.

A: Director Deal: If the Governor is willing to implement exchange by executive order, that is an option some are hoping he will pursue.

Question #2:

Since there is universal agreement that the rate of increase in the cost of health care is unsustainable, what are insurance companies doing to bend the future cost curve? How can reimbursement methodology influence the cost of health care?

Regarding Question #2, Mr. Kreiling said he believes the approach has three prongs: employer, provider/physicians, and insurance companies. No one can change the cost alone. Collectively, the community seeks innovation, ways to do things differently. With the current fee-for-service model, there is no incentive for the physician to control cost. In the State of Washington, Regence rolled out a plan for Boeing. Ten percent of the employees were driving 90% of the cost. The employer built in wellness incentives (walking program, exercise, etc.) and was at the table with providers and hospitals. Until then, no one had been incentivized to help employees who had chronic conditions. The type of program we used in Washington is something we have rolled out here. We want to provide data and improve the system. How do we predict the future of what is going to happen in order to cover our costs? We are getting better at accessing and sharing data to make meaningful decisions about population. How are we managing their care? Start realigning, risk sharing, get discounts down and put things in place to share risks. We have an opportunity in Idaho; we need to have frank discussions.

Question and answer:

Q: One of the major contributors to the cost of care is the administrative cost of getting paid for the care provided. What can be done to simplify the reimbursement process?

A: Mr. Kreiling: Simplification can occur when physicians reach out to patients; aligning incentives; and when savings and incentives are sent back to physicians. Preventive care services can be utilized to avoid readmissions. Learn from Medicare, where hospitals get reimbursed for care of heart attack patients and then work to keep them out of the hospital. Have folks follow up, calling patients to ensure they are taking medication correctly and not stopping because they feel better.

Q: Medical homes were mentioned. Can this occur without insurance companies paying? Do insurance companies endorse this?

A: Mr. Self: All three insurers have worked with the Medical Home Collaborative. Yes, we are participating and offering to pay a management fee to physicians. We can't be data rich, information poor. We have to share information with the provider community for the best results.

A: Mr. Kreiling: Every hospital system approaches things a little differently. Insurance companies have to be flexible. It's not one-size-fits-all.

A: Mr. Tobiason: We need a team approach, getting people around the table with everyone working on the same issue. In terms of getting the message across regarding medical home, it is about getting people together.

Question #3:

How do insurance companies view the consolidation taking place among health care providers? Are integrated systems a threat due to their bargaining clout or do they present an opportunity to help bend the cost curve?

Regarding Question #3, Mr. Self said that scale matters. From the carrier's perspective, as long as there is value versus volume moving in the right direction, carriers want to sign on for these partnerships. The speed with which it is happening is a little daunting, but as the landscape changes; we adapt. The willingness to partner is good. It is challenging to nail down methodology for all. There are business decisions that play into this, but carriers are moving forward with this as a great opportunity.

Mr. Kreiling added that exciting things are happening. Insurance companies are trying to focus on the opportunities – not the complexities of ACA. It is challenging to keep health care affordable because of initial costs, but there must be some consolidation as well as the ability to adapt quickly on reimbursement. Some kind of metrics must be in place. It is challenging, but people are trying to drive things in the right direction. Hospitals doc

Question and answer:

Q: Please address regulations in regard to quality.

A: Mr. Tobiason: Medicare has gone to a star rating, which aids the consumer's understanding of quality. Regulators at the federal level have done so for years. That is their background. Now with the private healthcare market coming out of the Medicare market, we will see a trend in private market regulations to emulate those we have seen in Medicare.

Panel 2:

Health Care Coverage - Medicaid and Idaho's Medicaid Program

Moderator: Denise Chuckovich, Deputy Director, Idaho Department of Health and Welfare and Health Care Council Executive Leadership Team

Ms. Chuckovich remarked on Medicaid's important transition to managed care and community care networks to stimulate more effective services and to address Medicaid expansion. She introduced the following speakers.

- Russ Barron, Administrator, Division of Welfare, Department of Health and Welfare, who made a PowerPoint presentation on [Medicaid Readiness and Expansion](#). Mr. Barron pointed out ACA is a challenge in terms of requirements, and the eligibility system must be ready to accommodate ACA requirements by October 2013.
- Paul Leary, Division Administrator, Division of Medicaid for the Idaho Department of Health and Welfare, made a PowerPoint presentation specific to [Medicaid Expansion and Managed Care Options](#). Mr. Leary said regardless of what the legislature decides about Medicaid expansion, some expansion will occur. The Division has six months to develop its plan.

Question and answer:

Q: If we don't expand Medicaid, how do we care for those at the poverty level? With new eligibility, will clinics be able to process eligibility from their locations?

A: Mr. Barron: We are looking at how we can be more efficient, less costly. Because of complexity, determining eligibility belongs with the decision makers. We need connections to help those who are eligible for Medicaid to reach us. We are not considering having hospitals dedicate staff to *determine patients'* eligibility for Medicaid, but there are opportunities to help them *facilitate the process* of applying for Medicaid.

Q: Regarding managed care, why do we not include pharmaceuticals, etc. when we are trying to develop a cost effective health plan?

A: Mr. Leary: We are seeking the development of more comprehensive community-based mental health services. As we move forward with our plans for accountable systems of care – whether or not they are community care networks, ACOs or MCOs – we will move toward more integration of all health care.

Q: You mentioned Medicaid has robust coverage compared to “mental health plans.” What parts might go away in Medicaid with ACA?

A: Mr. Leary: Limitations of services. We tend to have few limitations in Medicaid whereas plans under the ACA (plans on the exchange) will have limitations and financial responsibilities as well.

Q: Would you see creating limitations for Medicaid, cost sharing, or will that stay the way it is?

A: Mr. Leary: We will look to see what will be allowed. We must specifically treat the expansion population as an expansion population. Expansion is under Medicaid, which is entitlement, and we are seeking health insurance for these individuals that looks more like health insurance.

Ms. Chuckovich concluded the panel discussion by pointing out that the Governor appointed two work groups to facilitate development of a health coverage exchange. They are looking at several options related to whether Medicaid should expand to “option” population, and are conducting a cost study regarding offsets related to expanding to that population. That group will be making a recommendation to the Governor next month.

Panel 3:

Health Care Delivery System - Status Reports

Moderator: Stephen Weeg, Idaho Health Care Council Executive Leadership Team

Mr. Weeg moderated a forum featuring three specific initiatives, discussed and studied at the June 2011 forum, with the purpose of securing a status report on their respective activities and next steps. Mr. Weeg asked each presenter to respond to the following three questions:

1. What accomplishments or significant steps have been achieved during the past year?
2. Where do we need to get to in the next three years?
3. What are the key incentives and barriers to system improvement?

The featured presentations included:

- [Workforce Development](#), by David Schmitz, MD, Family Medicine Residency of Idaho and Chair, Health Professions Education Council
- [Behavioral Health](#), by Ross Edmunds, Administrator, Division of Behavioral Health, Department of Health and Welfare
- [Health Information Technology and Healthcare Transformation](#), by LaDonna Larson, Coordinator, Health Information Technology, Department of Health and Welfare

Each of the presenters provided a PowerPoint presentation containing specific detail. The PowerPoints are included as Attachments F, G and H respectively. Among the key points each presenter communicated were the following:

- Regarding Workforce Development, Dr. Schmitz said the annual report from the Idaho Health Professions Education Council comes out in December.
- Regarding behavioral health, Mr. Edmunds pointed out 20-40 percent of all people will have a mental health diagnosis within their lifetime. Suicide is the second leading cause of death in Idaho among those 18-34 years of age, and 90 percent of those who complete suicide have a diagnosable mental health or substance use disorder. The Department of Health and Welfare is pursuing statutory change in the next legislative session to establish regional behavioral health boards that are authorized to take the lead in developing important community-based supports, and that will provide a point of contact for the Department of Health and Welfare to implement community-based support funding currently managed by the Department.
- Regarding Health Information Technology, Ms. Larson said it is a tool for the medical community, and noted the important work of the Idaho Health Data Exchange (IHDE). IHDE connects practices, clinics, labs, hospitals and payers to facilitate information sharing and reduce data management costs.

Question and answer:

- Q. If we replace public behavioral health with for-profit managed care, will we have more or less community clinical service? If there is to be more and better community behavioral health, where will the money come from?
- A. Mr. Edmunds: Managed care will likely grow community services, particularly in rural areas. A lot of that depends on the model that is proposed under managed care and who eventually wins the behavioral health contract. They have to provide services in the more rural parts of the state. So, that should drive better access.
- Q: Can you comment on the most common barriers for small communities to recruit physicians? Why is it so hard? How can people find rural physicians?

- A: Dr. Schmitz: You have to know the solution to the equation. It is pretty simple. All we need is the right people doing the right things in the right places. We need to influence the people who will be happy in the State of Idaho. We do a good job retaining interns. Idaho is a great state to live in. It's about recruitment and retention. In the right places, we look for the work force. We need to look at the distribution of our work force. The number one recruitment factor barrier is spousal satisfaction. Idaho is unique. We need to train people to do what they need to do in order to deliver services. We need a very robust residency training system. It's in place now.
- Q: For the benefit of the IHDE, doctor's office's electronic medical records will need to push information to IHDE. Are there funds from the State to help facilitate this?
- A: Ms. Larson: Yes. IHDE has funding to help defray cost of attaching to the exchange.
- Q: Which systems have been approved for electronic prescriptions of controlled substances? How do you find out if your system is approved?
- A: The Drug Enforcement Agency (DEA) does not have a certification site to tell you which systems are certified.. Ask your vendor to provide you verification that they have met that DEA certification through an audit.
- Q: Could IHDE be used to deliver continuing medical education focused on specific Idaho Health issues? For example, prescription drug abuse and Board of Pharmacy medicine rules, or stroke trauma/systems of call?
- A: Ms. Larson: The Data Information Exchange is going to be critical. In terms of continuing medical education, that's not something we've thought of.
- A: Scott Carrell, Idaho Health Data Exchange Executive Director: Students come out of school expecting this technology. That's where we find the support link coming from. Organizations are moving toward those discussions.
- Q: Moderator: over the next 12 months, what is the primary issue/challenge that you think you will face?
- A: Ms. Larson: I think there will be a huge jump in the number of people connected to the exchange in the next year. We will undoubtedly double the number of users and data sources. Our biggest challenge is to have resources to make it happen.
- A: Mr. Edmunds: I think it will be successful implementation of the behavioral health managed care contract. It is happening and will be both a challenge and an opportunity.
- A: Dr. Schmitz: Now that you see some improvement in the economy, will we see improvement in the vulnerability of individuals (homeless, etc.)? When we are deciding to staff our communities, how do we begin to meet those needs? We must see the connection between workforce and providing medical services.

Panel 4:

Health Care Delivery System

Moderator: Stephen Weeg, Idaho Health Care Council Executive Leadership Team

Mr. Weeg moderated a second forum focused on initiatives related to the health care delivery system from the perspective of hospitals and physicians. Each of the following four presenters were asked to describe what changes to the delivery system their organization has made or been involved in during the past year and where will it be in three years?

Physicians:

- Scott Dunn, MD - Multi-Payer Patient-Centered Medical Home
- Susie Pouliot, Chief Executive Officer, Idaho Medical Association

Hospitals:

- Casey Meza, Executive Director of Regional Services, Kootenai Health
- Larry Tisdale, Vice President-Finance, Idaho Hospital Association

From the perspective of the Collaborative Medical Home, Dr. Dunn quoted Wikipedia's definition, as "a team-based health care delivery model led by a physician, P.A., or N.P. that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes." Dr. Dunn went on to describe three important aspects of establishing a medical home:

1. Creating a personal relationship between the medical home and the patient. Relationships are what make it a "home." Patients are people who live in the community with you. Patients with chronic medical conditions benefit from this kind of relationship.
2. Ensuring better access with expanded hours with your team.
3. Increasing preventative care and establishing proactive contact through better coordination with consultants and in-patient services. A medical home can maximize information exchange and minimize harm done to patients where there is no coordination.

Governor Otter created the Idaho Medical Home Collaborative in September 2010. Twenty-three organizations will participate in a pilot program to begin January 2013, involving 290,000 patients. The system will be two tiered. Tier 1 patients are basically healthy; Tier 2 patients require more intense medical care or have chronic medical issues. Idaho's medical home pilot will test medical home theory in the context of Idaho's reality. Idaho's pilot features rural and urban areas, small and large practices, and practices at all levels of certification. The pilot features Medicaid, Blue Cross, Regence BlueShield and PacificSource insurers. Within the medical home, the group seeks to incorporate all primary care specialties. The pilot features Medicaid *and* private care providers. The pilot will try to prove what works and what doesn't with what's already on the ground in Idaho.

Ms. Pouliot indicated that much of the work in which the Idaho Medical Association (IMA) is involved has been presented during the course of this meeting. Regarding health care delivery reform, IMA has generated policy positions supported by all members, and they are specifically looking for ways to enhance primary care reimbursement. Regarding the development of community care networks in response to Medicaid Managed Care, IMA members support a physician/provider-driven effort to

generate efficiencies. IMA is also talking with members about ways to become involved and engaged in creating the plan for health care delivery in Idaho, and specifically regarding the medical home initiative.

Ms. Meza emphasized the need and value of rural health care and the important role of telemedicine in its delivery. She said improvements exist in health care in rural communities, but they still face a lack of services. Technology offers northern Idaho counties the opportunity to come together on critical issues, connecting primary care doctors in small towns with access to expertise from any part of the state. It offers patients the opportunity to receive care in their home towns. Using technology to bring people together is the key to success. Building relationships is important, as well as having access to information. Idaho is in a perfect position to deploy this opportunity. With technology, family practice doctors at any location can truly be a medical home. Technology will push us to the next level of care that patients deserve and want. Technology will also help nursing homes and be a resource to our aging population. Kootenai is trying to pull 10 northern counties together. 350,000 people live there. We need to keep patients in Idaho, not going to Washington for their care. Costs in Idaho are less, and the quality is as good, maybe even better.

Mr. Tisdale described hospitals' efforts respective to:

- ACA: Large hospitals have had to complete surveys on quality and satisfaction. Eventually the outcome of these surveys will affect payment. In and of itself measurement does not increase quality. The idea is to be able to measure quality and outcomes and then effect changes in outcomes. Hospitals see this as a great opportunity.
- Rural hospitals are working with the Department of Rural Health to improve quality and establish measurements.
- The Idaho Hospital Association switched to Data Gem, a fairly robust reporting system that provides analysis to show hospitals how they are doing compared to peer groups across the country. Hospitals are becoming data driven and quality driven.
- Idaho hospitals continue their commitment to EHR and appreciate the work of the IHDE.

Question and answer:

Q: We are talking about keeping people well, about the medical home, about reducing emergency room use. If everyone is working on reducing hospitalization, what is the hospital's response to that?

A: Mr. Tisdale: At first blush there is a conflict. If you step back, you can see we are not on a path – we are on a *freeway* – of unsustainability. Are we insurers? Are we health care providers? If we don't do something, we're going to be left out of the process. It will be done for us. In Idaho we are uniquely qualified to address this. We are not as overcapitalized as the rest of the nation. We are looking at a demographic shift to the elderly. We are not afraid of reduced hospitalization utilization over time; we are more afraid of not being part of the solution. We don't want to be an over-capitalized industry.

A: Ms. Meza: We should be the pilot sites for these opportunities. We are going to get 101% of our cost back. We are the perfect place to test this. The visiting nurse program helped drive re-admission rates down.

Q: Are accountable care organizations (ACO) good for patients or not?

- A: Ms. Pouliot: ACOs have not been a significant topic of conversation at IMA or its House of Delegates. Part of the reason is that when it was first introduced, the question was asked about where that would happen in Idaho. To be honest, IMA has not spent a lot of time here developing policy. How do physicians view this mode of integrated care? Members are on all sides of the discussion regarding integrated health care systems. The truth is—it's being integrated. The key is coordinating transitions, communication, and sharing with the aid of robust data systems, which are all strongly supported.
- A: Dr. Dunn: My personal view is the medical home is the foundation and ACO is built on that. Some people view it the other way around. If we have an ACO model, we have to have medical home in place.
- Q: Please address fee-for-service and transition to care management. With cost-based reimbursement, you get most back of, for example, a visiting home nurse. If you had a magic wand, what would the new payment for the patient-centered medical home look like? What would you tell Blue Cross and Blue Shield?
- A: Dr. Dunn: Dr. Epperly has spoken to this in the past. We are beginning that blended payment model, sort of *tiptoeing* into it. A smaller and smaller amount of total reimbursement will be fee-for-service amount. There are shared savings in some cases. You want to incentivize behavior. If you want less procedures, you want to pay more for what you do want.
- A: Mr. Tisdale: Medical homes are the foundation of integrated health care. Medical graduates are looking for jobs, not practices. We can deal with variable costs by not having patients; how do you deal with fixed costs that you have? We need to create payment processes to incentivize us to reduce our admissions. Savings can be created through primary care management; we need the network to share costs and savings.
- Q: You talked about the many benefits of telemedicine. Is reimbursement for these services improving?
- A: Ms. Meza: We are working to enhance reimbursement with Medicaid. There are pilots with Blue Cross that are hand in hand with St. Alphonsus on this technology. Blue Cross is paying for a lot of the services. Yes, reimbursement is there. The real issue is we can't afford not to deliver this care to our patients, or they will travel out of state.
- Q: What is the Collaborative doing to put the patient at the center of the team by increasing patient engagement and health literacy?
- A: Dr. Dunn: Getting employers to pay for the care. Part of a medical home is convenience, medical access. Patients want and need access, but it has to be at the right time in the right form. We are not convenient. It is a hassle to go to the doctor's office. If we can make it more convenient, they are more likely to access care.
- A: Ms. Pouliot: IMA members are thinking of ways to stimulate patients to be more incentivized with respect to their own care. They are considering the patient's accountability piece and how to encourage that.

Comment: (Dr. Epperly): I want to stress the importance of mental health care. If we keep a patient engaged in the practice he/she belongs to, you can imagine the benefit of care on site. The patient does not want to drive a long distance to see a psychiatrist. Good quality care in communities creates trust, decreases the stigma that prevents them from driving long distances. A solid primary care net with televideo will mean much to people in small communities. Mental health is enhanced with this setup. We do not want a carve-out system where patients are uncoupled from the initial source of care. You can see how the stigma could become an issue. Need to couple primary care and mental health care. Need practice-based care by other providers. Patients need a usual source of care and an established payment method.

Q: One of the models is boutique medicine. For X, payment is made to me at the beginning of the year, and I will be there 24/7. That sounds like a rich man's medical home. Is it possible to establish something like this for everyone?

A: Dr. Dunn: I think it is possible to imagine this happening with a couple of caveats. It would be limited to basically healthy individuals, not the chronically ill. In a medical home, it's not just one person, it's a team. It includes quite a few players. You need a team to take care of chronically ill patients effectively. How do you have a global payment to take care of all these things?

Take Away Messages

Following the presentations, the Executive Leadership Team shared the following observations and conclusions respective to the meeting discussion.

Ms. Chuckovich noted that the community is undergoing tremendous change, and a great snapshot of this change has been presented at this meeting. She encouraged the group to watch for unintended consequences. For example, when Medicaid expansion became optional, folks with federal poverty level up to 20% were covered. Folks with 100% and above were covered. Folks between 20% and 100% had nothing unless coverage was extended. Working through change can be quite complex. Ms. Chuckovich noted the many important initiatives underway, and expressed her confidence that Idaho's good working relationships, size, and collaborative way of working will serve Idaho well over the next several years.

Director Deal noted his appreciation for the day's discussion, the progress that has been made so far, and his enthusiasm for moving forward. He said many things are happening. Idaho is actively working -- expanding some programs, facing challenges, and making good decisions-- as we move forward with issues dealing with medical care. He said this meeting establishes another platform on which to move forward.

Director Armstrong expressed his appreciation for the group's advice and counsel, and encouraged all to continue to share their thoughts. The Department of Health and Welfare and Medicaid are pursuing many efforts with imminent schedules and important outcomes. He thanked the group for their engagement and willingness to help guide the evolution of Idaho's health care system. Together we will have a good, positive result.

Based on the day's discussion, Stephen Weeg observed a resounding commitment to better patient care with good quality.

Joe Morris noted the community health care network is shifting from treatment to prevention. Based on the day's discussion, Mr. Morris presented six takeaway messages for the group:

1. A lot of collaboration exists around technology and exchange care coordination prevention that needs to be fostered and accelerated to evolve an Idaho health care system.
2. An Idaho insurance exchange is strongly supported for a second year.
3. Building the health care cost curve and transforming health care can only occur if provider, payer, and patient incentives are aligned.
4. Consolidation and integration of health care providers, while possibly increasing cost in the short run, also makes possible risk-sharing global payments to value-based purchasing in which we have the potential to reduce cost over the long run.
5. Medicaid managed and integrated care can lead to better coordinated care and lower cost (medical/mental health).
6. Almost all Idaho health care initiatives are dependent upon having a sufficient workforce providing the right care at the right place, especially in mental health.

List of Participants (from Sign In Sheets):

Richard Armstrong, Idaho Department of Health and Welfare
Russ Barron, Idaho Department of Health and Welfare
Georganne Benjamin, Regence BlueShield
Lynda Bennett, Mountain States Group
Brenda Bielke, Idaho Medical Association
Marsha Bracke, Bracke and Associates, Inc.
Scott Carrell, Idaho Health Data Exchange
Stacey Carson, Idaho Hospital Association
Dr. Marc Chasin, St. Luke's Hospital
Melissa Christian, Regence BlueShield
Denise Chuckovich, Idaho Department of Health and Welfare
Jeff Cilek, St. Luke's Hospital System
William "Bill" Deal, Idaho Department of Insurance
Tom Donovan, Idaho Department of Insurance
Linda Duer, Idaho Physicians Network
Russ Duke, Central Health District
Dr. Scott Dunn, Idaho Medical Home Collaborative
Ross Edmunds, Idaho Department of Health and Welfare
Dr. Ted Epperly, Family Medicine Residency of Idaho
Peggy Evans, Qualis Health
Michael Farley, Idaho Department of Health and Welfare
Thomas Faulkner, Gem County Commissioner
Tom Fronk, Idaho Primary Care Association
Senator John Goedde
Alberto Gonzalez, Idaho Department of Health and Welfare
Christine Hahn, Idaho Department of Health and Welfare
Drew Hall, Idaho Department of Health and Welfare
Tim Heinze, Idaho Primary Care Association
Margaret Henbest, Idaho Nurses Association
Bart Hill, St. Luke's Health System
Zach Hodges, Qualis Health
Amy Holly, Unity Health
William Jonakin
Scott Kreiling, Regence BlueShield
Bruce Krosch, Southwest District Health
LaDonna Larson, Idaho Department of Health and Welfare
Paul Leary, Idaho Department of Health and Welfare
Sharon Lee, Idaho Physical Medicine
Palina Louangketh, Qualis Health
Tyler Mallard, Risch Pisca
Michael Malone, St. Alphonsus Regional Medical Center
Casey Meza, Kootenai Health
Steve Millard, Idaho Hospital Association
Joe Morris, Health Care Council Leadership Team
Tim Olson, Regence BlueShield

Linda Osgood, Boise State University
Governor C.L. "Butch" Otter
Linda Payne-Smith, St. Alphonsus Regional Medical Center
Tammy Perkins, Office of the Governor
Tom Perry, Office of the Governor
Susie Pouliot, Idaho Medical Association
Shad Priest, Regence BlueShield
Richard Rainey, Regence BlueShield
Dr. Richard Roberge, Board of Health and Welfare
Representative John Rusche
Neva Santos, Idaho Association of Family Physicians
Tim Saylor, St. Joseph's Regional Medical Center
Dr. David Schmitz, Family Medicine Residency of Idaho
Dr. Steve Schneider, Qualis Health Medical Center
David Self, PacificSource
Mary Sheridan, Idaho Department of Health and Welfare
Corey Surber, St. Alphonsus Regional Medical Center
Connie Smith, Bracke and Associates, Inc.
Gary Smith, Regence BlueShield
Linda Smith, St. Alphonsus Regional Medical Center
Lincoln Smyser
David Taylor, Idaho Department of Health and Welfare
Larry Tisdale, Idaho Hospital Association
Steve Tobiason, Blue Cross of Idaho
Michele Turbert, Idaho Department of Health and Welfare
Kathy Turner, Idaho Department of Health and Welfare
Stephen Weeg, Health Care Council Leadership Team
Amy Wernsing, Office of the Governor
Dr. William Woodhouse, Idaho State University Family Medicine Residency Program