HUMAN SERVICES DEPARTMENT

New Mexico Primary Care Payment Reform
Frequently Asked Questions

These responses to frequently asked questions about the Medicaid Primary Care Payment Model will continue to be updated as new information is available.

Q. Why is New Mexico changing how primary care providers are paid?

Research has found that accessible, equitable, and high-quality primary care is foundational to an effective healthcare system. However, the current fee-for-service (FFS) reimbursement system for primary care providers does not reward or offer incentives for primary care; in fact, the FFS system generally creates disincentives for primary care. Therefore, we (the Human Services Department [HSD] and Primary Care Council [PCC], with input from other stakeholders) are developing and will implement a new approach to paying for primary care services that will offer appropriate incentives for enhancing the role of primary care in the healthcare system and improving the quality and efficiency of care.

Q. What are New Mexico's goals for reforming payment for primary care?

We intend to transform and revolutionize primary care payments in New Mexico to support primary care providers and benefit the patients they serve. The new Medicaid Primary Care Payment Model is designed to increase compensation for primary care clinicians and practices, to help these providers retain their current workforce and attract new team members, to improve access to primary care services for patients, to increase health equity, to manage healthcare costs carefully to ensure that the system is sustainable, and to enable clinicians to devote the necessary time to their patients and thereby increase their job satisfaction and reduce burnout.

Q. These goals sound wonderful, but as we know, the devil is in the details. How will you address the following concerns from stakeholders regarding changing payment for primary care?

- How will individual clinicians and small practices succeed under the new payment model?
    - The Medicaid Primary Care Payment Model is designed so there are multiple ways clinicians can participate and ultimately succeed, including supporting investments in a team-based approach to care and the data systems necessary to track and report performance and collaborate with other clinical organizations.
- Will the new payment model address health equity and patient experience of care?
    - The quality measures integrated into the payment model will include actionable performance measures that address health equity and patient-centered care.
- Won't this add to doctors' administrative burden?
    - We are very sensitive to this concern, and as we implement the payment model, we will strive to minimize the administrative burden for primary care clinicians.

Q. How will this payment reform benefit providers, patients, and the people of New Mexico?

For the people of New Mexico, we are creating a primary care system that will maintain access to care in urban, rural, and frontier communities and be sustainable in the future.

For patients, we will ensure a primary care delivery system that offers equitable care, treats the whole person's needs, and integrates physical health with behavioral health needs.

For primary care providers, the payment model will enable them to spend sufficient time with their patients rather than having to see as many patients as they can within their day and having to bring work home at night; and will support physician-led teams where all staff contribute at the top of their licenses and collaborate with other clinicians across the continuum of care.

Q. How will this new Medicaid Primary Care Payment Model reimbursement system work?

We are designing a three-tiered framework that will enable clinicians to participate at a level appropriate for their capabilities and tolerance for financial risk. The levels are Tier 1: Integrated FFS Payment Reform (equivalent to Health Care Payment Learning and Action Network (LAN) Framework level 2c); Tier 2: Collaborative Partnerships (equivalent to LAN 4b); and Tier 3: Capitation with Shared Savings (equivalent to LAN 3b and 4b). The payment reform approach will be designed to gradually increase performance expectations and requirements over time to allow participating providers to develop the necessary processes, systems, and innovations to succeed.

Q. Is this initiative just about cutting costs?

No, the aim of the Medicaid Primary Care Payment Model is to improve quality of care in the New Mexico primary care delivery system. Quality of care is an essential component of the payment reform. The quality measurement structure will include nationally validated clinical process and outcome measures; reporting requirements; and access to care standards, person-centered measures, and health equity measures that are appropriate for New Mexico. The design is built around a glide path to improvement, with performance expectations tied to level of payment. In addition, initially, we will focus on the most impactful and relevant measures and then expand the requirements over time.

Q. What support will be offered to primary care providers (PCPs) to help them make the transition?

We will provide webinars, in-person training sessions, office hours, and additional learning opportunities and technical assistance going forward. The State is also exploring various grant programs and avenues of financial assistance to support providers in their efforts to establish the systems and processes to succeed in the Medicaid Primary Care Payment Model. The payment reform will also leverage existing supports that facilitate data sharing, such as New Mexico's health information exchange (SYNCRONYS).

Q. Many "integrated" PCPs are the ones who are currently employed by a hospital, which is far more expensive than physician fee schedule practices. Why are you structuring this to further advantage the employers of physicians? There is data that small independent practices do better at keeping people out of the hospital.

The payment reform is not designed to advantage integrated PCPs over other PCPs. While it is true that integrated PCPs may be able to operate at Tier 3 of the Medicaid Primary Care Payment Model sooner in the implementation timeline, integrated systems are not a requirement and integrated PCPs will have the same quality requirements, performance expectations, and shared savings opportunities. To the extent small independent practices can avoid hospitalizations more effectively, they will be able to

participate in and benefit from shared savings arrangements and invest these savings to continually improve their performance.

Q. Will there be any effort made for other insurers (private and Medicare) to adopt similar payment reforms in New Mexico? How will PCPs juggle still having a large patient population in the traditional FFS world and joining this program?

HSD is considering a multi-payer approach and will work with payers, providers, and other stakeholders to align performance measures to the extent feasible. This multi-payer alignment is intended to create sufficient volume for practice transformation and minimize provider burden by aligning performance measures.

Q. How will a baseline be determined in the "shared savings" model and what factors will influence that figure?

The baseline will likely be developed by managed care organizations (MCOs) with guidance from the State or the State's contracted actuarial firm. The intent is that the baseline will be a form of risk-adjusted historical data, modeled to be consistent with the level of need typically displayed by the population and adjusted for sample size credibility when necessary. It will also be projected forward to account for any programmatic changes that have occurred since the historical data period, such as general increases or decreases in hospital/ED utilization. We will assess the baseline formula via data analysis and provider input and make annual adjustments accordingly.

Q. New Mexico already has a shortage of primary care physicians. Patients already have to wait 4 to 6 months for an appointment in some areas of the state. Decreasing the volume of patients seen by a PCP will further increase the wait times for appointments. This increases the need for more PCPs.

The Medicaid Primary Care Payment Model is intended to help with provider supports and retention to address the current workforce shortage. We also hope to shift services away from physicians to licensed practical nurses (LPNs), registered nurses (RNs), and community health workers/representatives (CHWs/CHRs) as clinically appropriate. This approach is intended to address access to care concerns while not reducing payments to PCPs. In addition, incentives for proactive preventive treatment should reduce the level of patient acuity and therefore the need for ED visits and hospitalizations, thereby improving patient health and lowering stresses on the healthcare system. Further, a payment structure that encourages spending more time with individual patients will enable more holistic care, is intended to be more gratifying for clinicians, and should increase job satisfaction and therefore retention.

Q. With our ACO organization, there's one health plan that won't participate in value-based care. Am I to understand that under this model they will need to do value-based care?

The Medicaid Primary Care Payment Model will be a requirement for MCOs to deliver and operationalize.

Q. For primary care providers employed by hospital-based systems, how will the Medicaid program or contracted MCOs assure that increased FFS payments in House Bill 2 will pass through to the provider and not be scraped off by the system?

HSD is dedicated to ensuring rate increases in House Bill 2 are passed directly to providers and clinicians. Safeguards and tracking systems are being put in place.

Q. How will the model account/adjust for transient patients?

Transient patients present challenges for attribution logic and capitation payments but are still able to be included in the Medicaid Primary Care Payment Model. The model treats them like other high-mobility populations and incorporates payment adjustments that allow for capitation rates to be right-sized for any movement by patients to non-attributed providers. Reconciliation payments can be made for services provided by non-attributed providers to ensure payment is directed properly for the care provided. In this way, attributed providers can benefit from any consistent care delivered to transient patients while non-attributed providers are not penalized for the mobility of patients with a high propensity to see other providers.

Q. How can practices, especially those in very rural areas, establish needed partnerships? There aren't sufficient dental practices, behavioral health providers, or pharmacies in rural areas. Will PCPs be penalized for not meeting the state's expectations in this regard?

Partnerships among provider types can be established as practical for the primary care physician. The Medicaid Primary Care Payment Model is designed with flexibility, allowing a PCP to bundle payments for services where there is an ability to establish partnerships. In Tiers 2 and 3 of the payment model, PCPs can accept capitation for (1) only the services they directly provide or (2) for their directly delivered services plus services that a PCP can influence (such as specialty care, behavioral health, or dental). We understand not all practices will be able to pay other providers and process claims, so this is not a requirement for participation but rather an opportunity for enhanced alignment for willing and able providers. To the extent a PCP is only able to receive capitation for their own directly provided services, we anticipate specialists and other providers will be reimbursed largely as they are currently and there will be no penalties for the PCP.

Q. Can the quality measures be shared so that PCPs can provide input?

The quality measures are still being developed and HSD is working with stakeholders – including primary care clinicians – to get input on the proposed measures, so that we develop and implement a measure set that is feasible for clinicians and meets the state's goals for performance and quality improvement.

Q. What are the risks involved with this new model, such as in Tier 3 as we move away from the high volumes to more quality?

As the Medicaid Primary Care Payment Model is expanded and providers participate at Tier 3, there can be downside risk to providers if utilization levels increase over the previous baseline. This is particularly relevant in shared facility risk scenarios, where a provider can benefit for reductions in ED utilization among their attributed population but may also be at risk for increases in ED utilization. We will monitor providers' risk and reimbursement and consider adjusting the payment model as needed.