NM HSI Summit, August 19, 2015
Payment Model Committee Notes

Topic	Discussion	Next Steps/Follow-Up
Introductions	Pass around sign-in sheet and collect at end of session	
	Discussion	
A goal of this meeting is to refine and/or add to the recommendations we have already made to the HSI design. Given your discussion in the mixed Round Tables, we may want to "dig a little deeper" into some of the issues that fall within our committee charge and/or our recommendations. ***~Ask each committee member to share***:	What was the 1 – 2 key "learning" or "take away" from your round table discussion? • What meaning do some of these have for our committee—is it something that we need to address now? 1. How will the IT infrastructure handle new payment model metrics? Will it be developed in a way that integrates public and private plans and delivery systems/providers? 2. Is this a carrot or a stick approach? Will the "savings" be redistributed or retained, publicly and in the private sector? 3. What services will be considered as part of the medical/loss/administrative ratios? 4. Payment reform section was not broad, not specific. 5. The HIE system is not robust; the data need to be readily available. We need a robust way to [access?] quality and outcomes. 6. Model seems "Medicaid-heavy"—how does PCMH transfer to the commercial side? We should work on commercial payment reform. How do public payers (government payers) drive charges and improvement? 7. How do we build infrastructure for a PCMH in rural communities (Taos); is there an adequate payment structure? 8. Variation among the plans for a payment model? Who will reform the payment model? We need flexibility in the payment model—as in CHW reimbursement. 9. The model seems to be a [federal?] model. 10. How do we fund workforce training? Who will pay for population health? How will we pay for it? We should review the funding stream for care coordination and who should be responsible. 11. How do we not dis-incentivize providers from caring for the sick, disabled, poor, undocumented? 12. There's $11 million in county indigent money—NM Rural Primary Healthcare Act. How do we fund and pay for uncompensated care?	
Committee tasks and approach to complete Committee work given the timeframe and deliverables: *August*—***Does the current version of the HSI design***	The Payment Model section needs to be better delineated. The first 2 paragraphs refer to "value-based" purchasing approaches. These are primarily off-shoots of the current fee-for-service (fee-for-volume) system. Performance metrics intended to incentivize tend to take the form of penalties against providers on issues over which they (individually) do not have control.	

adequately incorporate the recommendations made by and the work done by this committee? If not, please list what needs to be incorporated and provide as part of the summary question (below) responses.	The third paragraph gets closer to the goal of population health improvement if teams, networks or coalitions have accountability for the health of a population AND sufficient funding in a global payment to distribute to all of the needed members in the team. The network needs to have sufficient ROI and the ability to retain a significant portion of the "shared savings." The incentives won't work if the savings are siphoned by the government payers or are earmarked for specific functions outside of the network. This latter approach should be more of the focus for HSI with allowance for flexibility, experimentation and pilots. Such an approach is preferable to the directive, micromanaged approach of VBP.	
Report Out Preparation		
Identify at least 4 key recommendations for the HSI model design in your committee's area of responsibility. These can be new, adapted, or enhanced recommendations based on your discussion. These will be reported out. 15 minutes	1. **Within the payment model, do not pay extra for a health outcome that is already a standard of care**, such as improving low birth weight, but rather pay a "reward" for outcome measures that are above and beyond the standard. (Example: if the average hospital readmission rate is 6%, do not "reward" for a rate of 5% - 7%, but do for lowering the readmission rate to 1% - 2%.) 2. **Reimburse for outcomes-based metrics** (on top of fee for service) and redefine "primary care" to include oral and behavioral health (holistic approach). Include coverage for alternative, holistic healthcare in the payment model. 3. **Involve all players—MCOs, DOH, FQHCs, local governments, community businesses—in the support and funding of the multi-modal community wellness model**. Fund and encourage local community collaborations to optimize local care delivery 4. In the design draft, **do not necessarily de-incentivize "high cost services" (like a transplant that may be necessary to save a life), but instead de-incentivize "unnecessary or duplicative services**." 5. **Increase the effectiveness and utility of the state health information exchange by making New Mexico an "opt out" state.** 5. The savings generated from the payment model should be used to help fund medically necessary care (especially for those who are under- or uninsured) and address social determinants. Assure alignment of Centennial Care (Medicaid), Medicare, self-insured and commercial payment mechanisms. 6. Include incentives for hospitals to transition care to outpatient settings (as appropriate); incentivize medical providers to use community resources to improve outcomes. An example includes the hospital discharge summary being available at/for the member's outpatient follow-up appointment.	

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