### Discussion Questions

1. **Payment system reinforces the health system we want.** (But the system needs to shift to a culture of well-being.)

2. **Simplify the administrative practices by standardization across MCO’s for** claims, prior authorizations, portals, performance metrics, bundled payments, and/or shared CHW’s

3. **Better access for services** (Transportation, quality food, coordination of care at community and provider level, behavioral health, technology)

4. **Education** (in terms of cultural competency, whole body/mind integration, prioritizing the “at risk” population, prevention)

5. **Funding** (especially how to pay for services currently unpaid)

6. **CHW utilization**

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### Payment Model Committee

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<th>Topic</th>
<th>Discussion</th>
<th>Next Steps/Follow-Up/Barriers</th>
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<tr>
<td>Introductions</td>
<td>(see above)</td>
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### Topic | Discussion | Next Steps/Follow-Up/Barriers |
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<tbody>
<tr>
<td>Your team is charged with transforming healthcare for NM. What are the 3-5 most important health priorities this plan needs to address?</td>
<td>1. <strong>Payment system reinforces the health system we want.</strong> (But the system needs to shift to a culture of well-being.)</td>
<td>How will we pay? What will be the appropriate payment methods look like?</td>
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<td>2. <strong>Simplify the administrative practices by standardization across MCO’s for</strong> claims, prior authorizations, portals, performance metrics, bundled payments, and/or shared CHW’s</td>
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<td>6. <strong>CHW utilization</strong></td>
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| What specific components would you include in your plan? | ~ The plan would include finding diverse funding sources that would be sustainable.  
~ The plan would include re-evaluating CPT Codes to “de-incentivize” high cost medical procedures and to place additional value on lower-cost items like vaccinations and well-child checks.  

The PCMH:  
~ Will be certified to NM standards with set outcome measures.  
~ Would meet the needs of the patients “where they are.”  
  * Be open later hours to accommodate work schedules.  
  * Be able to accommodate walk-ins.  
~ Include pharmacy services in the medical home.  
~ Would have a shared saving model among providers.  
~ Would avoid bill-focused payment / fee for service. It would use a PMPM or Capitation model.  
~ Will undertake a value-based payment change.  
~ Will make CHW/Promotores an integral member helping clinics address social determinants of health and coordination of care/outreach.  
~ Would have integrated Behavioral Health.  
~ Will be aligned with school based health clinics.  
~ Will have a large emphasis on prevention and education.  

| What resources do we already have in place? Which areas are better served (have more resources) than others? | ~ Option: Increase property taxes to make funds sustainable.  
~ Need law & policymakers to be on board.  
~ Initiate a non-political “backbone agency” to facilitate and allocate services to underserved areas.  
PCMH Model will not necessarily be a “one size fits all” one and will most likely vary slightly from community to community.  
Behavioral Health has too many demands on providers and too many regulations.  

| Project Echo  
638 systems  
Existing PCMH Structures  
Health QHC’s  
CHW Programs, EMT programs, home visiting programs  
Health Councils  
Telehealth  
Health Homes  
Treatment Centers | We need to consider the unique needs and characteristics of a given community and start there.  
We should look to find which doctors are supporting these models. |
**Health System Innovation**  
*July 15, 2015 Healthcare Committee Notes*

| What are the gaps? And what specific ideas do you have to bridge those gaps? | • Behavioral health needs partnerships with doctors.  
• Working in individual silos with no avenue to access data.  
  *Break down the silos to integrate and coordinate the system and community.*  
• Information sharing gaps due to HIPAA.  
  *Pass legislation or regulations that allow the process for information sharing to flow easier.*  
• APCD needs  
  *Outcomes-based data is needed.*  
• Transportation needs  
• Education needs  
  *Utilize school based health centers for education purposes.*  
• Funding  
• Workforce training and retention is needed to have an adequate number of providers at different levels available to meet the population needs.  
  *Build in incentives to support existing NM residents become health care providers in their communities (“home grown” providers).*  
• A need for more providers to fill NM needs.  
  *Reciprocity laws for licensed providers should make it easier for out of state providers to work in New Mexico.* |
| Create incentives to providers for integrated care.  
• We need to have data-driven community planning. |

| How would you propose transforming payment to align with and incentivize your new plan? | • Unique payment designs to a network of providers where no one provider owns the patient.  
• Hybrid payment models to address/fund coordination of care.  
• Salaried providers in place of fee-for-service methods.  
• Insurance provider covers all and patient decides where to go based on best care reputation of care service.  
• Pay for wellness programs  
• Pay for care coordination among BH and other providers. |

| How can we eliminate the payment culture? | How can we eliminate the payment culture?  
| Look at/consider the Vermont model |
Identify at least 4 recommendations for the model design that you’d like to provide to the HSI Steering Committee. These will be presented during the report out.

15 minutes

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<tr>
<th>Recommendation</th>
<th>Details</th>
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<tr>
<td>1. Include broad utilization of Community Health Workers/Promotores in the health (care) system - CSW shared across MCO Payers.</td>
<td>1. Ensure adequate technology for information-sharing among providers.</td>
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<td>2. Ensure standardization of administrative processes</td>
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<td>4. Understand plan costs and cost-drivers to be able to identify opportunities for cost-savings.</td>
<td>5. Pay for initiatives to promote wellness</td>
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<td>6. Incentivize promotion of preventative measures while de-incentivizing high cost medical procedures.</td>
<td>7. Use per member per month (PMPM) contracting and risk management.</td>
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<td>8. Return a portion of shared savings to support the community.</td>
<td>9. Use shared savings to fund education and prevention in schools.</td>
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<td>10. Be responsive to community needs.</td>
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