



FOR A HEALTHIER NEW MEXICO

**New Mexico Stakeholder Summit
September 16, 2015**



New Mexico Health System Innovation (HSI) Stakeholder Summit
September 16, 2015, 8:30 am – 4:00 pm
DoubleTree Hotel, Albuquerque, NM

- 8:30 - 9:00** **Registration, Coffee and Informal Question/Answer Session**
- 9:00 – 9:10** **Welcome**
Retta Ward, Cabinet Secretary, Department of Health
Michael Nelson, Deputy Cabinet Secretary, Human Services Department
- 9:10 - 9:30** **Metrics for the HSI Design**
Lois Haggard, Epidemiology and Response Division, DOH
- 9:30 – 10:30** **NM Health System Innovation (HSI) Model**
HSI Model: Question and Answer Session
Tres Schnell and Friends, DOH and HSD
- 10:30 – 10:45** **Break**
- 10:45 – 12:00** **Focused Discussion about the NM HSI Design**
Mixed Committee Member Roundtables
- 12:00 – 1:30** **Lunch on Your Own**
- 1:30 – 3:00** **Stakeholder Committee Sessions**
Review committee-specific design section for content, accuracy, and missing elements
- Population Health (red): Coral Salon I
Health Care (light blue): Crystal Room II
Payment Model (black): Quartz Boardroom
Alignment and Integration (yellow): Coral Salon II
Health Information Systems (orange): Coral Salon III
Tribal (navy blue): Azurite Room
Workforce Development (green): Crystal Room I
- 3:00 – 3:15** **Break and Rejoin the Large Group**
- 3:15 – 4:00** **Round Table Report**
Terry Bryant, Office of Policy and Accountability, DOH
Stakeholder Committee Report - All

Next Summit: December 15, 2015
(Details to come. Location at DoubleTree Hotel.)

Check the website for all things related to *New Mexico Health System Innovation*: resources, committee work, and information on the developing design.

www.nmhealthsysteminnovation.org

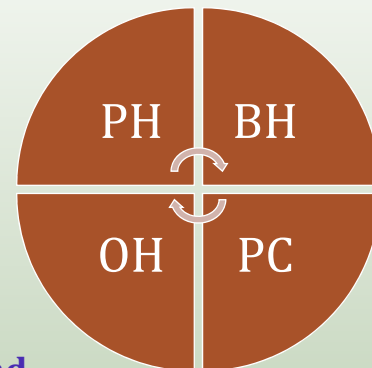


WELCOME

Health System Innovation Design
September 16, 2015

THE END RESULT IN MIND

- **A Designated Community Centered Wellbeing Home with an Aligned and Integrated Health System**
 - ✓ Public health (health promotion/primary prevention/early intervention/health literacy)
 - ✓ Behavioral health (mental health, substance misuse);
 - ✓ Oral Health (preventive, treatment); and,
 - ✓ Person Centered Primary Care aligned with Pharmacy, Acute, Long Term, Home and Hospice Care.

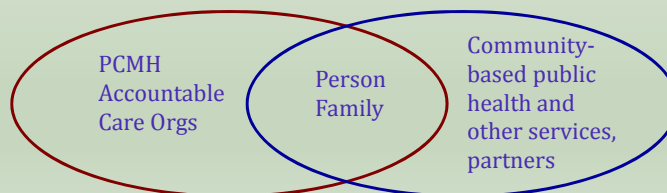


MODEL DESIGN VISION

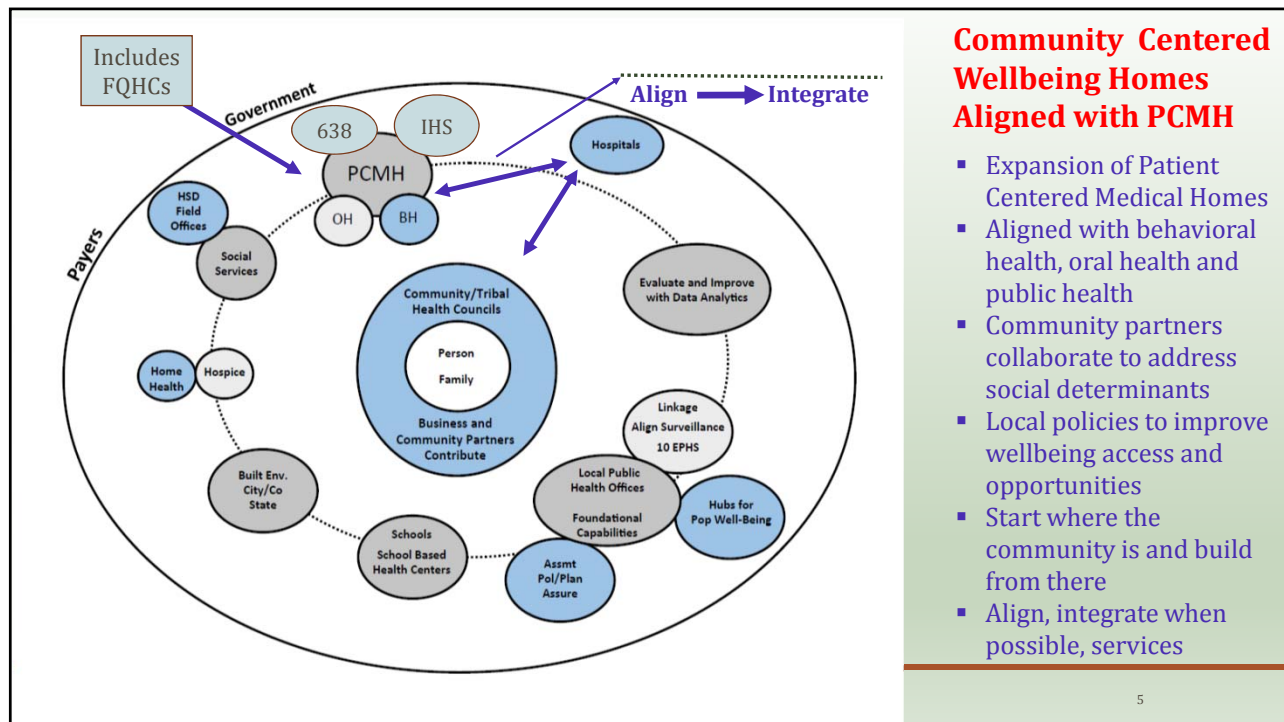
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COMMUNITY CENTERED WELLBEING HOMES (CCWH) WITH A PCMH APPROACH TO IMPROVE POPULATION HEALTH

1. **CCWH with a PCMH to provide high quality person-centered healthcare while also addressing underlying social determinants of health and health equity**
 - Takes upstream approach to prevent health problems and promote well-being
 - Improves health and well-being at both individual, family and population levels
 - Solves multiple problems at once, i.e., *improving neighborhood walkability can enhance outcomes for diabetes and heart disease*
 - Works two-ways: PCMH refers patients to community services (legal, food, housing, transportation) and community services refers client to medical, behavioral or oral care ("No wrong door")
 - Build on existing New Mexico models that are working!



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GUIDING PRINCIPLES

1. Foundation

- Adopt a whole person philosophy focused on wellbeing
- Promote primary prevention in the community setting
- Build on foundation of PCMH model and existing successful statewide and tribal efforts
- Establish a set of standards for NM PCMH certification/accreditation
- Include risk-stratification of populations seeking services
- Be both community and person/patient centered
- Improve health equity and health literacy to serve as cornerstones of the system
- Leverage technology to provide services
- Incentivize individuals to engage in healthier behaviors, taking responsibility for their own health

2. Improve access to wellbeing and healthcare

- Provide a "No Wrong Door" approach to improve access to the health system
- Ensure access, safety, and quality of service in a culturally and linguistically competent manner
- Engage multi-disciplinary cross-organizational teams
- Teams focus on comprehensive care coordination and seamless transitions of care across services and providers

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GUIDING PRINCIPLES

3. Payment model

- Supports the Model Design and is based on improved health outcomes vs. fee for service.
- Incentivizes payers to reimburse and providers to provide services that are based on healthy lifestyles and results in improved outcomes.

4. Metrics

- Measure and assess overall population health outcomes, key clinical interventions that are linked to state-level health indicators, and effectiveness of the Model Design.

5. Consultation and Collaboration

- Assure consultation and collaboration with NM tribes, pueblos, and nations in accordance with the state Tribal Collaboration Act.

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KEY STRATEGIES

1. Build Model Design
2. Develop and grow designated Community Centered Wellbeing Homes, aligning (integrating) public health, primary care, behavioral health, oral health
3. Standardize Patient Centered Medical Home (PCMH) requirements (minimum standard set for NM – not one certifying body)
4. Develop a payment model to support the Model Design
5. Standardize and align performance metrics
6. Identify and pursue policies and regulations

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KEY STRATEGIES

7. Transform and grow the workforce
8. Promote clinical and public health practice transformation
9. Build technology capabilities
10. Roll out, evaluate and improve the model
11. Grow local and statewide public / private partnerships to improve the health of people in New Mexico
12. Further development - Health System Governance (state/local); Financial Plan; Financial and System Sustainability; Ongoing Consumer and Community Engagement

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STRATEGY 1: BUILD THE MODEL DESIGN

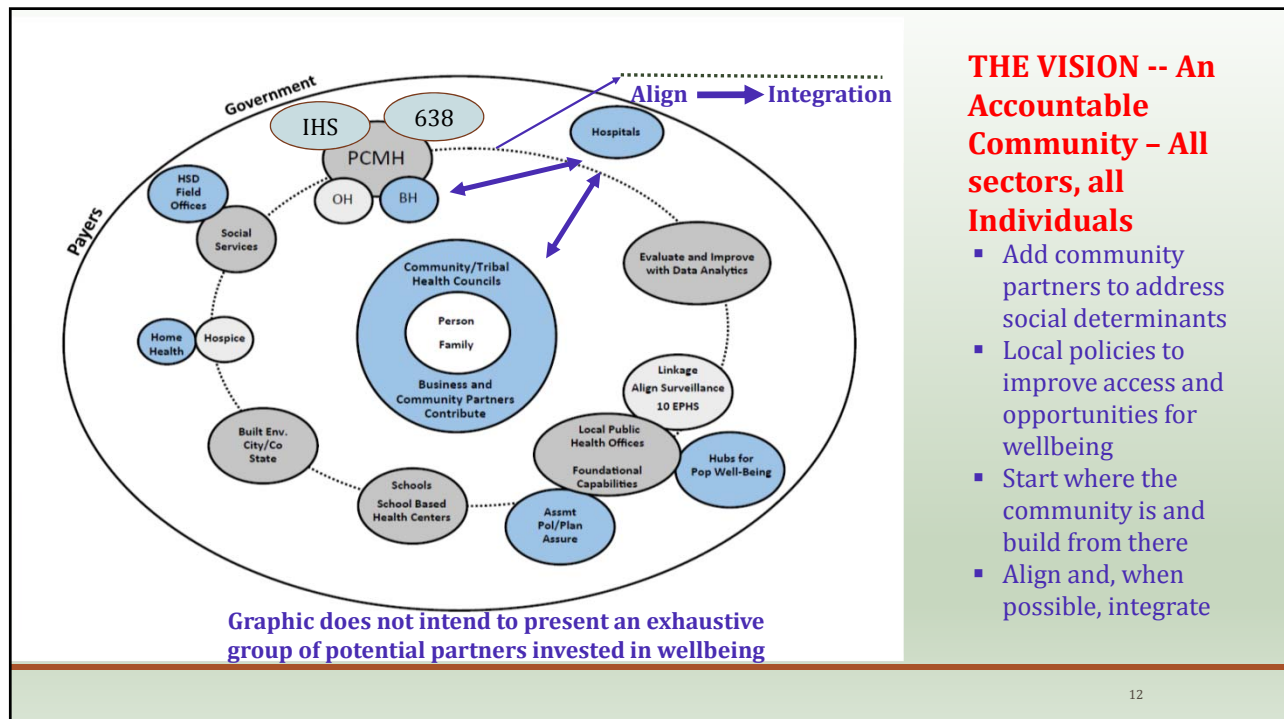
1. Develop a statewide system of Community Centered Wellbeing Homes (CCWH).
2. Use the Patient Centered Medical Home (PCMH) Model Concept, as emerging from stakeholder input and the Public Health System, as a core clinical concept of the CCWH system.
3. Actively Engage FQHCs, SBHCs, NMDOH Public Health Offices, Community Hospitals, Community Centers and other community resources as other core components of the CCWHs.
4. Use Community Health Workers (CHWs), EMS personnel, volunteers, and telehealth to engage the workforce, patients and caregivers.
5. Ensure compliance with competencies, treatment plans and measure health improvement performance.
6. Explore a more uniform PCMH model and provide practice transformation support to providers who may not have the resources/desire to become PCMHs.
 - Requires that some level of care coordination and/or community wellbeing will be integrated into their practices.

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STRATEGY 1: BUILD THE MODEL DESIGN

7. Review and develop policies and regulations that support the Model Design.
8. Develop accreditation requirements based on nationally vetted standards, blending PCMH models currently used in NM.
 - Such as NCQA, Joint Commission, and other certified PCMH-type models
9. Develop a range of services that address the following:
 - Improve community health – primary prevention, health promotion, health literacy
 - Improve access to quality and satisfactory care
 - Improve care coordination across organizations
 - Align with Centennial Care approaches
10. Tribal models of care
 - Build on the long-standing Indian Health Service “Improving Patient Care” (IPC) and PCMH models.

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STRATEGY 2: ESTABLISH DESIGNATED COMMUNITY CENTERED WELLBEING HOMES

- 1. Work with communities to establish a CCWH regional collaborative made up of representatives collectively working to promote wellbeing:**
 - NMDOH Regional and Local Public Health Offices (PHO)
 - Health Extension Rural Offices (HEROs)
 - County/Tribal Health Councils
 - Cooperative Extension
 - NMHSD Field Offices
 - Indian Health Service and 638 Clinics
 - Area Health Education Centers (AHEC)
 - Social service agencies, faith-based organizations, business
 - PCMHs
- 2. Collaborative provides assistance with community/county project guidance, technical assistance, networking and collaboration, performance management**

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STRATEGY 2: ESTABLISH DESIGNATED COMMUNITY CENTERED WELLBEING HOMES

The Population Health Stakeholder Committee proposed several key strategies and interventions that fit the Community-Centered Wellness Home model and which can improve population health outcomes in New Mexico. Criteria for their selection of strategies include those strategies that:

- Focus on community prevention and building safe, healthy lifestyle-supporting environments, and inclusion of non-traditional services that affect health (transportation, county planning, farming, etc.);
- Address adverse social determinants of health and reduce health disparities;
- Incorporate both person and community-centered approaches;
- Emphasize a holistic approach focused on well-being, and healthy, active lifestyles;
- Build on existing state (and other) programs that are evidence-based, successful or showing promise; and
- Address health issues—especially obesity, tobacco use, and diabetes—across the lifespan, from pregnancy to the end of life.

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STRATEGY 2: ESTABLISH DESIGNATED COMMUNITY CENTERED WELLBEING HOMES

Early Years (Prenatal to Age 8):

- 1. Establish partnerships among public and clinical (PCMH) health entities, education, social and community-based service agencies to bring about a comprehensive, high-quality early childhood development (ECD) system in each community and in the state. This ECD system will include:**
 - Access to first-rate prenatal care to all pregnant women, especially single and teen mothers from the first trimester.
 - Adverse Childhood Experiences (ACE) screening.

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STRATEGY 2: ESTABLISH DESIGNATED COMMUNITY CENTERED WELLBEING HOMES

Youth (Age 9 – 24) through Adulthood (Age 25 -59):

- 1. Focus on improving school (through college) and community environments to:**
 - Encourage healthy lifestyles
 - Promote healthy decision-making
 - Nutritious eating
 - Appropriate healthcare for youth and their families to prevent or curtail chronic disease
 - Expand SBIRT screening in primary care, school-based health centers, and public health
- 2. This strategy depends on aligned community-based well-being efforts implemented by a number of different partners:**
 - Public health offices
 - NM Place Matters
 - School-based health centers and school nurses collaborate with diverse partners, such as transportation providers, community planners, local government and others

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STRATEGY 2: ESTABLISH DESIGNATED COMMUNITY CENTERED WELLBEING HOMES

Age 65 to End of Life:

The third strategic area focuses on:

1. Maintain health and more effectively manage chronic disease and injury among the elderly, including:
 - ✓ Sustain and improve quality of life, including health literacy on advanced directives
 - ✓ Prevent injury, including falls
 - ✓ Prevent hunger and food insecurity
 - ✓ Prevent or reduce obesity
 - ✓ Prevent or manage diabetes
 - ✓ Prevent or reduce substance misuse (primarily prescription drugs)
 - ✓ Prevent or reduce tobacco use
2. Community-based interventions that rely on a blend of clinical intervention, self-management programs, and community supports have been identified.
3. Collaborate with senior centers, long term care, home health, and hospice to ensure coordination of care.

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STRATEGY 2: ESTABLISH DESIGNATED COMMUNITY CENTERED WELLBEING HOMES

1. Integration and Alignment for the Model Design:
 - The Health System Innovation Model should support population health status.
 - The Model should address the needs of the diverse communities and people of New Mexico to assure that no one is left behind.
 - Integration and alignment of services and agencies requires joint leadership support, collaborative priority setting and systemic connections – not just a geographic co-location.
 - Integration of behavioral health and physical health services can positively impact cost, quality and the overall experience of care.
 - Integration allows for local problem solving and local solutions – not all “innovative solutions will be evidence-based,” but could be examined.

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STRATEGY 2: ESTABLISH DESIGNATED COMMUNITY CENTERED WELLBEING HOMES (ALIGNMENT)

- 2. NMDOH assures the following foundational and essential public health services:**
 - Ensure that services comply with public health accreditation standards
 - Develop and implement policies and strategies aimed at primary prevention, increased access to services and improved health literacy of individuals, families and communities
 - Communicable and vaccine-preventable disease prevention and control
 - Chronic disease and injury prevention
 - Family and maternal/child health promotion
 - Emergency preparedness and response
 - Environmental health with the Environment Department

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STRATEGY 2: ESTABLISH DESIGNATED COMMUNITY CENTERED WELLBEING HOMES (ALIGNMENT)

- 3. Public Health Transformation and Alignment with Partners:**
 - NMDOH Divisions providing essential and foundational public health services should:
 - ✓ Assess the needs for those services and system strengths and opportunities at the community level
 - ✓ Identify the roles played, and areas of overlap, by NMDOH and partners
 - ✓ Collaborate with partners and communities to assure that local solutions (wherever/whenever possible) are used to solve identified gaps, problems and to improve health status
- 4. “No Wrong Door” Approach for Individuals and Families Seeking Health and Social Services**
- 5. Behavioral Health Integration and Alignment with Healthcare, Public Health and Community Wellness Continuum**

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STRATEGY 2: ESTABLISH DESIGNATED COMMUNITY CENTERED WELLBEING HOMES (ALIGNMENT)

- 6. Behavioral Health Integration and Alignment with Healthcare, Public Health and Community Partners**
 - ✓ The Behavioral health clinician works directly with the primary care provider and other team members
 - ✓ Agencies in the community support individuals with serious mental illness by providing comprehensive behavioral health services, including referral to social services
 - ✓ Align strategies with Centennial Care

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STRATEGY 3: ESTABLISH STATEWIDE PATIENT CENTERED MEDICAL HOMES (PCMH)

- 1. Establish one certifying body for PCMH in the state**
- 2. Establish a technical assistance center to facilitate education, promote best practices, and train practitioners in PCMH**
- 3. Establish a technical assistance center for Tribal 638 clinics who wish to become FQHCs that is aligned with the state-wide center**
- 4. Develop a glide path open to practices seeking the PCMH status**
- 5. Align state PCMH certification with nationally vetted standards**
- 6. Assess opportunities with tribal leaders**

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STRATEGY 3: ESTABLISH MINIMUM PCMH STANDARD SET

Based on National Committee for Quality Assurance (NCQA) and Joint Commission (JC) Core Components; each Standard will contain multiple requirements.

Standards may include:

- 1. Patient-centered Access to Care**
- 2. Team-based Care**
- 3. Utilization of SBIRT (Screening, Brief Intervention, Referral to Treatment)**
- 4. Population Health Management**
- 5. Care Management and Support**
- 6. Care Coordination and Care Transition across entities**
- 7. Performance Measurement and Quality Improvement**
- 8. Systems Approach to Safety**
- 9. Electronic Health Records**

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STRATEGY 4: DEVELOP A PAYMENT MODEL TO SUPPORT THE MODEL DESIGN

- 1. Align the payment model with value-based approach**
 - **Develop pay for performance and bundled payments to providers for episodes of care**
 - **Explore shared savings model with a risk-sharing component**
 - **Utilize risk stratification to ensure patients receive the level of service they need in the optimal setting**
 - **Develop risk adjustment model to assure adequate payment for providers whose patients are sicker or require more intensive services**
 - **Consider tiered reimbursement models related to PMCH certification and incentives for wellbeing programs**
 - **Utilize procedural terminology (CPT) code (encounter) data to identify opportunities to improve care and reduce cost via the APCD**
 - **Develop models to reduce duplicate testing, medication errors, etc.**

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STRATEGY 4: DEVELOP A PAYMENT MODEL TO SUPPORT THE MODEL DESIGN

- 2. Explore opportunities to resource multi-disciplinary service provider teams to address social determinants, sustain healthy behaviors, and manage chronic disease**
 - For example: social services, CHW and EMS services, prevention and wellbeing programs, healers and alternative medicine
- 3. Explore financial incentives for providers to achieve national and state PCMH certification**
- 4. Assess and improve PCMH certification already in place**
- 5. Explore opportunities and benefits of payment models relevant to tribal health systems**

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STRATEGY 5: STANDARDIZE AND ALIGN PERFORMANCE METRICS

- 1. Develop metrics that support the CCWH with PCMH models**
- 2. Use a collaborative process that includes providers, payers, public health, and other stakeholders**
- 3. Base metrics on nationally vetted measures and state health level priorities**
- 4. Standardize outcomes-based performance metrics across model performance, quality, clinical, and population health, including:**
 - Overall health (NM injury, disease rates)
 - Race/ethnicity/sexual orientation (equity)
 - Behavioral health
 - Social determinants of health
 - Quality of life
 - Life span
 - Efficiency (e.g., reduce readmissions)

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STRATEGY 6: POLICIES AND REGULATIONS

Policies and Regulations to be Addressed:

1. Explore designation for CCWH, establishing a set of common standards (Accountable Community for Health), a long term goal
2. Explore Accountable Care Organization (ACO) feasibility for inclusion into the HSI Design
3. Develop New Mexico specific PCMH Certification Standards
4. Develop PCMH Technical Assistance Center with attention to tribal specific needs (costs and development)
5. Develop PCMH Quality Collaborative
6. Review behavioral health policies and regulations and assess alignment
7. Expand workforce recruitment and retention policies and regulations (J-1 Visa Program, Health Service Corps, Rural Provider Tax Credit)
8. Incentivize use of electronic health records (EHRs)

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STRATEGY 7: TRANSFORMING THE WORKFORCE

1. **Build a network of multi-disciplinary provider teams and services that integrates services across the CCWH system**
 - Enhance the patient experience – Community Health Workers/Community Health Representatives
 - Enhance primary care role in rural areas – Emergency Medical Service (EMS) Personnel
 - Integrate telehealth and mobile devices as tools to improve access to care and improve workforce competencies – For example: Infinity Telemedicine, Project ECHO
 - Help providers connect patients to basic resources – Use of approaches such as Health Leads, Pathways model
 - Develop a local *Grow Your Own* strategy, training all categories of health providers including CHWs, RNs, medical students and family medicine residents in rural and underserved areas.
2. **Expand Health Information Technology (HIT) resources to be incorporated into the work flow and increase training opportunities**

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STRATEGY 7: TRANSFORMING THE WORKFORCE

- 3. Provide education to providers in use of telehealth and mobile device technology**
- 4. Improve retention and recruitment of health care professionals**
 - Employ workforce “pipeline” strategies to recruit primary care physicians and other healthcare professionals (local high school to health profession, residency to workforce)
 - Improve access to “bridge” programs for nurses (CNA – LPN, LPN – RN, RN to Advanced Practice)
 - Improve incentives for families to enable practitioners to remain in New Mexico
 - Utilize Project Echo to expand flexibility of service options for practitioners
 - Expand use of J-1 Visa option to recruit non-U.S. practitioners in underserved areas of NM
- 5. Expand use of National Health Service Corps, volunteers, and retired healthcare professionals**
- 6. Explore tax credit and reimbursement options for behavioral health trainees**

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STRATEGY 8: PROMOTE CLINICAL AND PUBLIC HEALTH PRACTICE TRANSFORMATION

- 1. Assess**
- 2. Develop policies and plans**
 - **Clinical practice to align with person centered care model**
 - **Public health practice to align with emerging community centered wellbeing design**
- 3. Measure performance and improve model**

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STRATEGY 9: BUILD TECHNOLOGY CAPABILITIES

1. **Expand services to meet the needs of the new model**
 - Connecting disparate systems – who needs to be connected to whom for care coordination
 - Sharing of data for care coordination and transitions of care
 - Data analytics tools – enabling improved care and performance metrics
 - Remote access – telehealth, mobile health
 - Patient portal – secure online website that gives patients convenient 24-hour access to personal health information
2. **Establish policies for data exchange**
 - Who has access to what data for what purposes – providers, patients, payers, researchers, health assessment, evaluation
 - Patient consent for sharing of data
3. **Align data exchange capabilities with roll out of services**
4. **Tribal communications – Ensure communication with IHS, Tribal Programs, Urban Clinics and tribal leaders to promote care coordination/continuity of care through health information exchange**

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STRATEGY 9: BUILD TECHNOLOGY CAPABILITIES

5. **Increase usage of New Mexico Health Information Collaborative (NMHIC), Health Information Exchange (HIE)**
 - Use Direct Secure Messaging, HL7 methodologies
 - Issue alerts to other providers – Provider portal
 - Implement Continuity Care Documents between providers
 - Add public health data
 - Build marketing strategies to enroll Medicaid providers
6. **Increase usage of certified EHR systems**
 - Rural/Frontier Providers
 - Behavioral Health Providers
7. **Incorporate alternative health service delivery systems (Mobile, Telehealth)**
8. **Explore and assess system to inform design of an All Payer Claims Database (APCD); conduct cost benefit analysis (CCWH/PCMH)**
9. **Consider Tribal data sharing pilot project**

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STRATEGY 10: ROLL OUT OF THE MODEL

1. **Phase-in Roll Out over time**
 - Underserved populations
 - ✓ Address populations with health disparities
 - Quick win opportunities
 - Demand by high volume regions
2. **Establish a roll out model that adapts to unique community needs**
 - Urban, rural, tribal, border
 - Areas already on the path to PCMH
3. **Align tribal health system rollouts with non-tribal rollouts to ensure integration**

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STRATEGY 11: GROW INNOVATIVE STRATEGIES DEVELOPED THROUGH CENTENNIAL CARE

1. **Increased use of community health workers (CHWs)**
 - Care coordination
 - Health education and literacy
 - Linkages into the community
2. **Increased use of telehealth**
 - "Office" visits with specialists including behavioral health providers
3. **Expansion of Patient-Centered Medical Homes**
 - Ensuring a minimum of the population is being served by a PCMH and expanding this year after year
4. **Coordination with public health offices and other service providers**
5. **Strengthen the behavioral health system through integration within the overall health system**

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STRATEGY 12: FURTHER DEVELOPMENT

- 1. Health System Governance (HSI at state/local level)**
- 2. Financial Plan**
- 3. Financial and System Sustainability**
- 4. Ongoing Consumer and Community Engagement**
- 5. Evaluation and monitoring of HSI model**

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ROUNDTABLE CONVERSATION

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EXAMPLES OF ACCOUNTABLE COMMUNITIES FOR HEALTH

State of Washington

http://www.hca.wa.gov/hw/Pages/communities_of_health.aspx

Authority: Washington Health Care Authority

As of July 2015: Two Accountable Communities of Health (ACH)

- State retains ultimate responsibility for the procurement of Medicaid contractors and bears legal and financial responsibility, monitoring and oversight.
- MCOs are the risk-bearing entities; not the ACHs
- The purpose of each ACH is to convene the multiple sectors and communities to coordinate systems that influence health. This convening and coordinating role is not intended to duplicated or replace the functions carried out by ACH member organizations. The role of the ACH is to coordinate the alignment of functions and investments to address regional priorities that contribute to the Triple Aim.
- MCOs play a vital role supporting and directing delivery system improvements and whole person care. Each ACH will recognize MCOs as vital partners to be included on the governing board.

ACH Designation Criteria:

- Demonstration of operational governance structure
- Governing body membership reflects balanced, multi-sector engagement.
- Community engagement activities are underway and additional are being planned
- Established backbone functions to perform financial and administrative functions.
- Initial priority areas (service gaps and/or health priorities) and strengths identified as part of ongoing regional needs inventory and assessment development.
- Initial operating budget established.

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EXAMPLES OF ACCOUNTABLE COMMUNITIES FOR HEALTH

State of Vermont

http://healthcareinnovation.vermont.gov/sites/hcinnovation/files/Population_Health/VT%20ACH%20Opportunities%20and%20Recommendations.pdf

Authority: Department of Vermont Health Access, in collaboration with the Population Health Work Group and Vermont Health Care Innovation Project Leadership

As of July 2015: six Vermont communities potentially form the basis of an ACH (effort in Vermont is based upon community prevention)

Prevention Institute nine core elements of the ACH Model:

- Mission that provides an organizing framework for the work
- Multi-Sectoral Partnership
- Integrator Organization: the integrator carries the vision of the ACH; builds trusts among partners; convenes meetings; recruits new partners; shepherds planning, implementation, and improvement efforts of collaborative work, etc.
- Governance
- Data and Indicators
- Strategy and Implementation
- Community Member Engagement
- Communications
- Sustainable Financing

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THANK YOU!

GLOSSARY OF MEDICAID TERMS

Accountable Care Organization (ACO) – An ACO is a network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending. At the heart of each patient's care is a primary care physician. It is a type of payment and delivery reform model that ties provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

Actuarially Sound – The federal statutory standard to which capitation payments made by state Medicaid programs under risk contracts to managed care organizations (MCOs) are held.

Actuary – A business professional who analyzes the financial consequences of risk. Actuaries use mathematics, statistics and financial theory to study uncertain future events, especially those of concern to insurance and pension programs. They evaluate the likelihood of those events, design creative ways to reduce the likelihood and decrease the impact of adverse events that actually do occur.

Bundled Payments – A single payment that covers services delivered for an episode of care defined by a specified set of services delivered by designated providers in a specified health care setting over a specified period of time for a procedure or condition.

Capitation Payment – A payment made by a state Medicaid agency under a risk contract, generally to a managed care organization (MCO). The payment is made on a monthly basis at a fixed amount on behalf of each Medicaid beneficiary enrolled in the MCO.

Capitation Per Member Per Month (PMPM) – The average per-member-per-month amount in capitation payments HSD pays to MCOs to provide care for Medicaid enrollees. Calculated by dividing total capitation payments by total member months.

Carve Out – The term used informally to describe the exclusion of certain services to which Medicaid beneficiaries are entitled from a risk contract between a state Medicaid agency and an MCO.

Centers for Medicare and Medicaid Services (CMS) – The agency in the Department of Health and Human Services (DHHS) with responsibility for administering the Medicaid, Medicare, and State Children's Health Insurance programs at the federal level. CMS was formerly known as the Health Care Financing Administration (HCFA).

Dual Eligibles – An individual who is eligible both for Medicare and for full Medicaid coverage, including nursing home services and prescription drugs, as well as for payment of Medicare premiums, deductibles, and co-insurance.

Federal Financial Participation (FFP) – The technical term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs.

Federal Medical Assistance Percentage (FMAP) – The statutory term for the federal Medicaid matching rate. The portion of the Medicaid services or administration costs which are paid by the Federal government.

Federal Poverty Level (FPL) – The federal government's working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain categories of beneficiaries.

Federally Qualified Health Center (FQHC) – Health centers that have been approved by the government for a program to give low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, like preventive care. FQHCs include community health centers, tribal health clinics, migrant health

services, and health centers for the homeless.

Fee-For-Service – A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide.

Health Home – A health home is a Medicaid State Plan Option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions. Health home providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the “whole person” across the lifespan.

Home and Community-Based Services (HCBS) – The HCBS programs offer different choices to some people with Medicaid. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help the elderly and disabled, mentally retarded, developmentally disabled, and certain other disabled adults. These programs give quality and low-cost services.

Managed Care Organization (MCO) – Entities that serve Medicare or Medicaid beneficiaries through a network of employed or affiliated providers. They serve beneficiaries on a risk basis with a state agency to provide a specified package of benefits to enrollees in exchange for an actuarially sound monthly capitation payment. The term generally includes HMOs, PPOs, and Point of Service plans.

MCO Expenditure PMPM – The average per-member-per-month actual cost of care MCOs pay to medical providers. Calculated by dividing total MCO expenditures on medical services by total member months.

Medicaid – A joint federal and state program that helps with medical costs for some individuals and families with low incomes and limited resources. Although largely funded by the federal government, Medicaid is run by the state where coverage may vary.

Medical Loss Ratio – The Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement. MLR requires insurance companies spend at least 80 percent or 85 percent of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases. If they fail to meet these standards, the insurance companies will be required to provide a rebate to their customers starting in 2012. This is intended to limit the portion of premium dollars health insurers may spend on administration, marketing, and profits.

Medicare – The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Patient-Centered Medical Home – is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. It is a way of organizing primary care that emphasizes care coordination and communication.

Payment Reform – Payment methods that reflect or support provider performance, especially the quality and safety of care that providers deliver, and are designed to spur provider efficiency and reduce unnecessary spending.

Per-Member-Per-Month (PMPM) – Is an alternative payment scheme in which a provider organization is given a set amount of money each month to provide an agreed upon range of services for the patients enrolled in the program for the period of time covered by the agreement.

PMPM Capitation Rate –The per-member-per-month capitation rate agreed upon by HSD and the MCOs to pay for Medicaid recipient care. This rate is required to fall within a range set by HSD’s actuary and approved by CMS.

Section 1115 Waiver – Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as: expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible, providing services not typically covered by Medicaid, and using innovative service delivery systems that improve care, increase efficiency, and reduce costs. In general, section 1115 demonstrations are approved for a five-year period and can be renewed, typically for an additional three years. Demonstrations must be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the waiver.

State Plan Amendment (SPA) – A state that wishes to change its Medicaid eligibility criteria or its covered benefits or its provider reimbursement rates must amend its state Medicaid plan to reflect the proposed change. Similarly, states must conform their state plans to changes in federal Medicaid law. In either case, the state must submit a state plan amendment (SPA) to CMS for approval.

Sub-capitation – An arrangement that exists when an organization that is being paid under a capitated system contracts with other providers on a capitated basis, sharing a portion of the original capitated premium. It can be done under Carve Out, with the providers being paid on a PMPM basis.

Supplemental Security Income (SSI) – A federal entitlement program that provides cash assistance to low income aged, blind, and disabled individuals. Individuals receiving SSI benefits are eligible for Medicaid coverage in all states except “section 209(b)” states.

Temporary Assistance for Needy Families (TANF) – A block grant program that makes federal matching funds available to states for cash and other assistance to low income families with children. TANF was established by the 1996 welfare law that repealed its predecessor, the Aid to Families with Dependent Children (AFDC) program.

Waivers – Various statutory authorities under which the Secretary of DHHS may, upon the request of a state, allow the state to receive federal Medicaid matching funds for its expenditures even though it is no longer in compliance with certain requirements or limitations of the federal Medicaid statute. In the case of program waivers such as the 1915(c) waiver for home- and community-based services, states may receive federal matching funds for services for which federal matching funds are not otherwise available. In the case of demonstration waivers such as the section 1115 waivers, states may receive federal matching funds for covering certain categories of individuals for which federal matching funds are not otherwise available. Under Section 1915(b) waivers, states may restrict the choice of providers that Medicaid beneficiaries would otherwise have.

September 16, 2015 Health System Innovation Summit Registration List

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