

NM HSI Summit, September 16, 2015
Payment Model Committee

Topic	Discussion	Next Steps/ Follow-Up
Introductions	Pass around sign-in sheet and collect at end of session	
Discussion		
	<p>A goal is to review the specific design content related to the work done by and recommendations made by <u>your</u> committee and workgroups. Review and refer specifically to slide(s) numbered: 7, 23, 24, 25 and others.</p> <p>The emphasis, at this point, is to refine and/or clarify input and recommendations already made, rather than to provide more recommendations. We hope the questions below help guide you.</p>	
<p>#1: Does the current version of the HSI design adequately incorporate the recommendations made by and the work done by this committee?</p> <p>If not, please describe what needs refining or changing.</p>	<ul style="list-style-type: none"> • Need to bring in other payers – not just publicly funded payers (i.e., Medicaid). What about QHPs? We need to spread the risk beyond Medicaid. It’s challenging to bring in other payers; they do not want to commit. Need to use modeling to show savings potential. That is how you appeal to commercial/non-public payers. Payers want to lower high-end costs. Need to identify what works. • Need to avoid duplication of what is already occurring. It is unclear how funding will be separated – i.e., Centennial Care versus care coordination at the community level. Danger of duplication and confusion. • Need to align with Medicare payment reforms. • Model should consider three tiers: 1. Investment (PMPM), 2. Performance (incentive payments), 3. Outcomes (rewards/shared savings). Get rid of conflicting incentives; align where possible. • Need to align payers with each other. PMPMs, shared savings, etc., should match if possible. • Sometimes FFS works well; we do not want to put providers out of business. • Cannot impose a structure without resources. Design must be intentional. • Remove bundled payment language; more appropriate in the hospital setting. 	
<p>#2: Are there any components or factors that have <u>not</u> been considered or reflected in the design that are important to <u>your committee’s specific area of expertise or interest</u>? If so, what are they?</p>	<ul style="list-style-type: none"> • Smaller providers need capital to support risk. The model needs to incentivize savings rather than withhold money based on population health. Risk-sharing is difficult for small provider groups. • Need alternatives to meet the provider where they are. Each provider may need a different model. Need to develop a continuum from risk to shared savings. • Payment model should stratify by risk – i.e., “risk adjustment model”. • Different ways to bend the cost curve: 1. Change the model AND/OR 2. Front load primary care and prevention. 	

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<p>(Again, refer to slide(s) numbered 7, 23, 24, 25 and others)</p>	<ul style="list-style-type: none"> • Should at least streamline the payment model for all providers in Medicaid so all four MCOs are doing things the same way. • Model needs to define a way of determining attribution across providers. Provider groups are unsophisticated. Need to develop ways to do data sharing and financial risk that will work for them. • Need to help providers in assessing data so they can make sense of their performance. Practice transformation funding is critical. 	
<p>#3: Are there any components or factors that have <u>not</u> been considered in the <u>overall design</u> that you feel are important? What factors are missing?</p>	<ul style="list-style-type: none"> • There appears to be a disconnect in providing funding sources for services people need outside of the health care system (i.e., social services). What are the payment models for those services? The health care system cannot pay for everything. What are the additional programs/services that need to be addressed and paid for? • What about creating a community organization model through which a PMPM would be paid to the community organization that would then pay the providers in the community? The community organization could be a center for managing care coordination. Could be called something like “Accountable Communities”. Communities could be required to match with their own funding to share in the investment/risk. • Need to enable connection and navigation. How do we get providers ready? Need to provide TA. Need to identify who these community organizations are, what their governance structures will be, etc. What are the critical roles they will play? • How do patients fit into the model? Need incentives to engage patients. 	

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	Report Out	
What are the key points from your discussion that you want to share with the rest of the Summit participants?	<ul style="list-style-type: none">• —• —• —• —• —	