Medicaid Value Based Care in New Mexico:

An Opportunity for Family Medicine

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Casa de Salud

Context & vision: Casa de Salud

At Casa de Salud, care is rooted in dignity, trust, creativity, cultural humility, and mutual respect. We see healthcare from a lens that understands histories of inequalities, oppressions, and structural forces. We see the strengths of our community members, as well as the cultural richness that exists around us. It is with this historical analysis and appreciation for the power within our community that we build towards collective wellness and liberation. **We situate ourselves in the community as a change agent, developing models for advocacy for patients and organizing for health rights.**

Iora Health

- Joe, a patient with end stage kidney disease, on dialysis
- Maria, a patient with type 2 diabetes
- Sonya, an elderly woman with several falls

Iora Health

- Culinary Extra Clinic - serving members of the Culinary Workers Union with chronic medical issues.

- How we staffed up - 3 health coaches per one doc

- Results - 40-50% reductions in hospital visits and ER visits, increased family and patient happiness, improved quality of life

NEW MEXICO PRIMARY CARE COUNCIL

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.

Payment Strategies

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

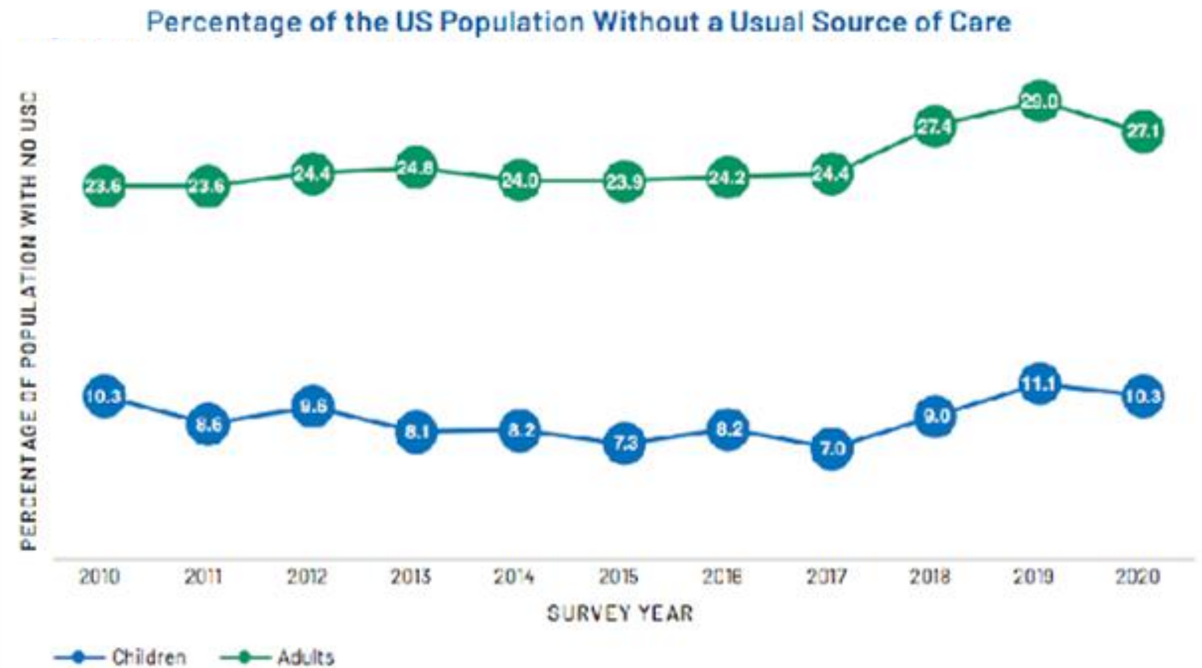
Workforce Sustainability

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



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

HEALTH CARE AUTHORITY

Investing for tomorrow, delivering today.

HOW DID WE GET HERE?

Payment reform is a complex process and it's critical to proceed thoughtfully, intentionally work to mitigate unintended consequences, and center the model on input from primary care stakeholders.

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

This process will take time! 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.

WHY MOVE TO VALUE-BASED PAYMENT?

Re-align the incentives of health reimbursement – move from payment for volume-based care to care that is rewarded for increasing quality and efficiency

Emphasize the importance of primary care in the delivery system

Offer primary care providers flexibility to address health equity and social determinants of health/health-related social needs

Enable patient-centered care

Deliver care at the right time, in the right place, and at the right level of service

HEALTHCARE PAYMENT LEARNING & ACTION NETWORK PRINCIPLES FOR PRIMARY CARE PAYMENT MODELS

Support primary care and minimize disparities

Promote health of patient populations

Enhance collaboration

Measures support whole-person care

Integration with behavioral health, link to community resources

Patients are partners in care delivery

Payers and primary care teams collaborate

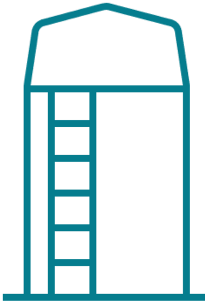
Source: http://hcp-lan.org/workproducts/pcpm-factsheet-final.pdf

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 inter-disciplinary 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 PATIENTS' HEALTH

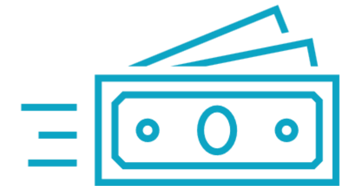
Under the primary care payment reform, Jackie's typical day transforms to involve…

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

MEDICAID PRIMARY CARE PAYMENT REFORM FRAMEWORK

Tier 3: Capitation w/ Shared Savings
HCP-LAN Category 4-B + 3-B

- Fully functional capitation arrangement, integrating more services & recognizing PCPs' impact on services not directly provided by them (e.g., bundled payments, shared savings)
- Quality metrics reinforce equity, quality, and outcomes
- Providers may have upside and downside risk
- May initially be best suited for integrated delivery systems

Tier 2: Collaborative Partnerships
HCP-LAN Category 4-B

- Providers are supported by partnership & met where they are
- Entry point into capitation; provider & MCOs establish what type of capitation makes sense for the provider (e.g., care management PMPM or direct service payment on a PMPM basis).
- May initially be best suited for medium-to-large providers with established relationships

Tier 1: Enhanced Reimbursement and Quality Rewards
HCP-LAN Category 2-C

- Two new funding sources: Enhanced fee-for-service tied to provision of services & incentive payments (e.g., for quality metrics, submitting data, continuation of current services)
- Allows immediate system-wide participation including:
  - Small-scale and rural providers, Indian Health Services, and other providers not ready for Tier 2 or 3

Detach payment from provision of services = increased flexibility

HEALTH CARE AUTHORITY

Investing for tomorrow, delivering today.

PAYMENT REFORM ROADMAP

2021
The Primary Care Council was established and identified payment strategies as a key goal.

2022
The PCC developed a vision for payment reform, HCA conducted listening sessions, and program development began.

2023
HCA ramped up provider supports to improve readiness. The payment program continued to be refined based on stakeholder input.

2024
PCPR VBP Program launched Summer 2024. All registered practices are participating in Tier 1 and eligible for a quality incentive payment.

2026
Tiers 2 and 3 of the PCPR VBP Program launch, along with additional quality measures.

2027
Additional quality measures are added and the Program becomes a true value-based payment program. Final set of quality measures are added in 2028.

PCPR VBP Program Quality Measures

DOMAIN	Group 1 July 1, 2024	Group 2 January 1, 2026 (reported only, not tied to payment)	Group 3 January 1, 2027	Group 4 January 1, 2028
REPORTING STANDARDS	Encounter Acceptance Rate (EAR)			
	Encounter Completion Rate (ECR)			
ACCESS TO CARE	Third Next Available Appointment (TNAA)			
BEHAVIORAL HEALTH	SBIRT Behavioral Health Structural Measure (2024) → SBIRT Measure			
		Follow-Up After ED Visit - Substance Use		
		Follow-Up After ED Visit - Mental Illness		
PATIENT EXPERIENCE	Patient Experience of Care Structural Measure (2024) → Patient Experience of Care Measure			
WOMEN'S HEALTH		Breast Cancer Screening		
		Cervical Cancer Screening		
		Prenatal/Postpartum Care		
CHILD HEALTH		Lead Screening in Children		
			Child and Adolescent Well-Care Visits	
				Immunizations for Adolescents
ADULT HEALTH			Statin Therapy for Cardiovascular Disease	
				Controlling High Blood Pressure
				Comprehensive Diabetes Care

Note: Quality measures and implementation order for Groups 2, 3, and 4 may shift.

For more information and to join our contact list for updates, visit
https://www.hca.nm.gov/primary-care-council/primary-care-payment-reform/
or scan the QR code to the right.

INVESTING FOR TOMORROW, DELIVERING TODAY.

New Mexico Primary Care Community Hub

Improving healthcare through dynamic engagement of health workers across the state

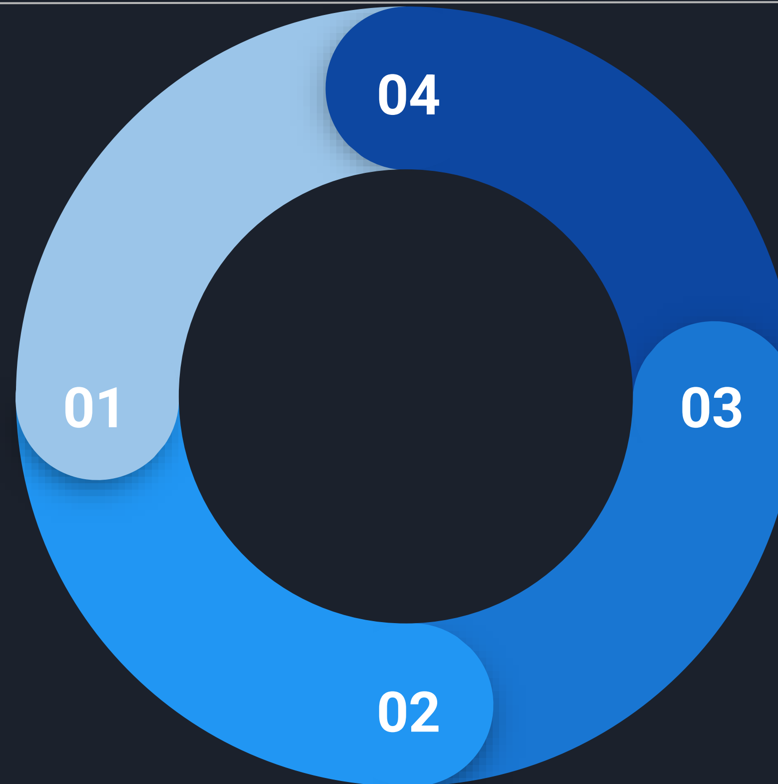
Anjali Taneja MD MPH, Primary Care Council

Build the infrastructure

Asynchronous communication hub like facebook or linkedin (networking) or like The Mighty (support, advice, discussion).

Map out ground level healthcare

Actively seek out neighborhood clinics, private practices, and more, to add to existing known network.



Gain feedback and iterate

Improve primary care, create asynchronous, dynamic, rapid response feedback in regions (this has been a defined problem) and from primary care providers to DOH/HSD and down.

Communicate

Self-organizing and discussion based communication (example: best practices in treating opioid addiction; or how are clinics using CHWs?). Folks can communicate 24/7 asynchronously, join topic forums, suggest ideas, learn about funding opportunities, build with other clinics

Return on Investment:

- Build community! Asynchronous communication 24/7
- Leverage technology to transform lives, to save lives (improve healthcare quality)
- Help develop priorities for the Primary Care Council for the future
- Technical assistance to smaller clinics/orgs to develop systems (+ ability to integrate HIE)
- Immediate communication from grassroots to state leadership and vice versa results in lives saved at community level (health action alerts, ideas, etc)
- Stem the sales of creative, local practices to hospital systems and private equity firms (in the US, more physicians are employed by health systems and private equity firms than have solo or group practices)
- Numerous other economic savings
- Ability to develop and iterate on new ideas and collaborations
- Retention of primary care providers (very significant and multiplier effect ROI)
- Inspiration to health professional students who are exploring staying in state or leaving the state for their careers (significant ROI)

Context: Opioid Addictions

- New Mexico's colonial and settler legacy frame the local context that has contributed to drug addiction in the city of Albuquerque and in Bernalillo County.
- Layered on this are factors of poverty, generational trauma, lack of treatment options, lack of housing – and the history of the medical industrial complex, which because of fear and stigma, has often treated people suffering from addictions as moral failures.
- All of this adds to the belief held by many people with addictions, that existing civic institutions and existing healthcare structures are not intended for them.

Question:

What could we create differently in primary care? Who would be on our team? How do we know what success looks like?

Ability to incorporate more, think outside the box

Questions and Tensions

- How do our healthcare systems respond to the needs of the community, partner in a way beyond the biomedical model?
- What does time look like in our systems?
- Who would be on our teams if we were designing a value based team from scratch?
- How does a primary care practice integrate both value based care (medicaid) and fee for service (patients with commercial insurance, uninsured patients)
- How do we meet the competing needs of new patients seeking care and creative approaches to existing patients receiving more intensive or team-based support?
- How can outcomes be patient and community-centered, instead of less meaningful?

Casa de Salud Fellowship in Reimaging Primary Care (+ opportunities to visit Casa)

Introducing the Casa de Salud Fellowship in Reimagining Primary Care

Our work at Casa de Salud is truly unique. Every day, we deliver care that is rooted in dignity, trust, creativity, cultural humility, and mutual respect. We see healthcare from a lens that understands the histories of inequalities, oppressions, and structural forces that affect our community. We also see the strengths of our community members, as well as the cultural richness that exists around us. It is with this historical analysis and appreciation for the power within our community that we build towards collective wellness and liberation.

We are a nonprofit organization (and not a federally qualified health center), providing critical primary care, integrative healing, harm reduction/syringe exchange, and addiction treatment services to our communities — including the South Valley, the International District, and other parts of Albuquerque and Bernalillo County. Most of our patients are from marginalized communities — the majority are uninsured or have Medicaid, many are Spanish speaking, many are immigrants. Other patients are queer, transgender, and/or gender nonconforming, and have experienced discrimination elsewhere. Many others are struggling with addictions or are returning citizens after periods of incarceration. We provide community-responsive, culturally humble, anti-racist, healthcare; provide intensive case management and medical debt navigation services; train up the next generation of healthcare leaders, mostly young people of color, through our health apprentice program; and develop leadership among patients, apprentices, and clinicians.

www.casadesaludnm.org/jobs

Fellowship:

Casa de Salud is launching a one year fellowship for family medicine physicians interested in culturally humble, anti-racist healthcare, new systems of care, quality improvement, community organizing/advocacy, business development, and provision of high quality primary care, integrative healing, and addictions treatment.

Candidates encouraged to apply are recent family medicine residency program graduates, as well as physicians with clinical and non-clinical work experience. Spanish proficiency is strongly preferred.

The ideal candidate will be an excellent clinician, excited to work in a transdisciplinary team, interested in systems change and creative approaches to health and healing, and will be a natural leader.

Casa de Salud is a permanent project of Justice, Access, Support & Solutions for Health, a 501(c)3 Organization
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How to Survive the End of the World Podcast episode on Casa de Salud:
https://www.endoftheworldshow.org/

NPR Well Woman Show, interview with Anjali Taneja about Decolonizing Healthcare
wellwomanlife.com/290show