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June 10, 2016

State of New Mexico:

Thank you for the submission of the State Health System Innovation Plan (SHSIP) for the SIM Model Design Cooperative Agreement on April 29, 2016.

In reviewing your submission, we have found that the State has provided the requested documentation and information to meet with the requirements outlined in the SHSIP Guidance. Below is a summary of the State Innovation Models Team's (SIM) assessment of your SHSIP's strengths and areas for improvement.

**Overall Feedback for NM:**

Overall, the timeline, project milestones and deliverables, and health care delivery and payment transformation models seem to be appropriate and well aligned with the SIM initiative and the FOA requirements.

**Vision for Transformation**

**Strengths:** The SHSIP describes a holistic transformation plan and ensures connections between various plan components. The State's Plan seeks to reward health care providers for better care, smarter spending, and healthier people through higher quality, instead of quantity of services by utilizing value-based purchasing across public and private payers. The SHSIP provides a well-detailed description of the proposed value-based models of care through the Patient-Centered Medical Home (PCMH) model, resulting in the statewide implementation of Accountable Health Communities (AHCs). The SHSIP outlines a long-term vision of building and expanding the PCMH model into a Community Centered Health Homes (CCHHs) model, which will focus on prevention and collaboration with other community-based organizations. Another strength identified is the amount of existing PCMHs operating within the State. The SHSIP provides a course of action to assist non-PCMH practices to become nationally certified, as well as, goals for a single, statewide PCMH model to be used by all providers and payers within the state. The implementation of the AHCs will be key in addressing social determinants of health within various communities and seems to align well with the PCMH goals. This focus on population and community health will enable the State to make a broader impact and support the long-term goal of moving towards a CCHH model. The focus on the improvement of clinical, behavioral, and oral health care within the urban, rural, and frontier communities is well aligned and consistent with the SIM goals and the overall Triple Aim initiative. Figure 18: Driver Diagram clearly shows how the State plans to achieve the Triple Aim by 2020.

**Authority Employed**

**Strengths:** The SHSIP adequately describes plans to implement current legislative, infrastructural, and regulatory levers, such as telehealth and the Medicaid 1115 waiver, to accomplish health care delivery system and payment transformation. Also, it is key that the State utilizes the existing collaborative levers with the various Native American entities, since this is a target population. In addition, utilizing state

levers for the certification of community health workers will be essential in targeting high-risk, rural populations within the State. Also, it is well-aligned with the proposed models of implementing Patient-Centered Medical Homes within Accountable Health Communities.

**Areas for Improvement:** While the SHSIP makes reference to the utilization of the Medicaid 1115 waiver, it does not provide a plan of action for when this waiver expires in December 2018. The SHSIP should identify the next steps or course of action. In addition to existing levers, the SHSIP should describe any changes to legislation or regulation required to implement components of the SHSIP.

### **Broad Multi-Payer Commitment**

**Strengths:** The SHSIP outlines a plan and has clearly described how the State is working towards achieving multi-payer participation and alignment with SIM efforts. The SHSIP goes beyond a Medicaid-centric approach by engaging a diverse group of payers.

### **Description of State Health Care Environment**

**Strengths:** The SHSIP provides a significant amount of detail as to the number and location of current health care facilities and providers throughout the State, including those being served by the PCMH model. Another strength identified is the alignment with physical, behavioral health, and long term care for Medicaid patients through the 1115 demonstration waiver. Improving and strengthening the rural hospitals with a focus on increasing access to core services, while decreasing acute care services will be key in reducing costs and improving health care for the most vulnerable populations within these geographic areas. Also, collaboration with other health care providers such as the FQHCs, will be essential in providing primary, behavioral health, oral, and preventative services (Centennial Care). Centennial Care seems to be well-aligned with the SIM program in that it focuses on PCMHs and CHWs, as well as, moving from volume-based payment models to performance and quality payment models. The SHSIP adequately describes the top insurers who have 70% of the State's total market share and the number of members they cover.

### **Report on Stakeholder Engagement and Design Process Deliberations**

**Strengths:** The SHSIP adequately describes how stakeholders will be engaged in the SHSIP moving beyond the design period. The stakeholder engagement process seemed to be highly productive throughout the model design period, resulting in a significant amount of meetings amongst various stakeholders. The SHSIP shows the participation of a variety of stakeholder engagement organizations, with the particular involvement of tribal entities, consumers and patient advocates in this process. This could provide an invaluable source of stakeholder feedback given that the ultimate impact of the proposed health care delivery and payment transformation models will affect these target populations. For example, stakeholders identified behavioral health as a key population health priority, which the state then added to the SIM areas of diabetes, obesity and tobacco. Similarly, transportation is incorporated into the Accountable Health Communities model design. The payment model section provides a thorough summary of stakeholder input on considerations, which could be used as the state identifies potential alternative payment models to be adopted from Centennial Care and aligned across multiple payers.

**Areas for Improvement:** Figure 1: Design Stakeholder Engagement Process provides a diagram outlining the key stakeholder groups, as well as, the input and feedback process. While it is important to have a core stakeholder committee dedicated to the Native American population since this is a target population identified for the proposed models of care, there seems to be no core stakeholder committee dedicated to the Hispanic population. Since this population makes up 41% of the State's total population and has, also, been targeted for the proposed model of care, there should be a committee

dedicated to this group, as well. The SHSIP indicates that the Hispanic population makes up a larger percentage of the total population than the Native American population, which comprises only 9%. The SHSIP indicated that the stakeholder input regarding the needs of the rural/frontier areas versus urban areas could not be incorporated into the current Design model. This could be an area to further delve into and flesh out beyond the SIM project. Lastly, the SHSIP should have included information as to which stakeholders were given a say in the final shape of the plan and who authorized the final document. Also, the SHSIP should include information on any disagreements that may have arose and how they were addressed.

### **Health System Design and Performance Objectives**

**Strengths:** The SHSIP provides adequate justification as to how the State plans to support greater linkages with primary and preventative care and community-based and social services, by establishing realistic goals, objectives, and strategies. The integration of the population health goals is key in addressing the State's top chronic diseases, key risk factors, and ways to improve these health outcomes. The role of hospitals is clearly articulated in the proposed transformation initiatives. Also, the SHSIP adequately describes the range of sectors involved in the plan beyond traditional health care delivery.

### **Value-Based Payment and/or Service Delivery Model**

**Strengths:** The SHSIP provides an adequate description of how the proposed payment model will align with PCMHs. Also, the SHSIP provides an adequate description of the providers and population that would be impacted by these proposed models. The plan considers that providers are in different stages and capacity for PCMH development. Technical Assistance Centers (PCMH and AHC) will support the creation of PCMHs, transition to community-centered health homes (CCHS) that take into account social determinants of health, and integration into regional Accountable Health Communities.

**Areas for Improvement:** The proposed model and approach should provide a description as to how the State would comply with FOA requirements of reach (e.g., 80% of payment in alternative payment arrangement). While the Plan discusses the state plans to adopt successful alternative payment models from Centennial Care and align them across payers, the plan should provide more of a description as to how this would be done. For example, in multiple areas, the plan notes that the same four Medicaid MCOs from Centennial Care also account for 70% of the private health insurance market. The Plan should describe how the state plans to leverage this.

### **Plan for Health Care Delivery System Transformation**

**Strengths:** The SHSIP describes a holistic transformation plan and ensures connections between various components within the plan. The Rural Health Strategy seems to be well aligned with the SIM Design project in that it integrates CCHHs and AHCs. Since community hospitals serve as a vital healthcare delivery system of care within the State, it will be key to utilize these hospitals and collaborate with other FQHC, PCMHs, etc. within the region. Utilizing the PCMH model to align with primary care and behavioral health, as well as, the future goal of transforming into a CCHH model is well aligned with SIM and has the opportunity to transcend beyond the SIM program.

### **Plan for Improving Population Health**

**Strengths:** A major strength identified within this Plan is the utilization of evidence-based strategies to address significant health indicators amongst specific age groups. These strategies are targeted towards prevention, promotion of healthy behaviors, reduction of chronic diseases, and elder services. For example, the utilization of Healthy Kids, Healthy Communities, is an evidence-based strategy that promotes early childhood development and home visiting. This approach goes beyond payment and delivery reform by integrating public health into the proposed models.

The SHSIP shows a clear path of how the population health focus will go beyond payment and delivery reform by displaying how PCMHs and regional/community coalitions will ultimately transform into AHCs. The SHSIP clearly describes the State's plan for addressing the most prevalent disease and social determinants of health. The State provides clear justification on the core performance measures to be utilized to positively impact these populations. The SHSIP provides a well-detailed description of the assessments of health disparities (i.e., obesity, tobacco use, diabetes, behavioral health, and other contributing lifestyle factors) that have contributed to the high cost and disease burden on the State. Also, the State provided an initial assessment of social determinants of health such as gaps in access to care and health disparities by County. The State describes in detail the health disparities facing the Native American population and current initiatives to combat these issues.

### **Health Information Technology**

**Strengths:** The State displays an excellent linkage of incorporating the HIT capabilities or requirements into the Design plan by driver and by initiative, including Tribal. Related to health IT areas, the State has led in seeking to address Tribal and IHS data and health IT infrastructure and considering the use of telehealth to support the frontier health needs as 10 of the 54 hospitals are designated as Critical Access Hospitals (CAH), which struggle economically. Thus, this work is very impressive and difficult. Conceptually multi-payer, but initially Medicaid focused. Medicaid funding approvals, etc. are critical to success and should be incorporated into timelines and "success" factors. The approach to the Plan is very detailed. HIT risks are still evident and success will be dependent on how the state moves from conceptual framework to operations. This Plan serves as an example of linking HIT with each element of the Design Plan and aligning the timelines. Overall, the Plan is very reasonable.

**Areas for Improvement:** Further explanation on the linkage of Medicaid to the SIM Design effort would be beneficial for the state, state stakeholders, and federal agencies as the potential for funding for some of the critical infrastructure exists. The implementation and funding may be challenging, so translating the document into business requirements and technology specifications or requirements will be important. ONC is available to work with the State and CMS if the state moves forward in this area.

For budget HIT Costs: (Attachment 1, Appendix F, starting page 292), the State staff are included and costs are reasonable, but it suggested that the state might need additional state staffing in this process that could be addressed through Medicaid. ONC could work with the state on pursuing Medicaid funding for State staffing, as well as, health IT technology and technical assistance. Although the decision was to move forward with the APCD with the current authority, there appears to be some potential risk that should be tracked. Also, the very detailed APCD document (Appendix H) identifies other areas of focus for implementation and use, including data quality, etc. ONC would suggest that as the state moves forward on the APCD, to consider clinical and claims aggregation as part of the longer term strategy. It might be beneficial to include the multi-payer stakeholders in the design process even though it is initially Medicaid, so the issues can be addressed in the design if possible. ONC agrees that the state would benefit from further study regarding scalability, uptake, and lag times for rolling out identified HIT interventions.

For more detailed comments regarding the HIT Plan, please refer to the ONC Final Feedback Report. ONC is available to work with the state on this area if the state needs further assistance.

### **Workforce Development Strategy**

**Strengths:** The SHSIP provides a plan to address the availability of an adequate and trained workforce within the State and provides a detailed description as to how this plan would work under the proposed models. The early focus on recruitment and training of high school students is key in educating and attracting a young, talented, and enthusiastic workforce, especially within their own communities. A

major strength is that the State is first in the Nation to support Federally Qualified Health Center primary care residencies with Medicaid funding, providing linkages to amongst other health care provider organizations (such as universities, hospitals, and primary care practices). Another strength identified is the certification of community health workers and promotores and reimbursement of services. This is key in serving the Native American and Hispanic populations which has been identified as target populations for the proposed models. The SHSIP clearly describes the data collection and analysis plan to enhance the health workforce within the State. The SHSIP addresses how the State plans to address the current supply and projections of future demand for the health workforce.

### **Alignment with Existing Initiatives**

**Strengths:** The SHSIP adequately describes the proposed models and how they build on and support the rollout of existing reform initiatives, particularly with rural and community hospitals and PCMHs.

### **Financial Analysis**

**Strengths:** The SHSIP adequately describes the projected expenditures and forecasted analyses planned to ensure that the proposed models show cost savings and potential for a return on investments, in order to improve health outcomes for diabetes, tobacco use, obesity, and behavioral health.

**Areas for Improvement:** The SHSIP describes that the ROI calculations make certain assumptions. It may be helpful to discuss some of these assumptions, especially where they may relate to overall transformation goals. For example, how many PCMH practices this assumes.

### **Monitoring and Evaluation Plan**

**Strengths:** The Plan provides a clear explanation of how the state engaged stakeholders, the criteria that was used for selecting measures, and the proposed measures demonstrate that the state is considering how to measure both implementation and outcomes. The SHSIP adequately describes the rapid cycle learning methods for self-evaluation to inform the proposed model implementation efforts for continuous improvement. The SHSIP addresses how challenges in implementation will be captured and course correction to overcoming barriers. Also, there is a focus on longer term outcomes and accomplishments. Overall, the Plan provides an adequate description of the plan to monitor progress and continuous improvement.

**Areas for Improvement:** The SHSIP describes how an external evaluation specialist would be secured to design an evaluation plan, should funding be made available. However, if this funding is not secured, the State should consider another avenue to continue this effort. Based on the proposed measures in the monitoring and evaluation plan, there are quantifiable goals, particularly for adoption of the PCMH model (e.g., number of PCMHs, share that incorporate behavioral health, etc.). However, the state may want to consider identifying some specific targets for these measures. Also, the state proposes population health/clinical measures and may want to consider to align applicable measures from this set with the proposed payment model.

### **Operational Plan**

**Strengths:** The proposed Plan seems to translate to specific, concrete actions, and are implementable. The SHSIP provides a detailed rollout process with activities over the next five years. Also, the timelines seems appropriate and the scale up strategy seems reasonable. The plan's phased roll out builds in time to seek funding for specific components of the plan (e.g., technical assistance centers) and assess results of pilot programs and earlier implementation that will allow the state to make improvements or adjustments in a rapid-cycle manner. In addition, a major strength identified is the focus on financial sustainability beyond SIM. The SHSIP outlines a business plan for strategies on seeking various short and long-term funding opportunities to avoid reliance on Centennial Care.

**Areas for Improvement:** The SHSIP should provide additional information on how the Operational Plan could be impacted given this timeframe and possible ways to overcome potential challenges. Even though each activity seems to be implementable, some activities may take longer to implement than others. Also, the financial sustainability component of the Plan should provide more description as to how model implementation efforts will be sustained over time if there is a lack of funding. In addition, the plan around PCMH development does not address how the state would operationalize certain components of this model. The plan explains that existing PCMHs are certified through three different programs (NCQA, AAHC and Joint Commission), and the lack of uniformity creates challenges for practices with respect to reporting and payment. While the plan suggests the creation of a more-aligned, statewide certification or model, it should describe a specific process for developing this. The Plan should address whether or how the state might incentivize PCMHs to become CCHs. Related to this, the Plan should address how or if the model would reimburse CHCC providers for additional coordination with non-medical social supports.

Keep this notice with your records to document that the Awardee is in compliance with the programmatic implementation requirement to submit a State Health System Innovation Plan.

Regards,

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Project Officer