



NEW MEXICO PRIMARY CARE PAYMENT REFORM

NEW MEXICO MEDICAL SOCIETY NOON ZOOM
MARCH 30, 2023

INVESTING FOR TOMORROW, DELIVERING TODAY.

BEFORE WE START...

On behalf of all colleagues at the Human Services Department, we humbly acknowledge we are on the unceded ancestral lands of the original peoples of the Pueblo, Apache, and Diné past, present, and future.

With gratitude we pay our respects to the land, the people and the communities that contribute to what today is known as the State of New Mexico.



Evening drive through Corrales, NM in October 2021.
By HSD Employee, Marisa Vigil

AGENDA

| Time | Agenda Item |
|-------|---|
| 12:00 | Land Acknowledgement, Welcome Remarks, and Overview of the Primary Care Council |
| 12:15 | Primary Care Payment Reform <ul style="list-style-type: none">a. Background on why New Mexico is pursuing payment reformb. Goals of the payment reform modelc. High-level overview of the payment reform and provider glidepath |
| 12:45 | Next Steps and Where to Find More Information |
| 12:55 | Closing Remarks |

MISSION

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

GOALS



We help NEW MEXICANS

1. Improve the value and range of services we provide to ensure that every qualified New Mexican receives timely and accurate benefits.



We communicate EFFECTIVELY

2. Create effective, transparent communication to enhance the public trust.



We make access EASIER

3. Successfully implement technology to give customers and staff the best and most convenient access to services and information.

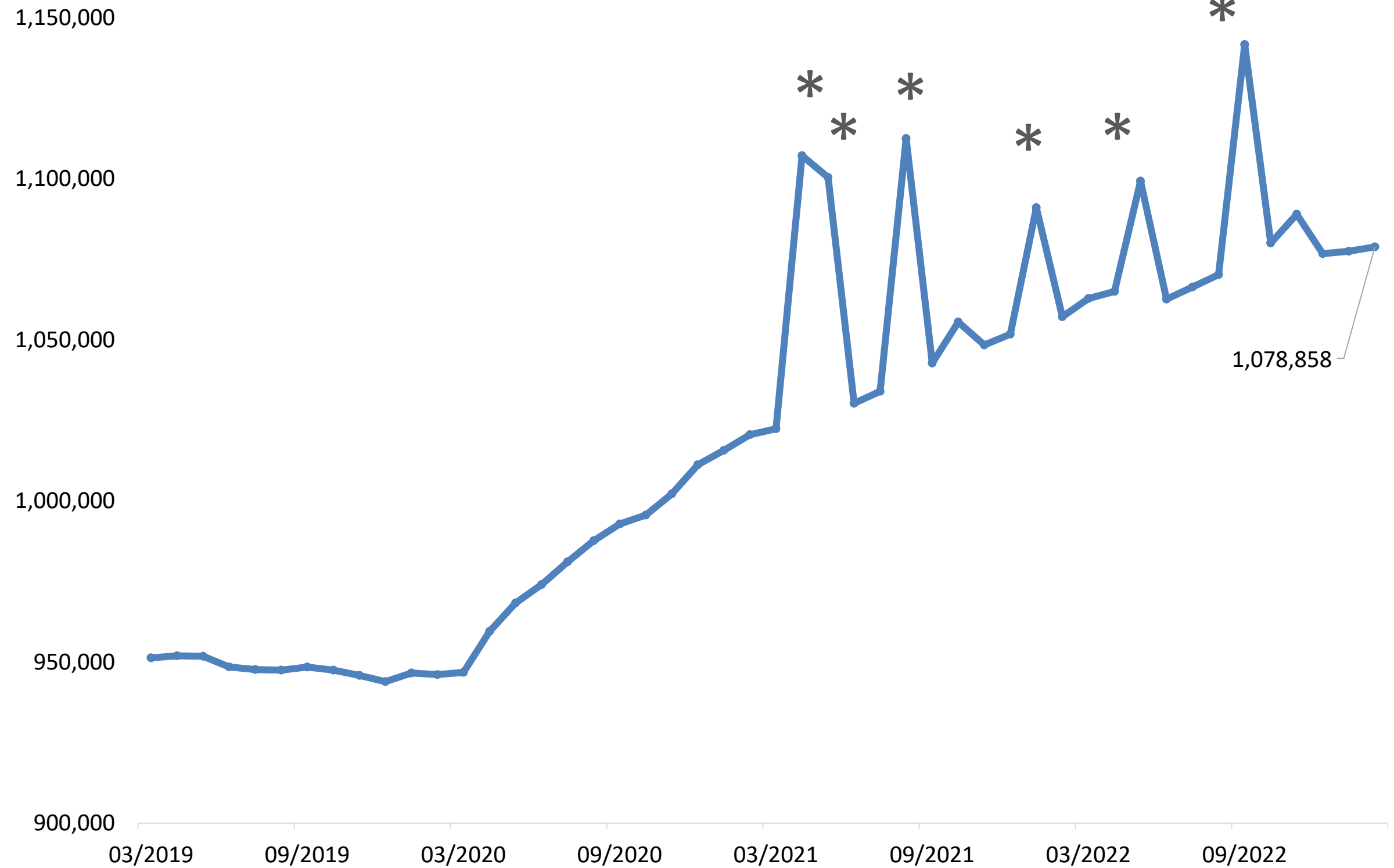


We support EACH OTHER

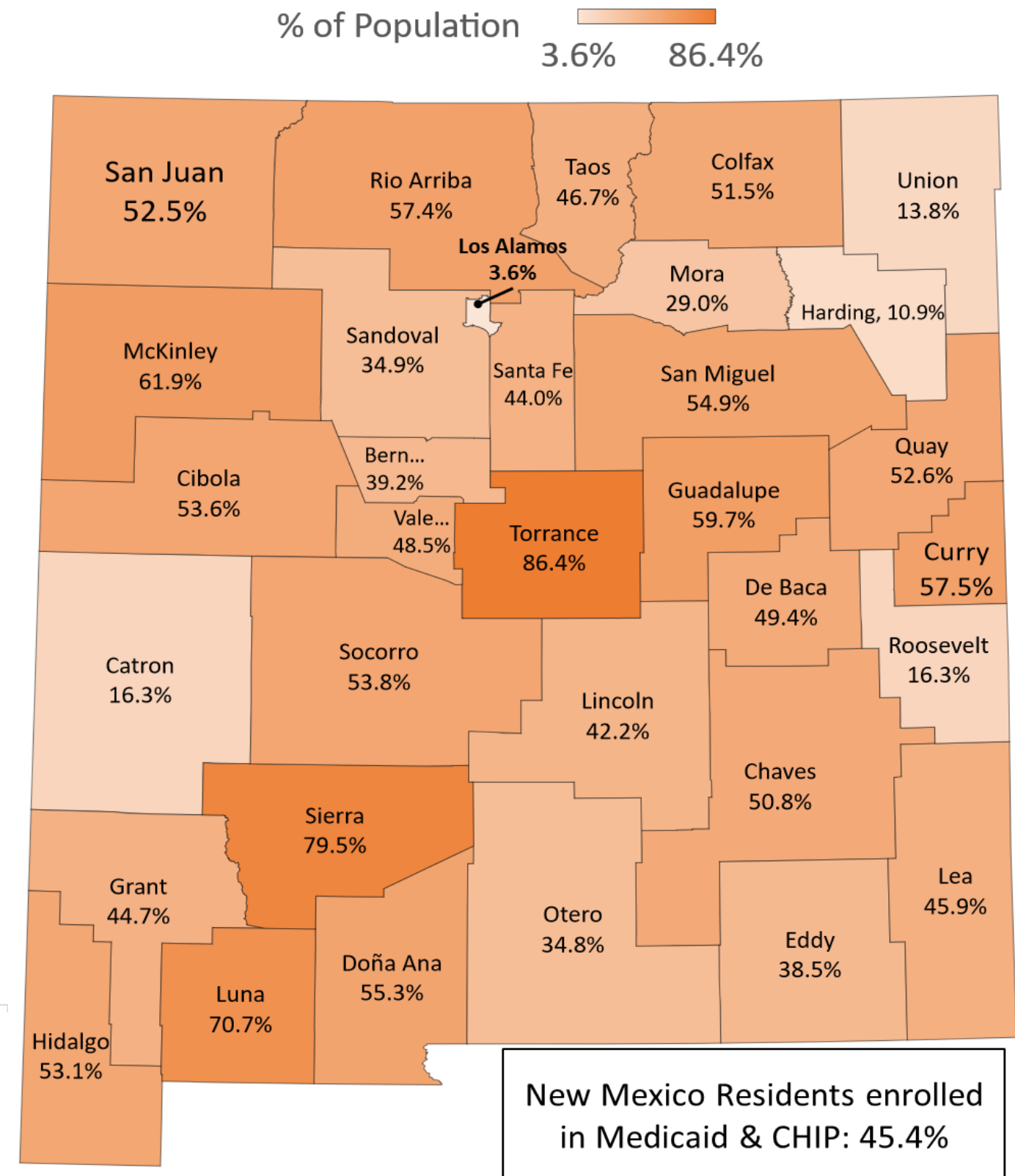
4. Promote an environment of mutual respect, trust and open communication to grow and reach our professional goals.

HSD SERVES 51% OF NEW MEXICANS

Unique HSD Customers, March 2023



Medicaid & CHIP Recipients as a Percentage of Population by County, June 2022



*Months with a Pandemic EBT Payment

MISSION

Revolutionize primary care into InterProfessional, sustainable teams delivering high-quality, accessible, equitable health care across New Mexico through partnerships with patients, families, and communities.

VISION

By 2026, New Mexico will exemplify same-day access to high-quality, equitable primary care for all persons, families, and communities.

GOALS

Health Equity



Develop and drive investments in health equity to improve the health of New Mexicans.

Health Technology



Develop and drive health information technology improvements and investments that make high quality primary care seamless and easy for Primary Care Interprofessional Teams, patients, families, and communities.



Payment Strategies

Develop and make recommendations regarding sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.



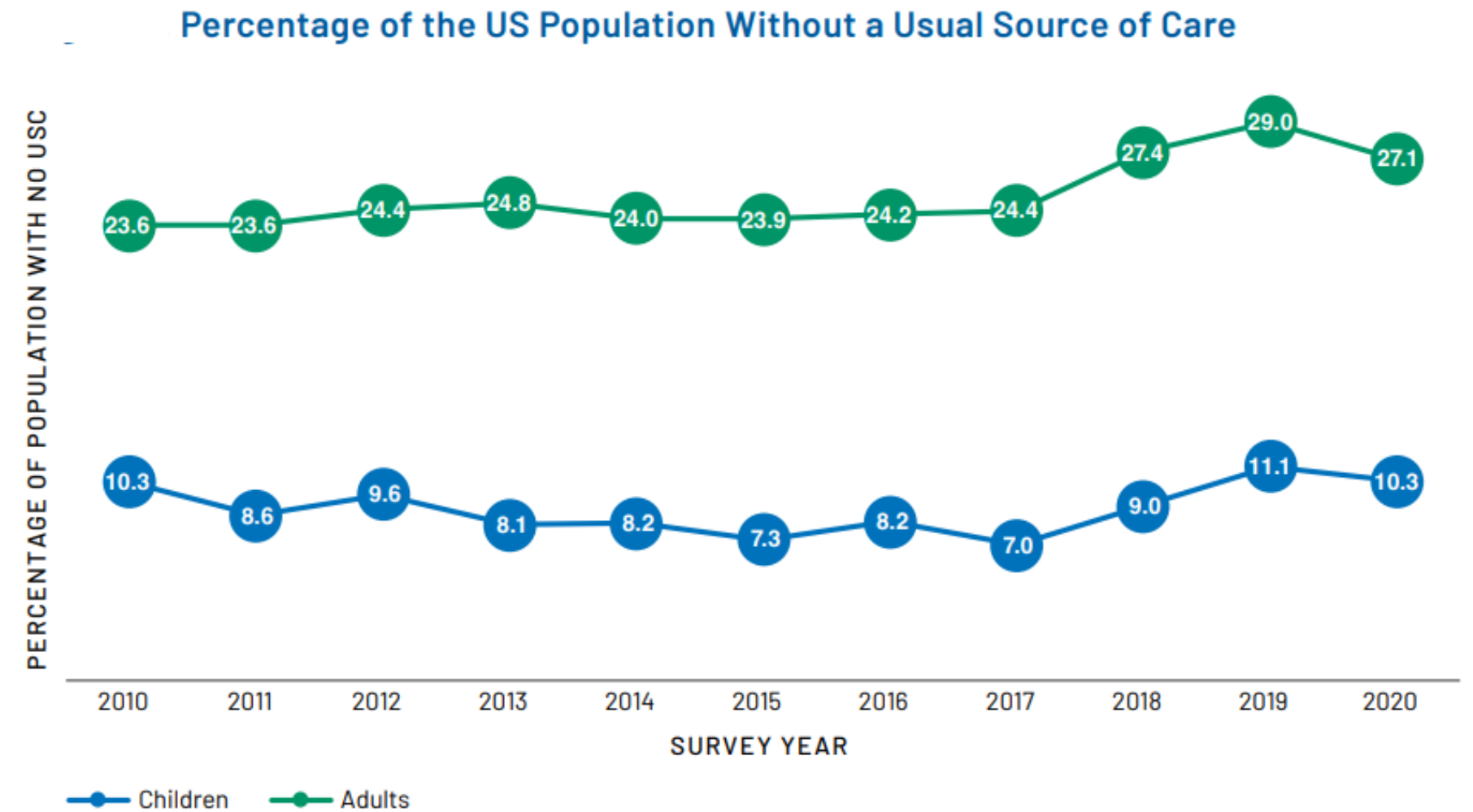
Workforce Sustainability

Create a sustainable workforce, financial model, and budget to support our mission and secure necessary state and federal funding.

WHY WE NEED CHANGE

Accessible, equitable, and high-quality primary care is foundational to an effective healthcare system.

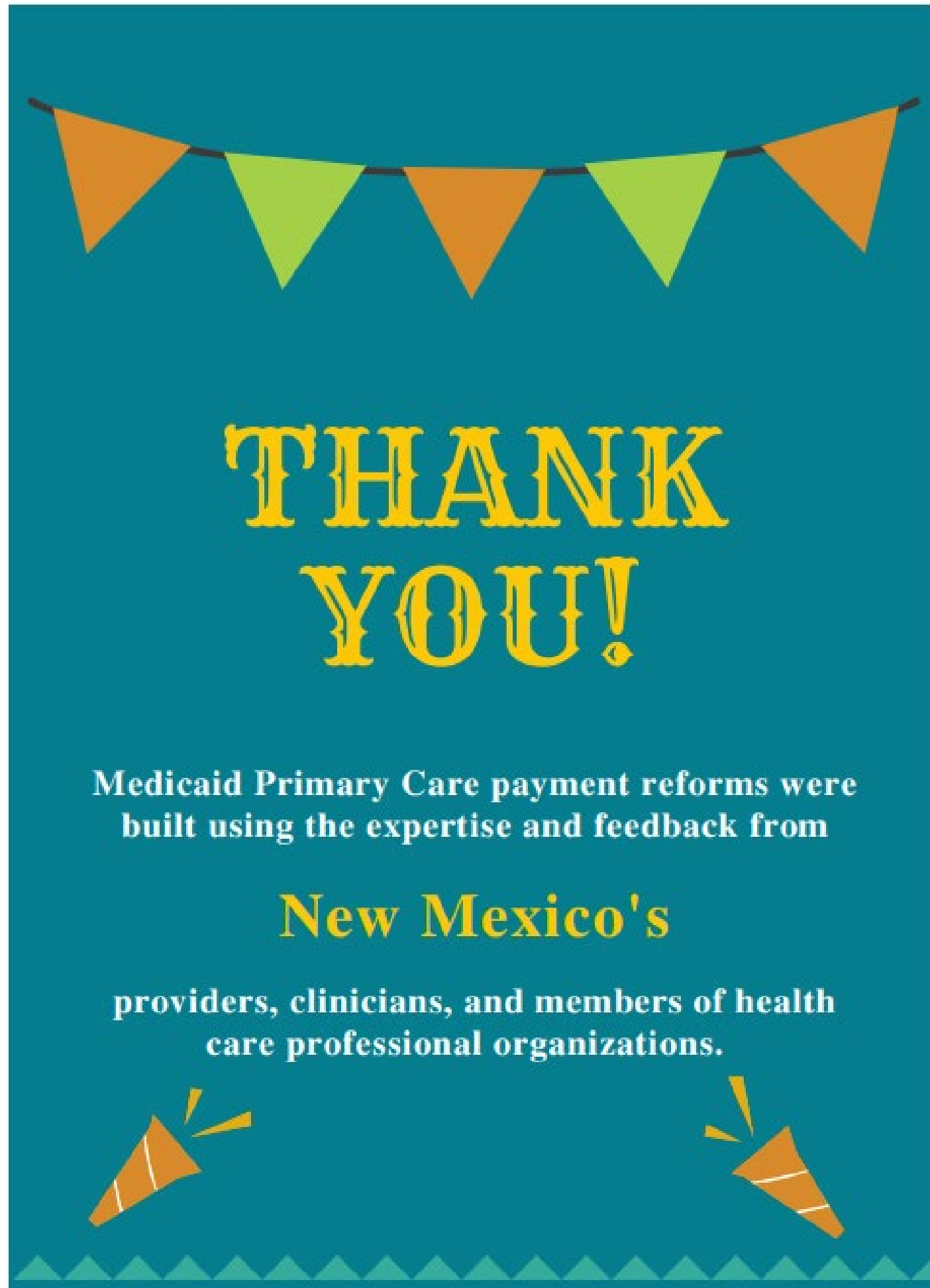
- The COVID-19 crisis brought to the forefront and exacerbated shortcomings in the current primary care system.
- Payment reforms will be transformative for primary care clinics, providers and clinicians:
 - Increased compensation for primary care clinicians and practices
 - New models retain current workforce and attract new team members
 - Increased access to primary care services for patients
 - Sustainable health care costs
 - Lowered clinician burnout



Data Source: Analyses of Medical Expenditure Panel Survey (MEPS) Data 2010-2020.

Notes: Usual source of care (USC) ascertained whether there is a particular doctor's office, clinic, health center, or other places that the individual usually goes when sick or in need of health advice. No usual source of care includes those who reported no usual source of care and those who indicated the emergency department as their USC.

Source: The Health of US Primary Care: A Baseline Scorecard Tracking Support for High Quality Primary Care https://www.milbank.org/wp-content/uploads/2023/02/Milbank-Baseline-Scorecard_final_V2.pdf



A MODEL DESIGNED BY AND FOR NEW MEXICO

- The Primary Care Council was established because the State listened to providers and clinicians who demanded an urgent response to the crises in primary care. The current work of the Council is in response to that need.
- HSD is complementing the work of the PCC through a partnership with Medicare:
 - Medicare payment reforms, “Making Care Primary”
 - Building interprofessional teams
 - Aligning payment models across payers

HOW DID WE GET HERE?

The proposed model for payment reform has been built to support providers and reflects what we've heard from...



We are working to develop a model that is specific to New Mexico's unique needs and to implement payment reform at a pace that works for providers.

During the roll-out and first few years of payment model reforms, HSD will continue to solicit feedback for future improvements. The model is built to grow as providers, clinicians, and the State have access to more knowledge, ability, and resources.

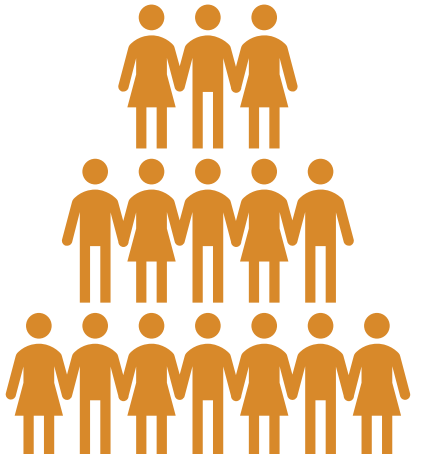
PAYMENT REFORM KEY TERMS

- **Fee-for-service:** A method in which health care providers, clinics, or hospitals are paid for each service provided. Examples of services include tests and office visits.¹
- **Capitation:** A method in which health care providers, clinics, or hospitals are paid a fixed amount of money per patient in advance of services being delivered.² The amount paid depends on several factors, such as the type of services provided and historical utilization of services.
- **Shared savings:** A strategy that incentivized health care providers to provide higher quality care by offering them a percentage of savings generated as a result of their patient care (“upside risk”).³ In some arrangements, providers also share in potential losses (“downside risk”).
- **Integrated care:** A model in which healthcare services are managed and delivered so patients receive a continuum of preventative, diagnostic, and treatment services coordinated across various specialties and levels of care.⁴ It is characterized by a high degree of communication and collaboration among healthcare professionals.⁵
- **Quality metrics:** Measures that help payers and other stakeholders quantify healthcare processes, outcomes, patient experience, and systems that are associated with the ability to provide high-quality healthcare.⁶



MEET JACKIE, A PRIMARY CARE CLINICIAN

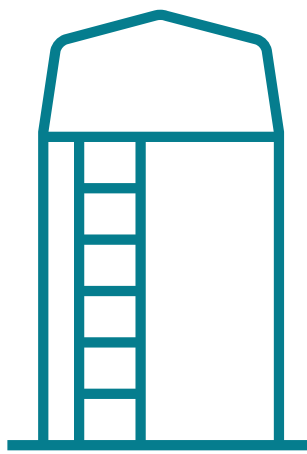
Under the current primary care payment model, a typical day for Jackie involves...



A focus on volume, seeing 20-25 patients per day



Reimbursement based on linking patient care to payment codes, not whole-person, high-quality care



Siloed work and no close collaboration with an interdisciplinary team to meet all of a patient's needs



Arduous documentation, including "pajama time"

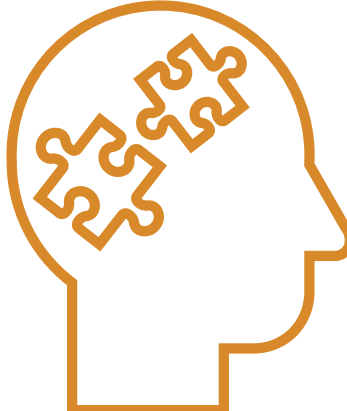


Fee-for-service reimbursement is retroactive and prior authorizations are a barrier to care



THE NEW MEDICAID PRIMARY CARE PAYMENT MODEL WILL IMPROVE JACKIE'S WORK AND HER PATIENT'S HEALTH

Under the primary care payment reform, Jackie's typical day transforms to involve...



A focus on quality, with volume of patients adjusted to accommodate complexity of patient need



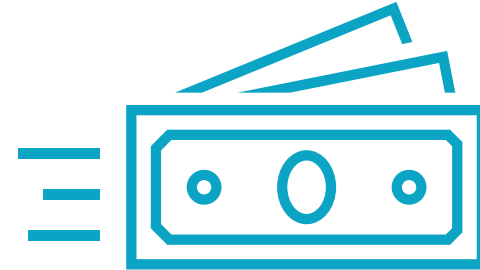
Population-health driven reimbursement that rewards high quality care and is data driven



Ongoing collaborative care by inter-professional teams to treat patients holistically and share best practices



Reduced administrative burden and time shifted to patient care



Payments are paid prospectively, and prior authorizations are less intrusive under capitation



BEFORE WE PROCEED, THREE IMPORTANT THINGS TO KEEP IN MIND

1

Primary care providers will continue delivering care as they are now. *In Year 0, nothing additional is expected in terms of how primary care is delivered.*

2

Primary care providers will be expected to report on baseline measures (under Tier 1). Supports needed to assist with this reporting will be identified and provided.

3

As a function of participating in the payment model, providers will receive an incentive payment to further invest in infrastructure, staffing, building additional capacity, etc. The incentive payment amount is yet to be determined.

MEDICAID PRIMARY CARE PAYMENT REFORM FRAMEWORK



**Tier 3: Capitation w/
Shared Savings**

HCP-LAN Category 4-B + 3-B



- Provider-specific PCP capitation payments with potential provider/MCO shared savings (non-PCP) based on cost and quality benchmarks
- Metrics reinforce equity, quality, and outcomes
- Providers will have upside and downside risk
- Providers responsible for all operational functions
- Initially accessible to integrated delivery systems

**Tier 2: Collaborative
Partnerships**

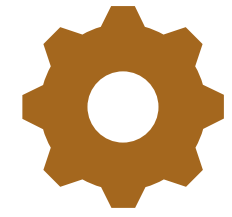
HCP-LAN Category 4-B



- Provider-specific PCP capitation payments with reconciliation and quality metric benchmarking
- Providers are “met where they are” and supported by partnerships among providers/MCOs/administrative entities
- “Menu” approach to payment model participation allowing appropriate calibration of risk and operational expectations
- Initially, medium-to-large providers with established relationships

**Tier 1: Integrated Fee-For-
Service Payment Reform**

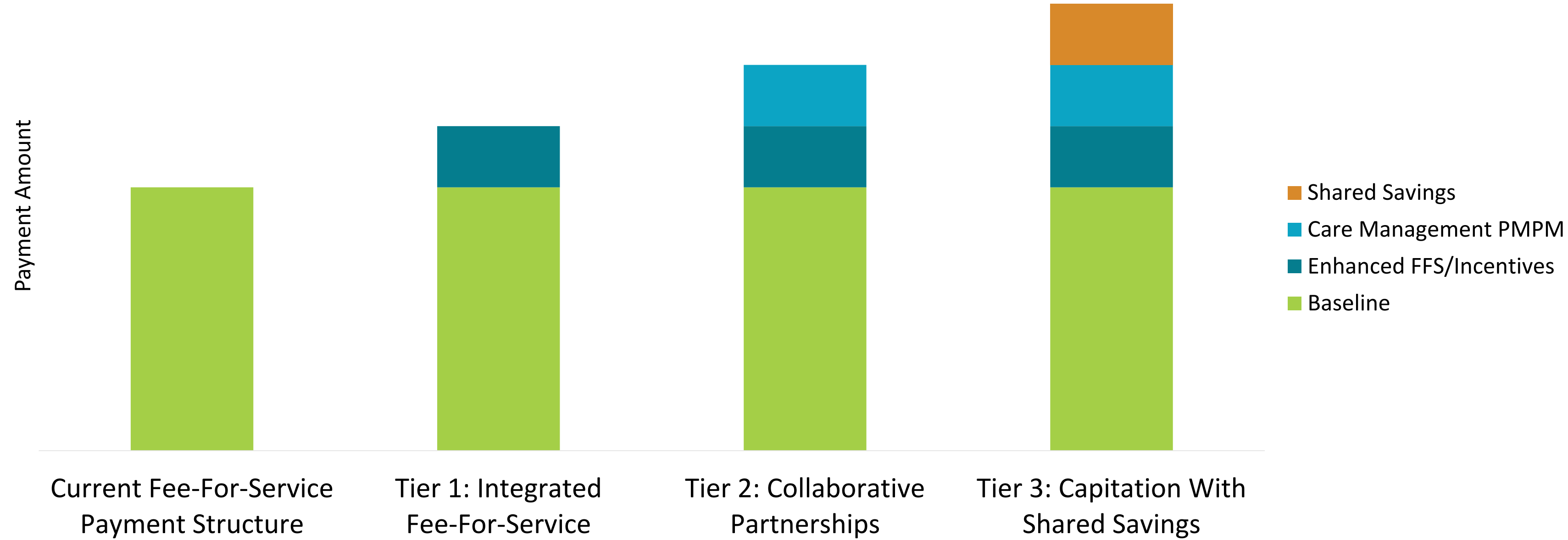
HCP-LAN Category 2-C



- Assessment of existing reimbursement and quality/incentive programs to understand breadth of existing supports
- Potential, targeted initiatives to ensure all providers are supported until formal payment model participation
- Allows system-wide participation including:
 - Small-scale and rural providers, Indian Health Services, and providers adverse to risk

THE NEW MEDICAID PRIMARY CARE PAYMENT MODEL OFFERS AN OPPORTUNITY FOR ADDITIONAL INVESTMENT

Primary Care Payment Reform Payment Tier Structure



**Chart is for illustrative purposes only and does not indicate actual dollar amounts or percentages.

PAYMENT REFORM AND INCENTIVIZING INTEGRATION

Tier 3: Capitation with Shared Savings

High Integration

- High levels of collaboration between primary care, specialists, and behavioral health providers. May incorporate a team-based approach to care. Some issues, such as a lack of an integrated medical record, may exist.
- Full collaboration between provider groups allows system cultures to merge into a single transformed practice. The operation is viewed as a single system treating the whole person and is applied to all patients.
- Payment covers care delivered by broad professional services providers (e.g., PCP, specialist, dental, vision, and behavioral health providers). Payment measures/rewards advanced clinical measures and all baseline measures.

Tier 2: Collaborative Partnerships

Medium Integration

- Closer collaboration between primary care, specialists, and behavioral health providers (e.g., may work within separate systems but in a shared facility). May include an embedded Care Navigator. Complex cases often drive consultation.
- Proximity supports, at minimum, occasional face-to-face meetings. Communication is improved and more regular.
- Payment covers care delivered by PCPs and limited specialists. Payment measures/rewards intermediate clinical measures.

Tier 1: Integrated Fee-For-Service Payment Reform

No to Low Integration

- Primary care, specialists, and behavioral health providers work in separate facilities and have separate systems.
- Providers rarely communicate about cases but do engage in periodic communication about shared patients (usually high-risk) and view each other as resources.
- Payment is made to the provider/practice exclusively. Payment covers care services for a single visit.

PAYMENT MODEL QUALITY FRAMEWORK

The primary care payment reform is intended to reward primary care providers for providing high quality care to their patients. Here's a high-level overview of the quality framework:

- Providers and MCOs will establish their own arrangements for data collection and reporting
- Metrics are a mix of clinical process and outcome measures, access to care standards, and patient-centered metrics
 - Metric selection is influenced by areas where New Mexico is low performing relative to national benchmarks
- The quality framework develops over time:
 - Initial focus on reporting, access to care, and patient-centered metrics
 - Additional metrics will be added each year
 - Metrics will be adjusted over time depending on performance, but no metrics will be removed for the first 1-2 years
- The same metrics will be utilized across all three tiers, but intensity of performance will increase at higher tiers
- The quality framework guides financial reward to providers and supports monitoring for public reporting on payment model progress

NEXT STEPS AND WHERE TO FIND MORE INFORMATION

- HSD will host webinars to support provider readiness beginning in May and throughout 2023 starting with following topics:
 1. Determining financial and operational readiness for payment reform
 2. Data collection, analysis, and reporting capabilities
 3. Transforming care delivery processes to align with value-based care
 - + Will be supplemented by a provider readiness checklist and office hours
- HSD will continue socializing the model at virtual and in-person conferences and other events
- To learn more and join our contact list for regular updates, visit:
<https://www.hsd.state.nm.us/primary-care-council/>
- Elisa Wrede, Primary Care Project Manager, HSD elisa.wrede@hsd.nm.gov



HUMAN
SERVICES
DEPARTMENT



CLOSING REMARKS

INVESTING FOR TOMORROW, DELIVERING TODAY.