HUMAN SERVICES DEPARTMENT

NEW MEXICO PRIMARY CARE COUNCIL MEETING
DECEMBER 5, 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

HUMAN SERVICES DEPARTMENT

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.

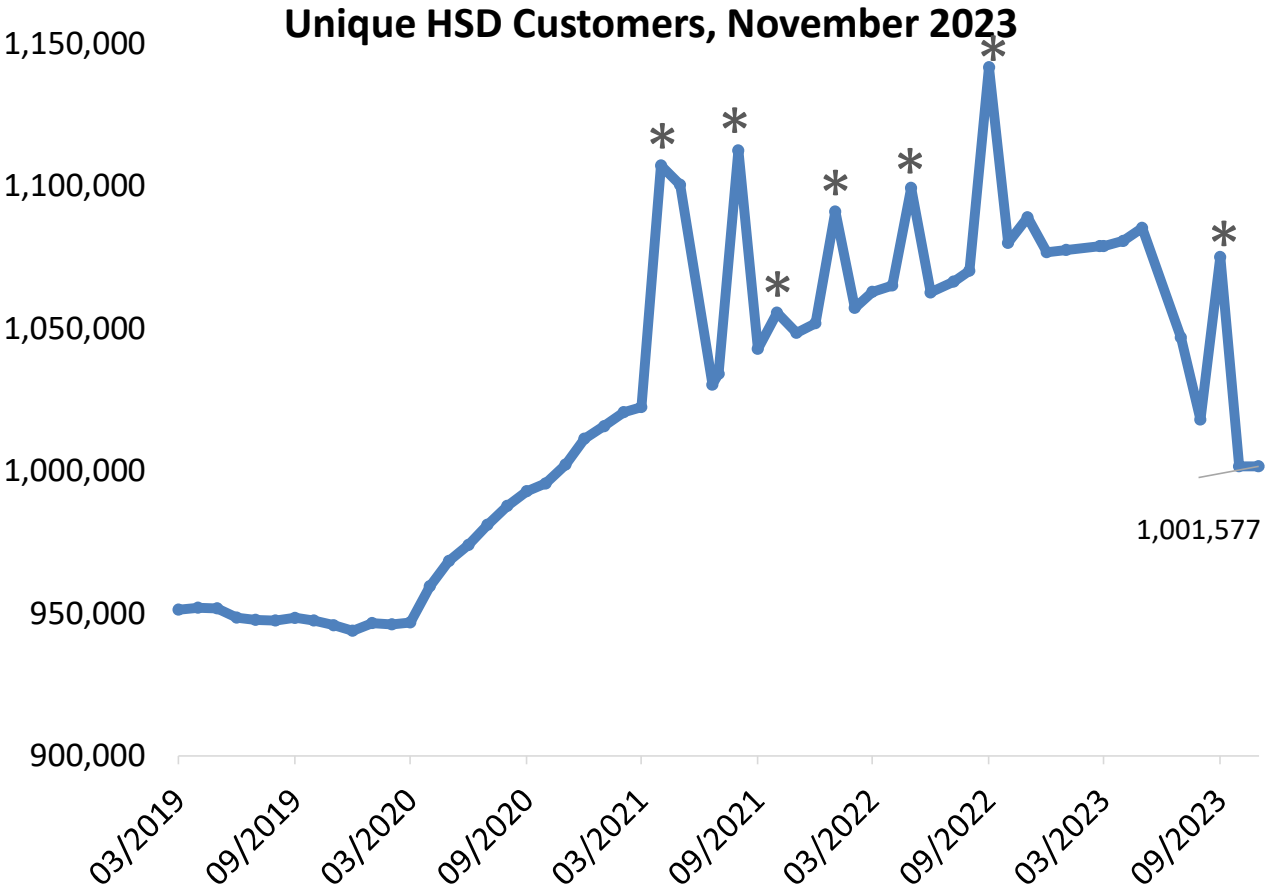
We make access EASIER

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

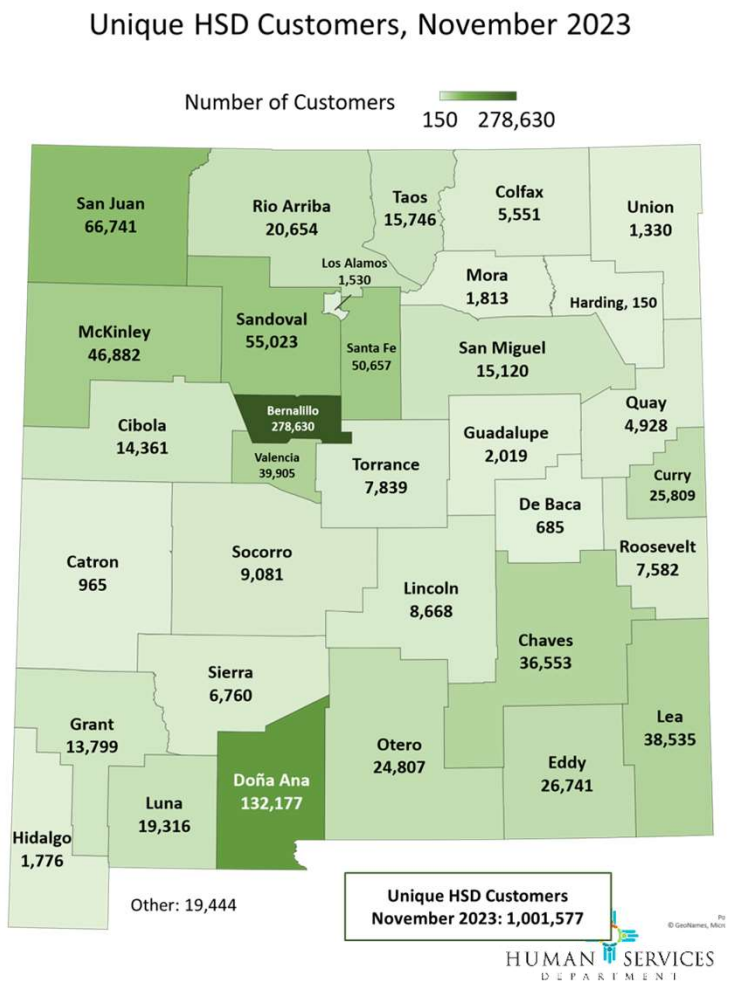
We support EACH OTHER

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

HSD SERVES 47% OF NEW MEXICANS



*Months with a EBT Payment



Investing for tomorrow, delivering today.

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.

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.

NEW MEXICO PRIMARY CARE COUNCIL

DEFINITON OF HIGH-QUALITY PRIMARY CARE

High-quality primary care is the provision of whole-person, integrated, accessible, and equitable healthcare by inter-professional teams and community partners who are accountable for addressing the majority of individuals' health and well-being across settings and through sustained relationships with patients, families, and communities.

Adapted from the National Academies' of Science, Engineering, and Medicine definition of Primary Care.

NORMS FOR TODAY'S MEETING

- Today's meeting is intended for members of the PCC.
- Members should raise a hand using zoom to make a comment/ask a question.
- Sub-groups of the PCC (residency expansion and transformation collaborative) and members public should use jamboards for questions and comments.
- Take breaks when needed.
- **Revolutionize, revolutionize, revolutionize!**

Raincloud Medicine, Rebecca Lee Kunz

Source: Tree of Life Studio

AGENDA

Time	Agenda Item	Facilitator(s) & Presenter(s)	Desired Outcome
9:00	Welcome	Elisa	Frame meeting and objectives, review agenda, and establish quorum.
9:05	Opening Remarks	Jen	
9:10	Primary Care Council Housekeeping	Elisa	Update members on Council activities and developments.
9:20	Turquoise Care: Supporting Primary Care	Elisa Alanna	Familiarize members about how Turquoise Care, due to roll out on July 1, 2024, will support Primary Care.
9:30	2024 Legislative Session 9:40 NMPCA Legislative Priorities 10:00 NMHA Legislative Priorities	Elisa Yvette Pamela	Shared understanding of FY25 priorities of the NM Primary Care Association, and NM Hospital Association.
10:15	Workforce Initiatives 10:15 Integrating Behavioral Health and Primary Care 10:45 Supporting Rural Integration 11:15 Workforce Workgroup Strategic Plan Update	 Maggie Pari Elisa	Discuss ways rural primary care and behavioral heath providers can partner to support each other and improve patient outcomes. Provide an overview of the work done by the workforce workgroup over the past several months including a revised workforce strategic plan
11:25	Making Care Primary Update	Elisa Nicholas & Roger	Provide an update on Primary Care Payment reforms and the Medicaid operationalization process.
11:50	Closing Remarks	Jen & Council Members	
12:00	*Adjourn*		

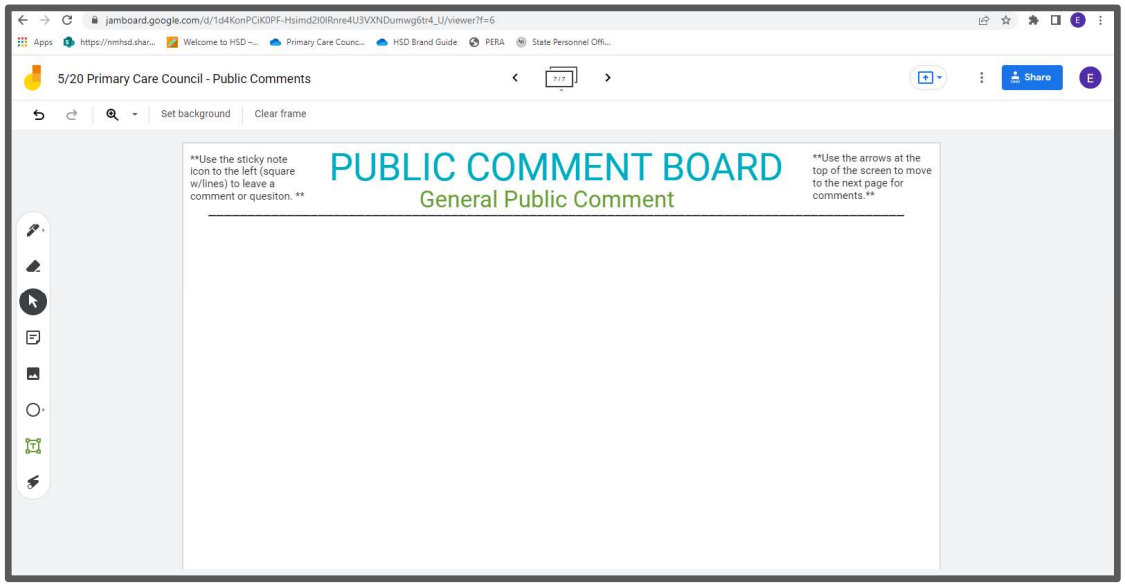
WE WANT TO HEAR FROM YOU

PCC Members:

- Please use the raise your hand function on zoom and ask questions in the chat. You may also use the jamboard.

Public comment:

- Please use the jamboard.



OPENING COMMENTS

Jen Phillips, M.D.
PCC Chair

Primary Care Council Annual Strategic Planning Cycle

HUMAN SERVICES DEPARTMENT

JAN-MAR

- Legislative Session
- Review enacted legislation and revise HSD Strategic Plan, if needed
- PCC Quarterly Meeting
- PC Residency Expansion Quarterly Meeting
- PC Residency RFA & Application Review

APR

- Solicit stakeholders for feedback on mission, goals, and strategic priorities

MAY

- Revise mission and goals, if needed
- Propose new initiatives (e.g., "Pitches for the People")

JUN

- Interim legislative hearings begins
- Evaluate strategic priorities based on stakeholder feedback
- Determine strategic priorities
- PCC Quarterly Meeting

Ongoing: PCC workgroup meetings, strategic plan implementation, stakeholder listening sessions, performance measure monitoring and evaluation.

JUL

- Revisit PCC strategic plan considering newly identified strategic priorities
- Draft legislation, if any
- PC Residency Expansion Contracts Start

AUG

- HSD submits budget request, strategic plan, and legislative requests
- HSD determines Special nonrecurring, Deficiency, and Supplemental Requests
- PCC Quarterly Meeting
- Residency Program Visits

SEP-NOV

- Create PCC budget request factsheets
- HSD submits Special nonrecurring, Deficiency, and Supplemental Requests
- Begin revising PCC Strategic Plan
- PC Residency Expansion Quarterly Meeting

DEC

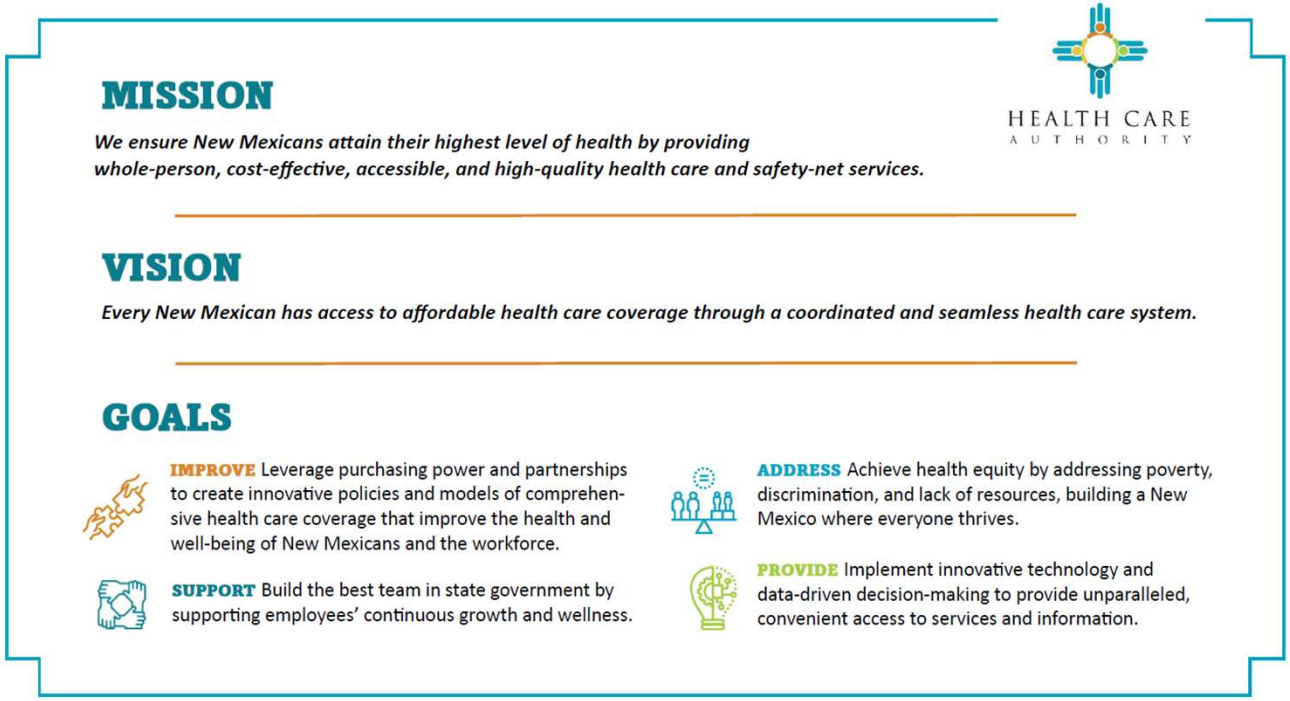
- HSD presents budget request to Legislative Finance Committee
- PCC Quarterly Meeting
- Revised PCC Strategic Plan is published
- PC Residency Quarterly Meeting

HUMAN SERVICES DEPARTMENT

Investing for tomorrow, delivering today

BETTER TOGETHER: NEW MEXICO HEALTH CARE AUTHORITY

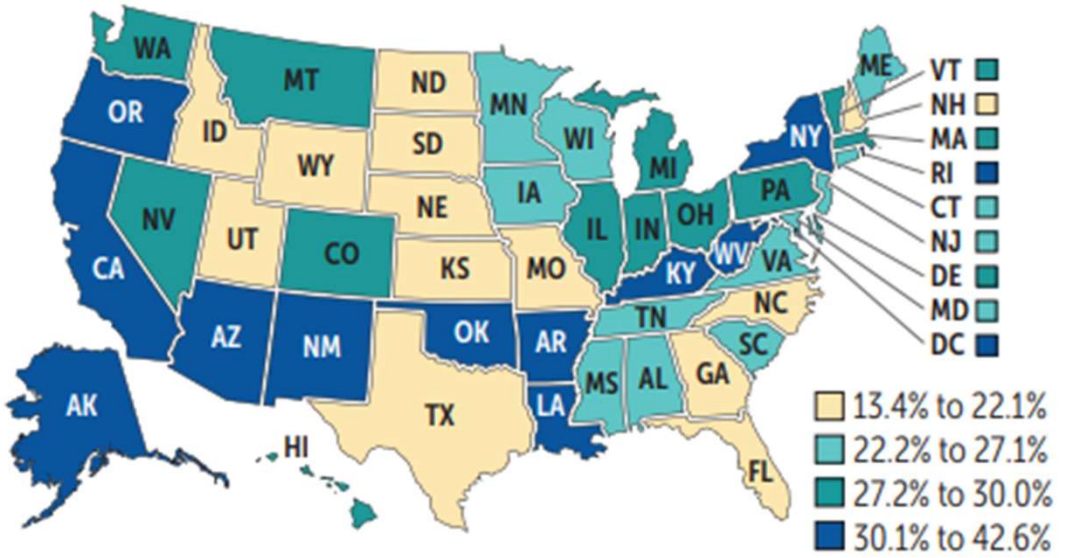
- Per Senate Bill 16, on July 1, the HCA will include:
  - All existing Human Services Department (HSD) divisions;
  - Division of Health Improvement from Department of Health (DOH);
  - Developmental Disabilities Supports Division from DOH; and
  - Employee Benefits Bureau from General Services Department (GSD).
  - New Office of Data & Analytics and Chief Data Officer (FY25 budget request item)



HCA IS POSITIONED TO LEAD THE NATION IN HEALTH CARE PURCHASING, EQUITY, AND ACCESS

- HCA demonstrates Governor's commitment to prioritizing health and well-being of every New Mexican by creating a single agency for health care purchasing, policy, and regulation.
- HCA will transform how NM purchases health care, leveraging purchasing power of Medicaid to improve cost, quality, and outcomes.
- HCA will leverage expertise, optimize data analytics, and drive accountability to achieve improvements in health care.

Children & Adults Enrolled in Medicaid or CHIP, 2022 (%)

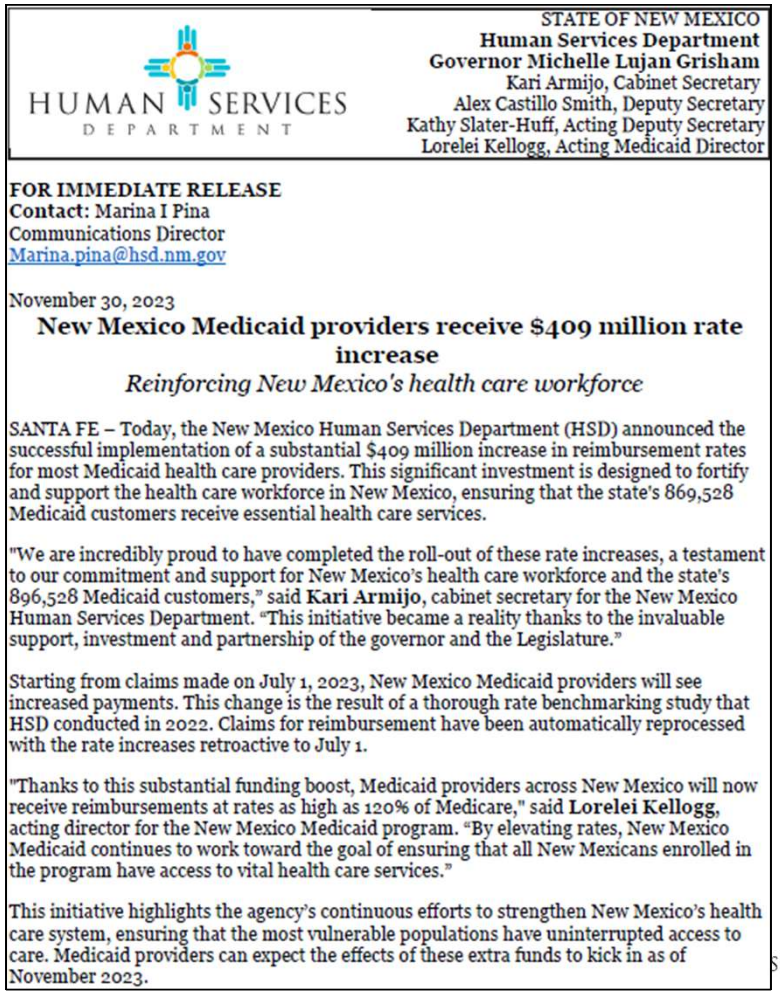


Note: Enrollment in Medicaid or CHIP represents individuals who are eligible for full Medicaid or CHIP benefits.

Source: https://www.medicaid.gov/sites/default/files/2023-04/beneficiary-ataglance-2023.pdf

MEDICAID BUDGET PRIORITIES FOR 2024 LEGISLATIVE SESSION

- Raise primary care, behavioral health, and maternal/child reimbursement rates from 120% of Medicare to 150%
- Maintain other reimbursement rates at 100% Medicare.
- Establish pay parity for non-physician practitioners (e.g. PA, CNS, CNP CRNA, AA, midwife, audiologist, dietician, dental hygienist, counselors).
- Reimburse for doulas and lactation consultant services.
- Address health-related social needs of New Mexicans:
  - Conduct Acupuncture pilot.
  - Expand vision benefits to all adults over 21.
  - Add Silver Diamine Fluoride as new benefit.
  - Provide Medicaid to justice-involved individuals 30 days prior to release.
  - Reimburse for home-delivered meals pilot program for people with disabilities and older adults.
  - Provide medical supportive housing for individuals experiencing homelessness.



HUMAN SERVICES DEPARTMENT

STATE OF NEW MEXICO
Human Services Department
Governor Michelle Lujan Grisham
Kari Armijo, Cabinet Secretary
Alex Castillo Smith, Deputy Secretary
Kathy Slater-Huff, Acting Deputy Secretary
Lorelei Kellogg, Acting Medicaid Director

FOR IMMEDIATE RELEASE
Contact: Marina I Pina
Communications Director
Marina.pina@hsd.nm.gov

November 30, 2023

New Mexico Medicaid providers receive $409 million rate increase

Reinforcing New Mexico's health care workforce

SANTA FE – Today, the New Mexico Human Services Department (HSD) announced the successful implementation of a substantial $409 million increase in reimbursement rates for most Medicaid health care providers. This significant investment is designed to fortify and support the health care workforce in New Mexico, ensuring that the state's 869,528 Medicaid customers receive essential health care services.

"We are incredibly proud to have completed the roll-out of these rate increases, a testament to our commitment and support for New Mexico's health care workforce and the state's 896,528 Medicaid customers," said **Kari Armijo**, cabinet secretary for the New Mexico Human Services Department. "This initiative became a reality thanks to the invaluable support, investment and partnership of the governor and the Legislature."

Starting from claims made on July 1, 2023, New Mexico Medicaid providers will see increased payments. This change is the result of a thorough rate benchmarking study that HSD conducted in 2022. Claims for reimbursement have been automatically reprocessed with the rate increases retroactive to July 1.

"Thanks to this substantial funding boost, Medicaid providers across New Mexico will now receive reimbursements at rates as high as 120% of Medicare," said **Lorelei Kellogg**, acting director for the New Mexico Medicaid program. "By elevating rates, New Mexico Medicaid continues to work toward the goal of ensuring that all New Mexicans enrolled in the program have access to vital health care services."

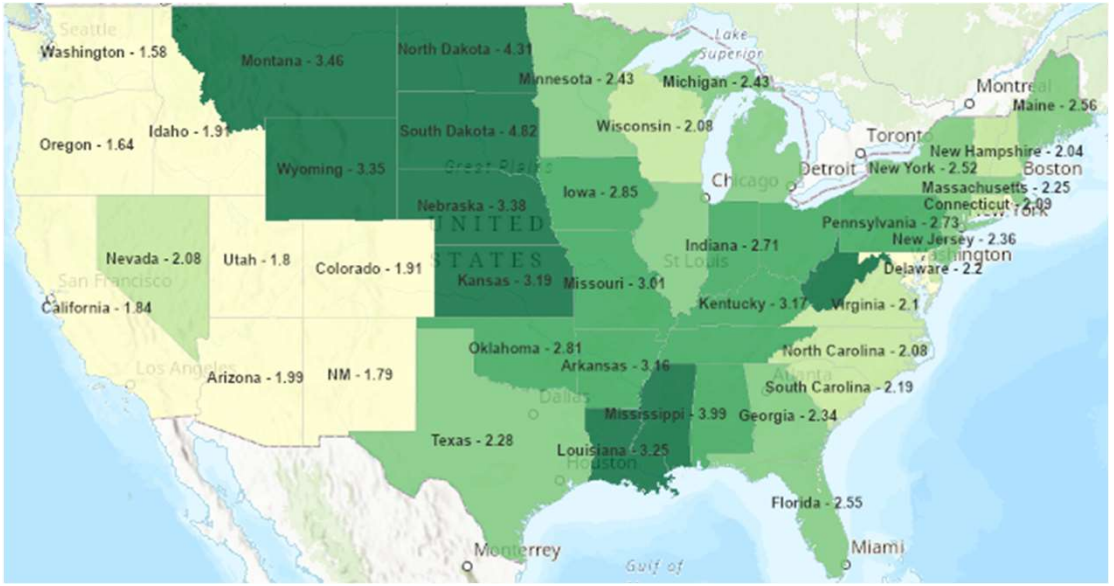
This initiative highlights the agency's continuous efforts to strengthen New Mexico's health care system, ensuring that the most vulnerable populations have uninterrupted access to care. Medicaid providers can expect the effects of these extra funds to kick in as of November 2023.

RURAL HEALTHCARE DELIVERY FUND

- Fund was established through 2023 Senate Bill 7
- $80M appropriated to HSD for SFYs 24-26
- Fund to defray operating losses for new or expanded services in rural NM counties.

Updates can be found at: https://www.hsd.state.nm.us/primary-care-council/

Hospital General Beds by State per 10,000 Population, 2020



Source: https://nmcdc.maps.arcgis.com/home/webmap/viewer.html?webmap=dc5a4b4a10f5458c8cccd1160c55710a

HUMAN SERVICES DEPARTMENT

Investing for tomorrow, delivering today.

RURAL HEALTH CARE DELIVERY FUND

RHCDF Access Champions announced on October 17:

- **Covenant Health Hobbs:** Expanding labor and delivery, pre-and post-natal care, and maternal health in Lea and Eddy Counties.
- **El Centro Family Health:** Start-up of dental health services in Taos County.
- **Gallup Community Health:** Increase primary care and behavioral health services in McKinley County.
- **Gerald Champion Regional Medical Center:** Restart in-person outpatient psychiatric services that ceased during the COVID-19 pandemic and expand inpatient behavioral health in Otero County.
- **Laguna Healthcare Corp:** Expand primary care services, pharmacy, laboratory, and radiology in Cibola County.
- **Mimbres Memorial Hospital:** Expand pediatric outpatient, inpatient, emergency, and labor and delivery services in Luna County.
- **Nurstead Consulting Services, LLC:** Create a 24-hour, 7-day-a-week drop-in facility to provide mental health support services in Curry County.
- **South Central Colfax County Special Hospital District:** Increase primary care services, particularly for older adults, and expand substance use services in Colfax County.
- **Sunrise Clinics:** Expand and increase primary care and behavioral health services for youth in Colfax, Guadalupe, Harding, Mora, Quay, Taos, and Torrance Counties.
- **The Learning Path, LLC:** Expand in-person behavioral health services in Socorro County.
- **The Psychiatric Care Center LLC:** Expand behavioral health services in Curry, De Baca, Lea, Quay, and Roosevelt Counties.

Access Champion Service Locations

HUMAN SERVICES DEPARTMENT

Investing for tomorrow, delivering today.

PAYMENT MODEL ROLLOUT

- All existing primary care payment arrangements continue through 12/31/25:
  - Providers will continue delivering care as they are now – nothing additional is expected in terms of care delivery
- Beginning 7/1/24:
  - Providers will complete quality metric reporting, requiring timely data submission
  - Providers will receive current reimbursement *plus* enhanced incentives linked to quality metric reporting (pay for reporting)
- Beginning 1/1/26:
  - Tiers 2 and 3 will activate for providers
  - Tiers 2 and 3 have additional requirements, including maintaining an attributed panel of patients, and additional financial incentives

MEDICAID OPERATIONAL WORKGROUP PROGRESS

- Solidified payment model rollout timeline
- Finalized payment model quality measures
- Determined where State systems changes are needed to support payment model monitoring
- Developed a plan for MCO and data intermediary engagement
- Upcoming topics: Patient attribution, supporting FQHCs in the model, stratifying patients for social and clinical complexity

COMPREHENSIVE PROVIDER TRAINING AND EDUCATION IN 2024

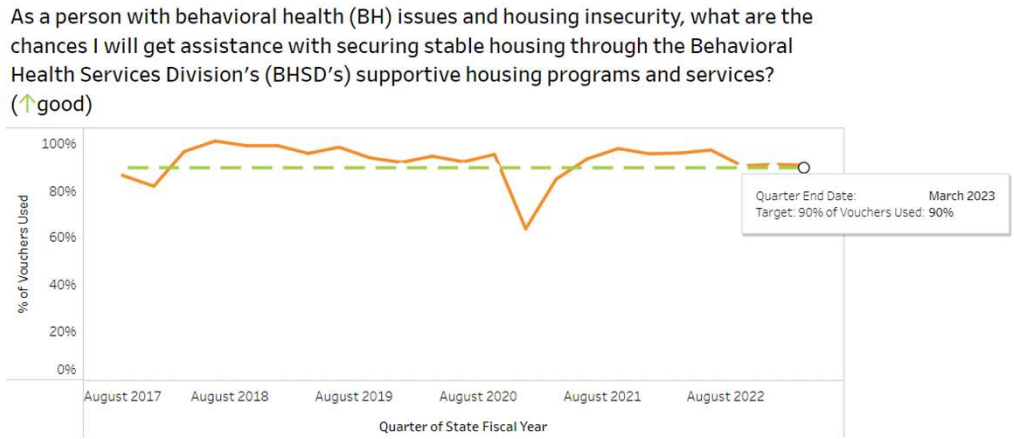
- **Training webinars** in January, February, March, and June
  - January 18th: Measurement Framework In Depth
  - February: Internal Reporting Infrastructure
- **Regional in-person workshops** in April and May (5 locations total)
  - Train-the-trainer model to maximize reach
  - Reporting process, reimbursement updates, what will change on July 1st, 2024

TURQUOISE CARE

Alanna Dancis, DNP, Chief Medical Officer
NEW MEXICO HUMAN SERVICES DEPARTMENT

TURQUOISE CARE: TRANSFORMING HEALTH CARE FOR NEW MEXICANS BEGINNING JULY 2024

- In negotiations with the federal government for January 2024 go-live of key programs:
  - Expansion of supportive housing for individuals with serious mental illness;
  - Expansion of Centennial Home Visiting Evidence Based Models;
  - Continuous eligibility for children up to age six;
  - Expansion of home and community-based waiver services by adding enrollment slots;
  - Addition of chiropractic services to the Medicaid benefit.



Source: https://sites.google.com/view/nmhsdscorecard/goal-1/BH

2024 LEGISLATIVE SESSION

Pamela Blackwell, Director, Government Relations & Communications
NEW MEXICO HOSPITAL ASSOCIATION

Yvette Ramirez Ammerman, CEO
NM PRIMARY CARE ASSOCIATION

Introducing the New Mexico Healthcare Workforce Dashboard

COALITION FOR A NM HEALTHCARE WORKFORCE DASHBOARD

- NM Center for Nursing Excellence
- NM Association for Home & Hospice Care
- Blue Cross Blue Shield of NM
- NM Hospital Association
- NM Medical Society

The Challenge:

New Mexico grapples with healthcare workforce shortages, exacerbated by its vast yet sparsely populated regions and an aging demographic that demands more medical services. The state's prevalent socioeconomic disparities further intensify the need for healthcare, stretching the limited workforce thin. This results in prolonged wait times, reduced access to care, and an increased risk of burnout among healthcare professionals. A strategic, data-driven, and collaborative approach is crucial to address these challenges and ensure accessible, quality healthcare for all New Mexicans.

The Solution:

The New Mexico Healthcare Workforce Dashboard is a state-of-the-art tool crafted to offer a comprehensive view of the healthcare workforce distribution within New Mexico. This innovative platform is crucial for stakeholders aiming to understand the current landscape of healthcare professionals, identify regions of scarcity, and develop targeted strategies to bridge existing gaps. By facilitating a data-driven approach, the dashboard ensures that healthcare delivery is equitably optimized across the state, directly impacting patient outcomes and the overall effectiveness of the healthcare system.

Interactive Map:
Visualize the distribution of healthcare professionals across different regions, considering various specialties and healthcare sectors.

Real-Time Data Analytics:
Utilize up-to-date information to analyze workforce trends, shortages, and surplus areas.

Workforce Projections:
Leverage historical data and predictive analytics to forecast future workforce needs and trends.

Integration with Educational Institutions:
Collaborate with medical schools and training programs to align education with workforce needs.

Resource Allocation Guidance:
Utilize data to optimize the distribution of grants, incentives, and other resources to areas in need.

Collaboration and Sharing:
Enable healthcare providers, policymakers, and educators to access and share data for coordinated planning.

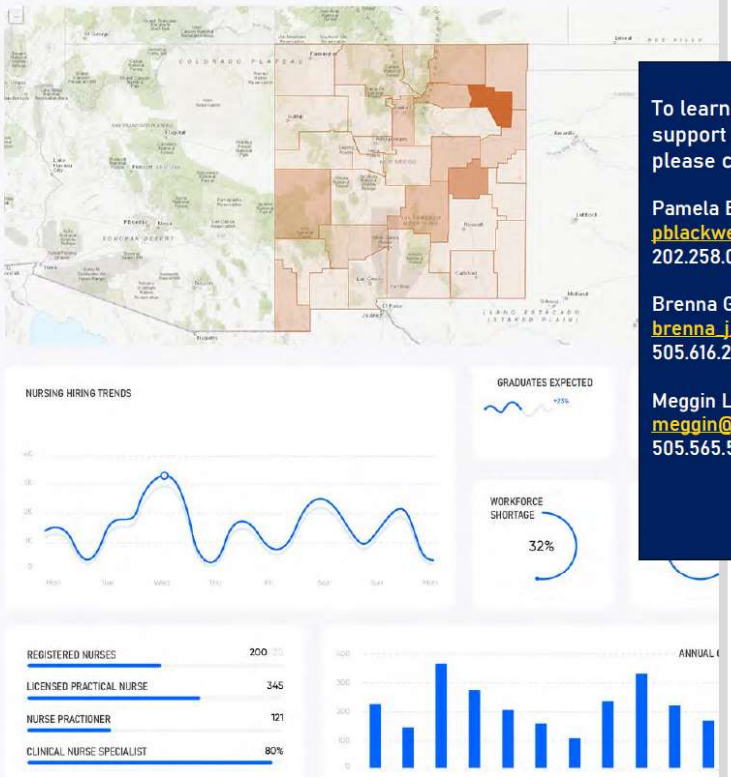


Image at left is an example of what our NM Healthcare Workforce Dashboard could look like.

To learn more, lend your support or join the Coalition, please contact:

Pamela Blackwell, NMHA
pblackwell@nmhsc.com
202.258.0727 (c)

Brenna Gaytan, BCBSNM
brenna_j_gaytan@bcbsnm.com
505.616.2211

Meggin Lorino, CNE & NMAHHC
meggin@nmahc.org
505.565.5777

WORKFORCE INITIATIVES

Maggie Mccowen, LISW, MBA, Executive Director
NEW MEXICO BEHAVIORAL HEALTH PROVIDERS ASSOCIATION

Gaurav Nagrath, ScD, MBA, Principal
HEALTH MANAGEMENT ASSOCIATES

Pari Noskin, MSW, LMSW, Program Manager/Grant Coordinator
UNM DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL HEALTH SCIENCES

Elisa Wrede, Senior Manager, Primary Care Innovation
NEW MEXICO HUMAN SERVICES DEPARTMENT

The Road to Value: NMBHPA Data Collection and APM Development Project

PCC Quarterly Meeting

Tuesday, December 5th, 2023

Project Purpose

Encourage behavioral health participation in innovative payment arrangements and, in the long term, develop a successful alternative payment model that can be implemented for behavioral health providers across the state.

- Built on a common set of meaningful, provider-driven behavioral health metrics.
- Support behavioral health organizations in developing infrastructure and capabilities to submit reliable quality data.
- Develop leadership activities necessary to transition from fee-for-service to value-based pay-for-performance reimbursement.
- Support New Mexico's vision for integrated behavioral health and primary care.

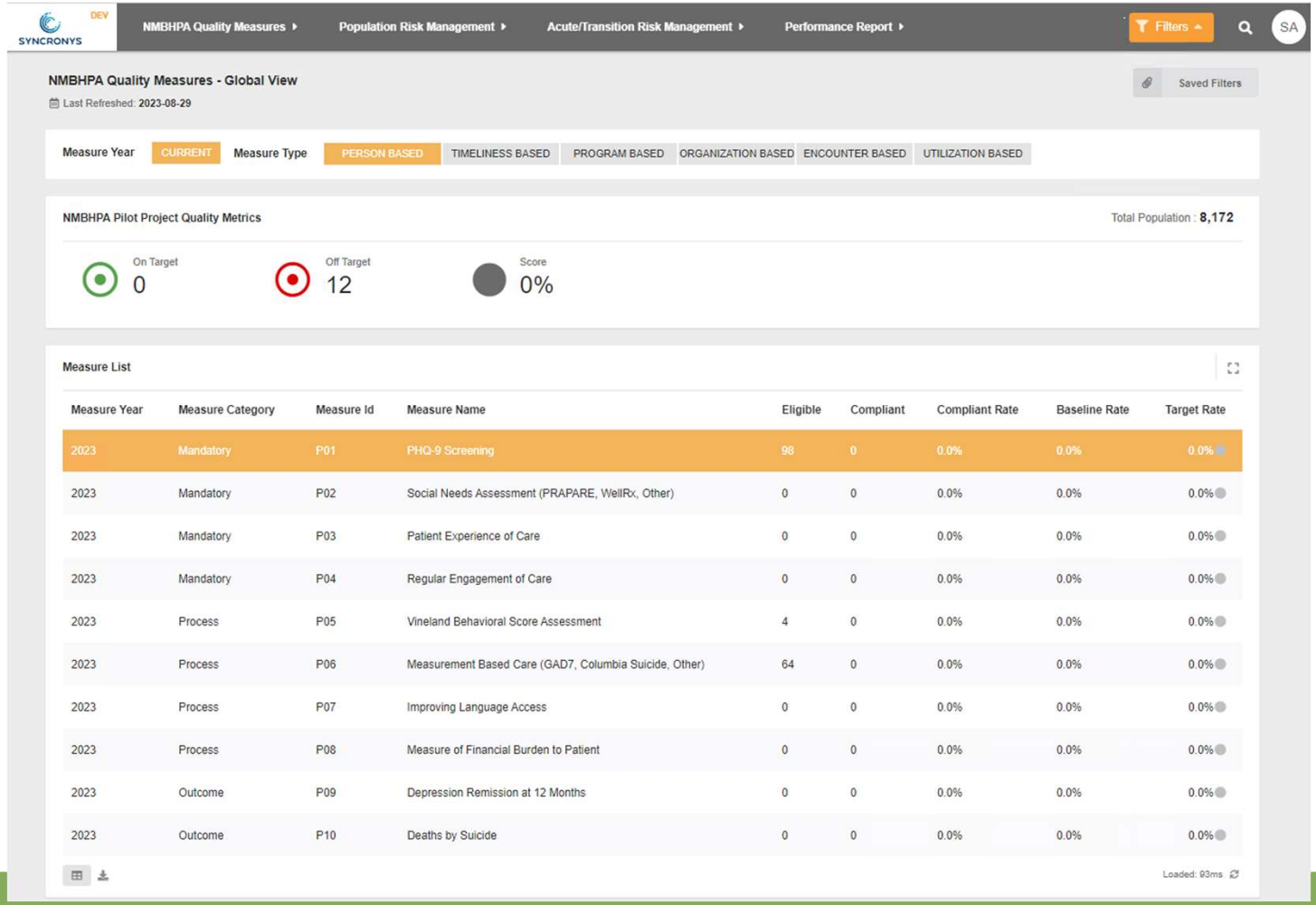
Traditional Behavioral Health Metrics vs. NMBHPA Pilot Project Metrics

Sample of Traditional Behavioral Health Metrics	Sample of NMBHPA Pilot Project Metrics
• Follow-up after Hospitalization for Mental Illness – 7 days, 30 days • Follow-up after Emergency Department Visit for Mental Illness – 7 days, 30 days • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication • Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c • Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia • Metabolic Monitoring for Children and Adolescents on Antipsychotics • Use of Opioids at High Dosage	• Measurement Based Care • Social Needs Assessment • Patient Experience of Care • Regular Engagement in Care • Time to Initial Appointment for Diagnostic & Treatment Planning/Evaluation • Readmissions within 30 Days • ASD Set of Patient-Centered Outcome Measure • % of Patients with Successful Discharges • Deaths by Suicide • Improving Language Access • Measure of Financial Burden to Patient • Depression Remission at 12 Months • Emergency Department Utilization

Metric Menu for Pilot Year

Mandatory Metrics *All must report*	Level I Metrics (Outcomes) *Choose 2*	Level II Metrics (Process) *Choose 2*
1. Measurement Based Care – PHQ-9 (APA)	❑ ASD Set of Patient-Centered Outcome Measure (ICHOM)	❑ Comprehensive Care for ABA Patients (Org-specific)
2. Social Needs Assessment (Org-specific)	❑ Functional Assessment Score Change (ICHOM)	❑ Improving Language Access (Org-specific)
3. Patient Experience of Care Survey (SAMHSA)	❑ Measurement Based Care – Other (Anxiety, SUD, etc.) (APA)	❑ Measure of Financial Burden to Patient (Org-specific)
4. % of Patients with Regular Engagement in Services (Org-specific)	❑ % of Patients with Successful Discharges (treatment goals achieved) (Org-specific)	❑ Depression Remission at 12 Months (MNCM)
5. Time to Initial Appointment for Diagnostic & Treatment Planning/Evaluation (SAMHSA)	❑ Net Promoter Score (Bain & Co)	❑ Emergency Department Utilization (Health Plan/State/Org)
6. Readmissions within 30 Days (NCQA)	❑ Deaths by Suicide (SAMHSA)	

Dashboard Snapshot



The aggregate view, showing compiled results from all organizations

Measure Baselines

The baseline represents the starting point. The target represents the realistic goal of where you want to end up. Combined, they are the key points needed to quantify progress over time.

- Baseline: July-October rate across pilot (cumulative numerator / cumulative denominator)
  - Only includes organizations that selected each addt'l measure
- Floor: Minimum of range calculated by taking the lower 95% confidence interval
- Ceiling: Maximum of range calculated by taking higher of the 95% confidence interval

	Measure	Baseline	Floor	Ceiling
Mandatory	PHQ-9 Screening	**1.0%**	0.0%	3.0%
	Social Needs Assessment	**9.4%**	0.0%	34.8%
	Patient Experience of Care	**2.0%**	0.0%	25.2%
	Regular Engagement of Care	**67.0%**	40.4%	100%
	Days from Intake to Eval	**1.2**	0.0	13.0
	Days from Intake to Eval-Treat First	**18.8**	6.2	36.9
	All Cause Readmission	**12.4%**	6.9%	19.8%
Process	Vineland	**0.0%**	0.0%	0.0%
	Measurement Based Care (GAD-7)	**1.0%**	0.0%	1.4%
	Measurement Based Care (Columbia)	**22.7%**	0.0%	39.3%
	Improving Language Access	**9.3%**	0.0%	38.1%
	Measure of Financial Burden to Patient	**17.6%**	0.0%	44.5%
Outcome	Depression Remission	**0.0%**	0.0%	0.0%
	Deaths by Suicide	**0.0%**	0.0%	0.0%
	Percent of Successful Discharges	**32.8%**	0.0%	74.1%
	ED Visits per 100	**4.4**	0.1	9.9

Remainder of Year 2

Refine quality measures as needed to ensure they are meaningful to providers, align with other reporting requirements, and accurately measure quality and access

Build from baseline performance and benchmarks to develop a pay-for-performance alternative payment model (APM)

Select 20 new pilot organizations to participate in project Year 3, with particular consideration given to adding small and rural sites

Proposed Year 3

July 1st, 2024-June 30th, 2025

Grow the Data Ecosystem

- 20 new pilot organizations begin submitting quality measures
- 10 continuing pilot organizations become key champions as payment reform expands

Collaboratively Design and Refine an Alternative Payment Model

- Providers, State representatives (BHSD and Medicaid), and MCOs provide input to finalize the APM
- APM tested and evaluated for efficacy
- APM broadly socialized with behavioral health providers statewide

Proposed Years 4 and 5

Year 4
July 1st, 2025-June 30th, 2026

- Entry-level APM, based on fee-for-service reimbursement, launches statewide

Year 5
July 1st, 2026-June 30th, 2027

- Enhanced APM tiers (e.g., shared savings/risk) launch statewide
- Comprehensive APM supports strong integration between behavioral health and primary care

BRIDGES TO WELLNESS
INTEGRATING BEHAVIORAL & PHYSICAL HEALTH CARE IN RURAL NEW MEXICO

DIVISION OF COMMUNITY BEHAVIORAL HEALTH
UNM DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Pari Noskin, MSW, LMSW, Program Manager/Grant Coordinator

December 5, 2023

BRIDGES TO WELLNESS

CURRENT STEERING COMMITTEE

BHSD

Betty Downes, PhD, Integrated Health Workforce Coordinator

GCLC

Michael Foust, LCSW, CEO

Kristi Hinojos

Rebecca Starkey, RN, B2W Integrated Care Coordinator

HMS

Teresa Arizaga, MD, Chief Mental Health Officer

Jackie Ramirez, Director of Care Coordination

UNM Department of Psychiatry and Behavioral Sciences, Community Behavioral Health Division

Debra Heath, MPH, Senior Evaluator

Tyler Kincaid, PhD, Research Faculty

My (Amy) Nim, MD, Evaluation Director

Pari Noskin, LMSW, Grant Coordinator

Mohammed Quazi, PhD, Statistician

BRIDGES TO WELLNESS

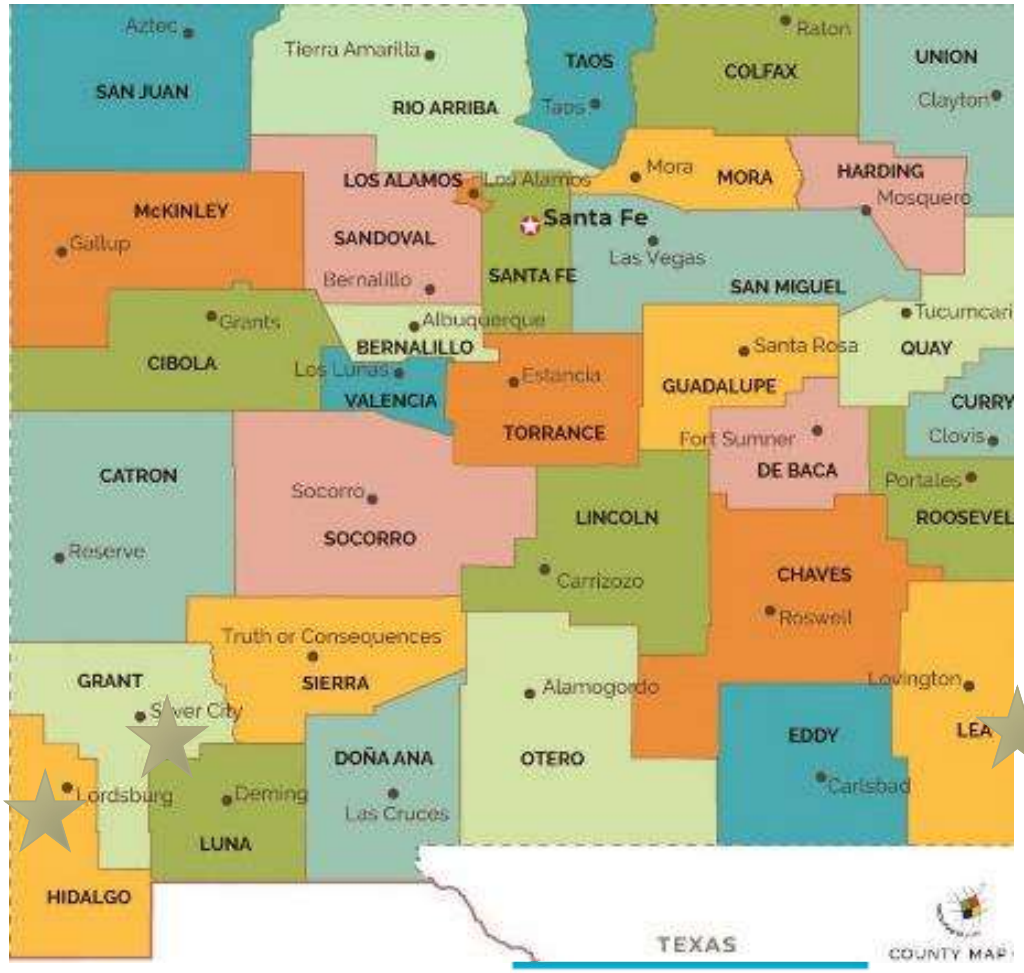
Five-year project to integrate primary care and behavioral health services
Funded by SAMSHA (October 2018 – September 2023)

Bi-directional approach

- FQHC – BH into PC
- CMHC – PC into BH

For adults who:

- Have co-occurring **physical health conditions** as well as **mental illness or substance use disorders**
- Do **not** have Medicaid (not insured or under-insured)



HIDALGO MEDICAL CENTER (HMS)
*FQHC - SERVES GRANT & HIDALGO COUNTIES

Guidance Center of Lea County (GCLC)
***CMHC - serves Lea County & surrounding areas**

HUMAN SERVICES DEPARTMENT

B2W GOALS

1. Promote integrated care and increased collaboration between primary care and behavioral health providers.
2. Improve the health, functioning and quality of life of people living with MI and/or SUDs and chronic illness who do not have insurance or are underinsured.
3. Increase workforce capacity of peer support workers and community health workers to engage service recipients in health promotion activities and care coordination
4. Describe integrative approaches and build momentum toward enhanced healthcare integration in New Mexico.

B2W INTEGRATION POLICY/PROCEDURE EXAMPLES

- Comprehensive Health Integration Framework (CHI)
  - National Council for Mental Wellbeing
    SAMHSA-funded Center of Excellence for Integrated Health Solutions

- **Examples**
  - HMS non-termination of patient provider relationships
    domain 5: subdomain 5.3 multi-disciplinary team; integrated care team training
  - HMS teaming policy
    domain 5: several subdomains
  - GCLC MOU w/Nor-Lea Hospital
    domain 1: screening and follow up
  - GCLC agreement with local rec center for discounts for B2W clients
    domain 4: self management

HOW DID CLIENT HEALTH & WELLBEING CHANGE?

Outcome Measures

Functioning in Everday Life: Able to deal effectively with daily problems, control one's life, get along with family, and handle social situations. (n=254)

Serious Psychological Distress: Indicator of serious mental illness as measured by the Kessler 6 scale. (n=246)

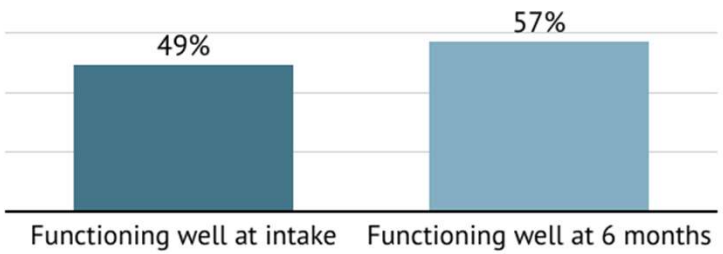
Overall Health: Client ratings of their physical, emotional and mental health on a scale from Poor to Excellent. (n=270)

Social Connectedness: Happiness with friendships, having people with whom to do enjoyable things, sense of belonging to one's community, and having support from family or friends. (n=266)

These charts show assessment results from B2W clients who were interviewed at intake and again 6 months later. Sample sizes ranged from 246 to 270, as shown in parentheses above.

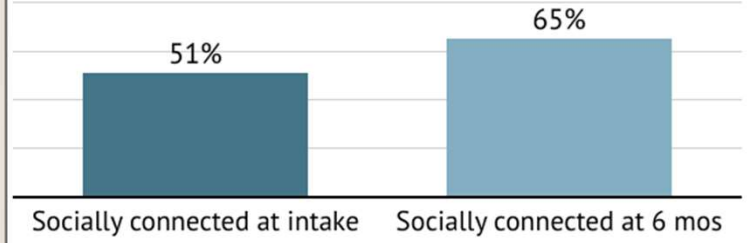
Functioning in Everyday Life

The percentage of clients reporting adequate levels of everyday functioning increased from 49% at intake, to 57% at 6 months.



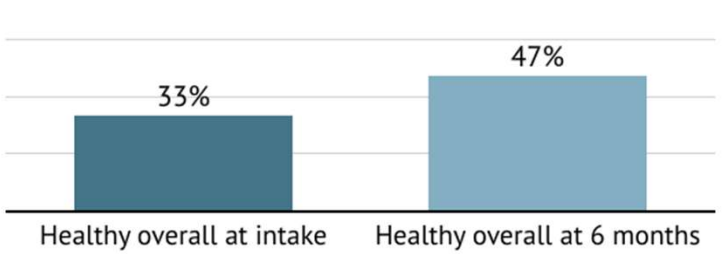
Social Connectedness

The percentage of clients reporting social connectedness increased from 51% at intake, to 65% at 6 months.



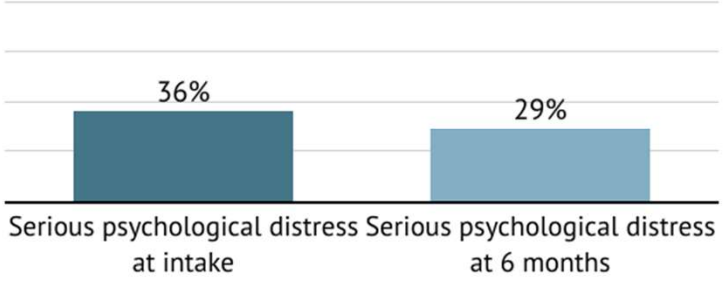
Overall Health

The percentage of clients reporting good to excellent health increased from 33% at intake, to 47% at 6 months.



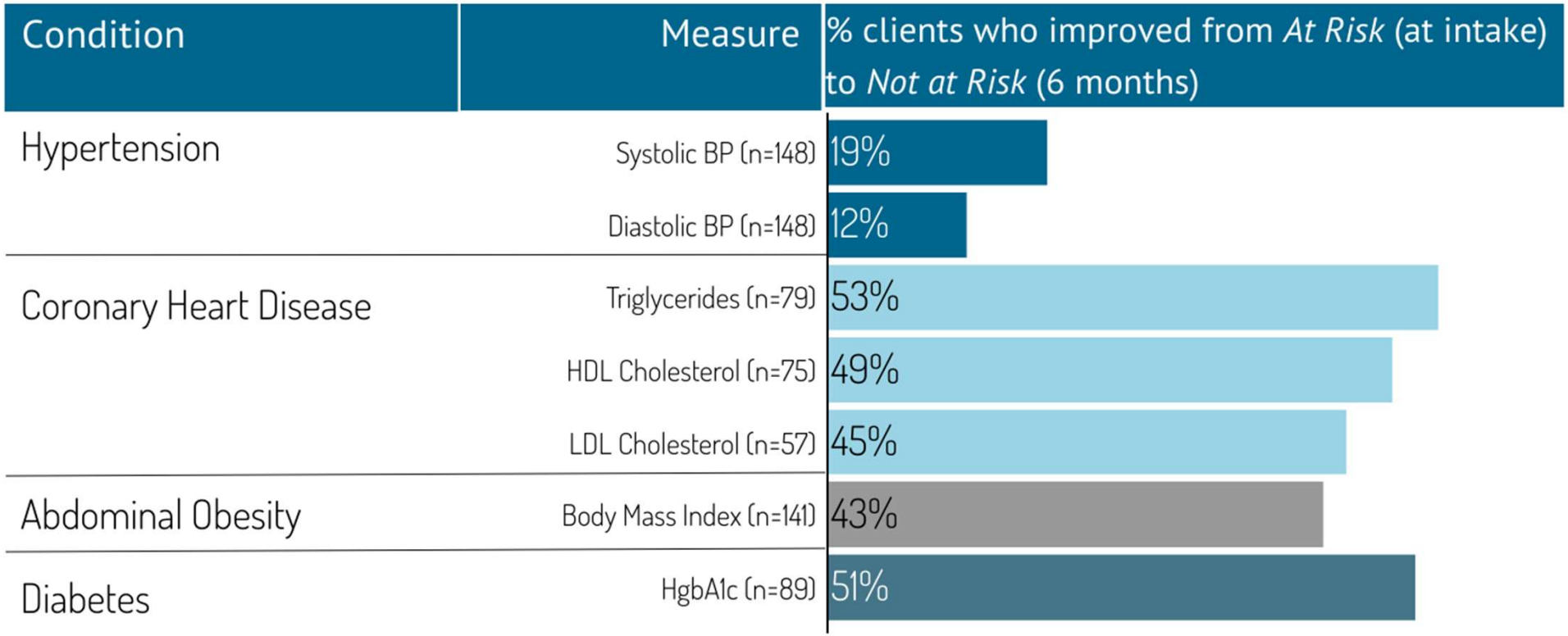
Serious Psychological Distress

The percentage of clients who screened positive for serious psychological distress declined from 36% at intake, to 29% at 6 months.



Physical Health Improvements

From intake to 6 months, about half of clients reduced risks for heart disease and diabetes.
Almost half reduced obesity levels.



IMPACTS ON PHYSICAL HEALTH

"When I started with the program my blood sugars were in the 500-600 range, I was always stressed out due to my lost of employment, Now my blood sugars have dropped tremendously. My A1c was 12 when I started with the program, now I am down to 7."

"I take my medications because of the help of the Bridges to Wellness team."

"I'm in better physical shape, mentally stronger, and I've lost 36 pounds since starting. I feel so much better, happier, and more self-aware."

"No longer smoking, changed my eating habits."

LESSONS LEARNED

IDENTIFYING IMPACTS & LEARNING WHAT WORKS

Integration is a process; each agency needs a plan that identifies:

- Its baseline
- Its integration focus
- An intended integration framework or model
  - Guides strategies, workflow, follow-up and closing loops
    - Comprehensive Integration Framework
- Incremental implementation targets
- Realistic outcome objectives given resources and timeline

Plan your integration budget to include:

- For on-site data collection
- For protected time to manage identified project
  - There are a lot of moving parts
  - Hard to do if added onto already busy schedules

IDENTIFYING IMPACTS & LEARNING WHAT WORKS

Be selective and start small:

- No one size fits all
  - Trying to do everything can be overwhelming
- Focus on your populations with highest need and identify actions

Communication is key:

- Co-location doesn't guarantee integration
- Build in time to communicate; builds trust
  - Relationships are critical to success
- Different systems of care have different cultures, languages
  - Eg: "Trauma," integration, data (qualitative/quantitative)

IDENTIFYING IMPACTS & LEARNING WHAT WORKS

Maximize staffing

- CHWs, CPSWs, Health Educators, MAs critical to effective integration
  - Can cross-train, but learn scopes of work
  - Ensure supervisors understand how to supervise
  - Building integration expertise in your agency

Financing integrated care:

- Payment hasn't caught up with many FFS mechanisms
- Decision support tool
  - https://www.thenationalcouncil.org/resources/financing-the-future-of-integrated-care/
- Build into PM/PM; prospective payment (CCBHC)
- Center for Integrated Health Solutions Decision Support Tool
- NMPCC tier 3 emphasis on behavioral health integration

WORKFORCE WORKGROUP UPDATE

Workgroup meets every other Friday from 12 – 1pm

Topics have included:

- Developing a workforce "Cascade"
- Partnering with other agencies including DOH, HED, and OSI
- Workforce data from 3D Health (included in the appendix)
- Developing a 2024 Strategic Plan

Strategic Plan Initiatives

(full list in the appendix)

INITIATIVE NAME	OWNER
Health Professional Loan Repayment Program	HED
Health Worker Burnout	HSD/PCC
Workforce Wellness	HSD/PCC
Workplace Violence	HSD/PCC
Workforce Analysis	PCC/HSD/NMHA
Primary Care Payment Reforms	PCC/HSD
Multi-Payer Alignment	PCC/HSD/OSI/CMS
Prior Authorizations	HSD/OSI
Claims Process	HSD/OSI
Residency / Workforce Expansion	PCC/HSD/NMHA/NMPCTC

CMS/CMMI MAKING CARE PRIMARY

Nicholas Minter, Director, Division of Advanced Primary Care
CMS INNOVATION CENTER

Roger Adams, Regional Officer (PCF & MCP)
CENTERS FOR MEDICARE & MEDICAID SERVICES

MAKING CARE PRIMARY (MCP)

Model Update

December 5, 2023

MCP MODEL UPDATE

Making Care Primary (MCP) Goals

MCP is a 10.5-year model (beginning July 2024) that provides a pathway from Fee-for-Service (FFS) payment to prospective, population-based payment to support comprehensive primary care that improves care quality and population health outcomes. CMS is eager to partner with other payers to help drive these goals for their beneficiaries.

Comprehensive Primary Care

Ensure patients receive primary care that is integrated, coordinated, person-centered and accountable

New Pathway for Value-Based Care (VBC)

Create a pathway for primary care organizations and practices – especially small, independent, rural, and safety net organizations – to enter into value-based care arrangements

Improved Quality and Outcomes

Improve the quality of care and health outcomes of patients

Who is Eligible to Participate?

Organizations that provide primary care services to patients may be eligible to apply to MCP. Due to MCP's payment and quality reporting design, certain organizations are not eligible to participate in MCP.

Organizations Eligible for MCP

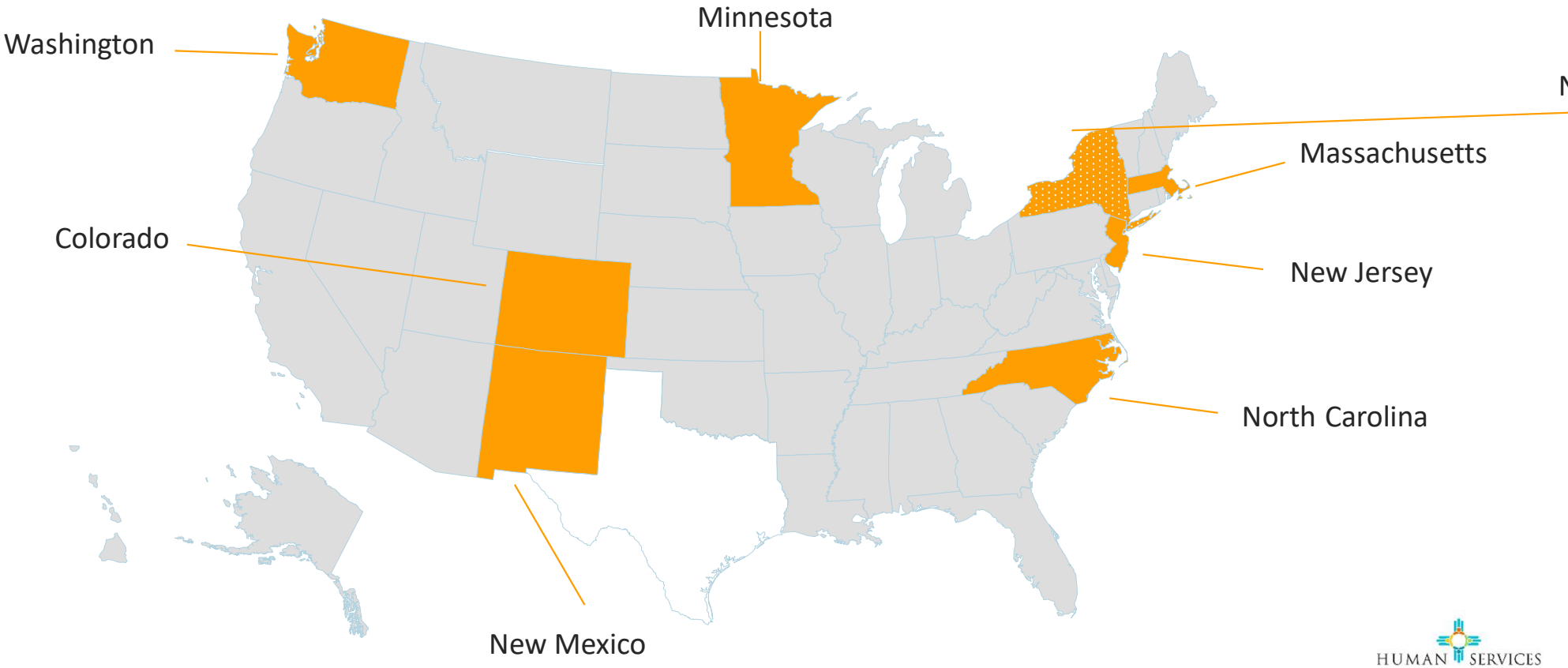
- Serve as the regular source of primary care for a minimum of 125-attributed Medicare beneficiaries
- Independent or solo primary care practices
- Group practices
- Federally Qualified Health Centers (FQHCs)
- Health Systems
- Indian Health Programs
- Certain CAHs
- Organizations operating in the listed MCP states

Organizations Not Eligible for MCP

- Rural Health Clinics
- Concierge practices
- Grandfathered Tribal FQHCs
- Primary Care First (PCF) practices and ACO REACH Participant Providers active as of 5/31/23
- Organizations not operating in the listed MCP states
- Organizations enrolled in shared savings models (such as MSSP and ACO REACH) will not be allowed to simultaneously participate in MCP, with the exception of bundled payment models

Participating States

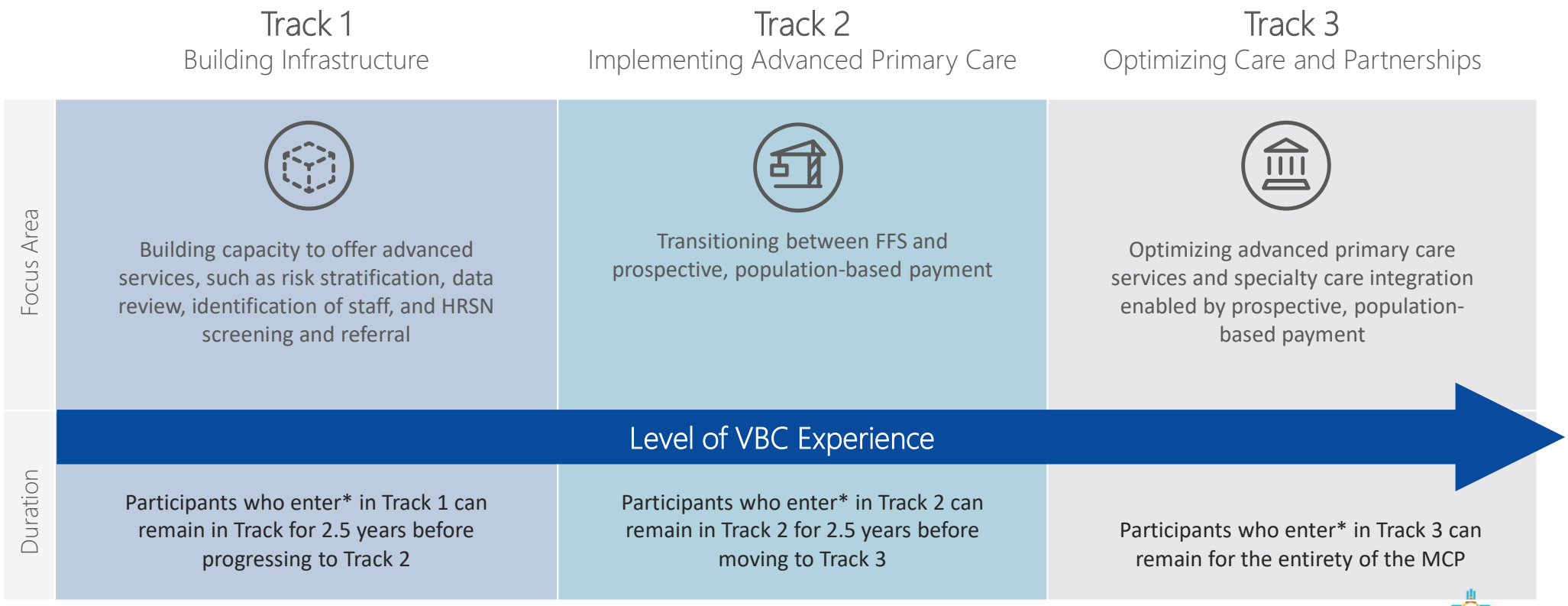
MCP will be tested in eight (8) states in partnership with state Medicaid agencies (SMAs) and other payers in each region. Payer partnership fosters alignment on core model features to minimize payer fragmentation, while allowing payers flexibility to tailor their MCP implementation.



Investing for tomorrow, delivering today.

Participation Track Options Overview

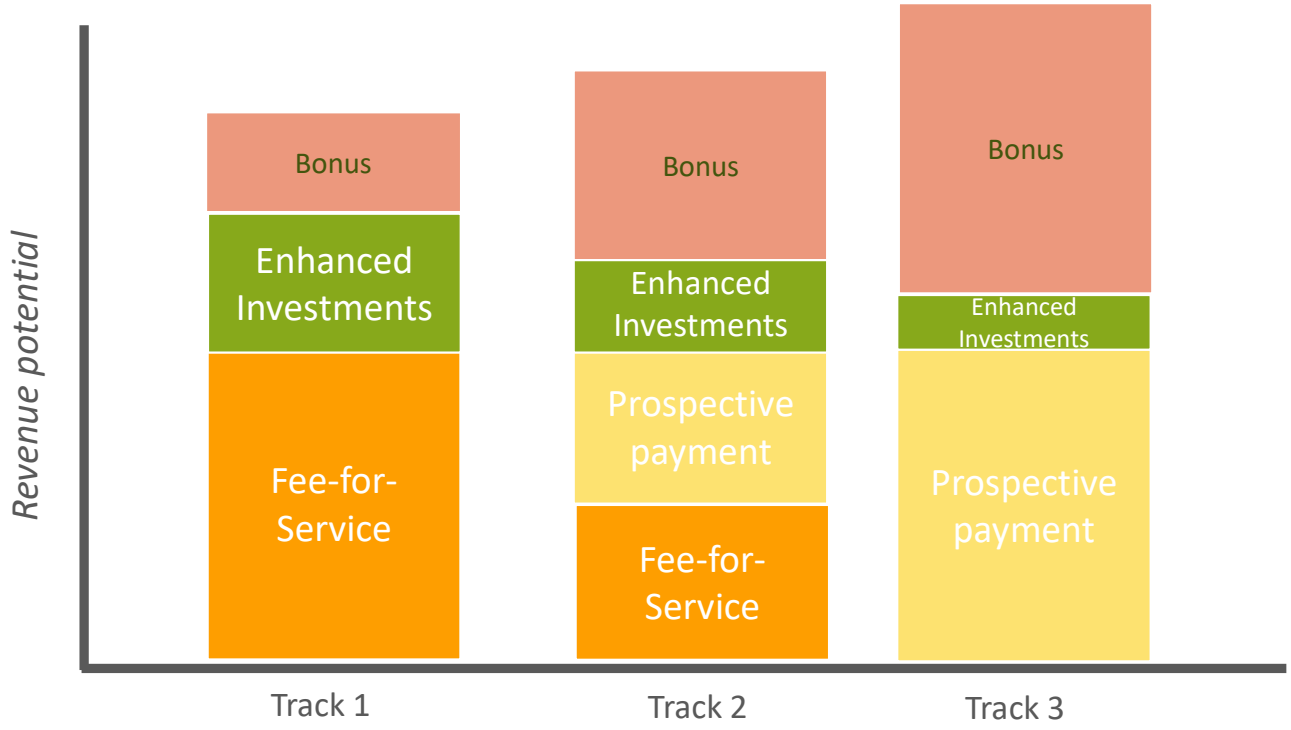
MCP includes three (3) tracks that health care organizations can select from when applying to the model. The three tracks provide opportunities for organizations with differing levels of care delivery and value-based payment experience to enter the model at a point that matches their capabilities at the start of MCP.



**Organizations that start in Track 1, 2, or 3 will have an additional 6 months (or half of a year) in that track, given the mid-year start date for the model. A participant's length of time in a track depends on which track they started in.*

PAYMENT APPROACH

- **Prospective Primary Care Payment** (PPCP) *increases* over time, while **Fee-for-Service** *decreases*, to support the interprofessional team.
- **Enhanced Services Payments** (ESP) *decrease* over time as practices become more advanced, and potential for payments tied to quality performance increases.
- **Performance Incentive Payment** (PIP) *potential greatly increases* over time to make up for decreases in guaranteed payments.



Illustrative, not to scale

HUMAN SERVICES DEPARTMENT

Investing for tomorrow, delivering today.

MCP Timeline

- New Application Deadline-December 14, 2023: In response to stakeholder feedback, CMS has extended the application deadline for the Making Care Primary (MCP) Model by two weeks; the new deadline for application submission is **Thursday, December 14 at 11:59 p.m. EST.**

- Q3/Q4 2023: CMS discusses potential partnership with payers based on *MCP Payers Guide to Alignment.*

- February 2024: Deadline for payers to sign Letter of Interest to become MCP Payer Partner.

  March 2024: Accepted provider applicants sign Participation Agreements to join MCP.

- July 2024: MCP begins for participating organizations.

- August 2024: Payer Partners provide details to CMS on their alternative payment model for primary care and how it aligns with MCP.

- February 2025 – December 2025: Payer Partners sign non-binding Memorandum of Understanding with CMS to advance partnership efforts.

QUESTIONS & ANSWERS

Additional Information

For more information and to stay up to date on upcoming MCP events:

Visit

https://innovation.cms.gov/innovation-models/making-care-primary

Help Desk

Reach out to MCP@cms.hhs.gov for questions

Listserv

Sign up for updates

Follow

@CMSinnovates

TBD PCC MEETING DRAFT AGENDA

- Workforce Sustainability Update
- Primary Care Payment Reform Update
- Legislative Session Review
- RHCDF Update

HUMAN SERVICES DEPARTMENT

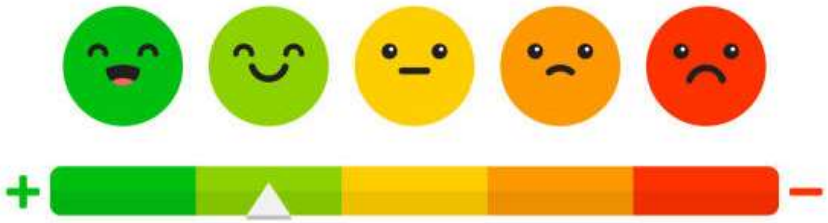
CLOSING COMMENTS

INVESTING FOR TOMORROW, DELIVERING TODAY.

YOUR FEEDBACK IS IMPORTANT TO US

MEETING CONTENT

- How would you describe our progress today?
- What topics would you like to see covered in future meetings?



MEETING DELIVERY

- What worked well? What didn't?
- In what areas can we improve facilitation?
- Do you have any other feedback or suggestions?

HUMAN SERVICES DEPARTMENT

APPENDIX

INVESTING FOR TOMORROW, DELIVERING TODAY.

APPENDIX TABLE OF CONTENTS & LINKS

- Kaseman Clinic Value Based Care Video
- NASEM Implementation Goals
- 2021 HB67 Duties
- New Mexico on the National Stage
- PCC Resources and Strategic Plan
- (Full Presentation) The Road to Value:
  NMBHPA Data Collection and APM Development Project
- Workforce Workgroup Strategic Initiatives

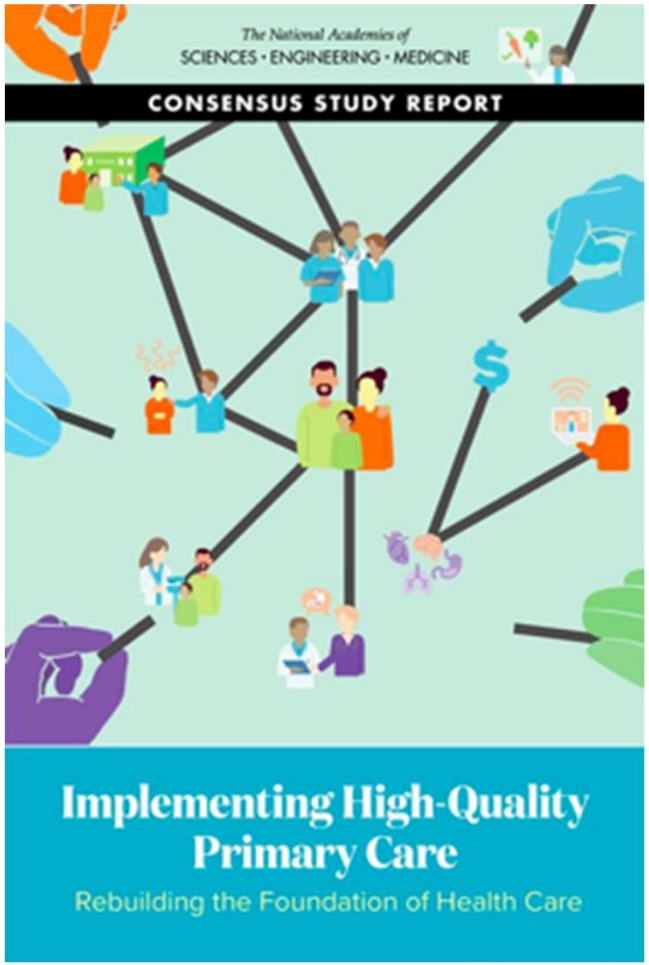
KASEMAN CLINIC VALUE BASED CARE PILOT

HSD worked with Presbyterian to better understand how Value Based Care (VBC) is being delivered in New Mexico. The Kaseman Clinic has a VBC pilot model they shared with us in the video below.

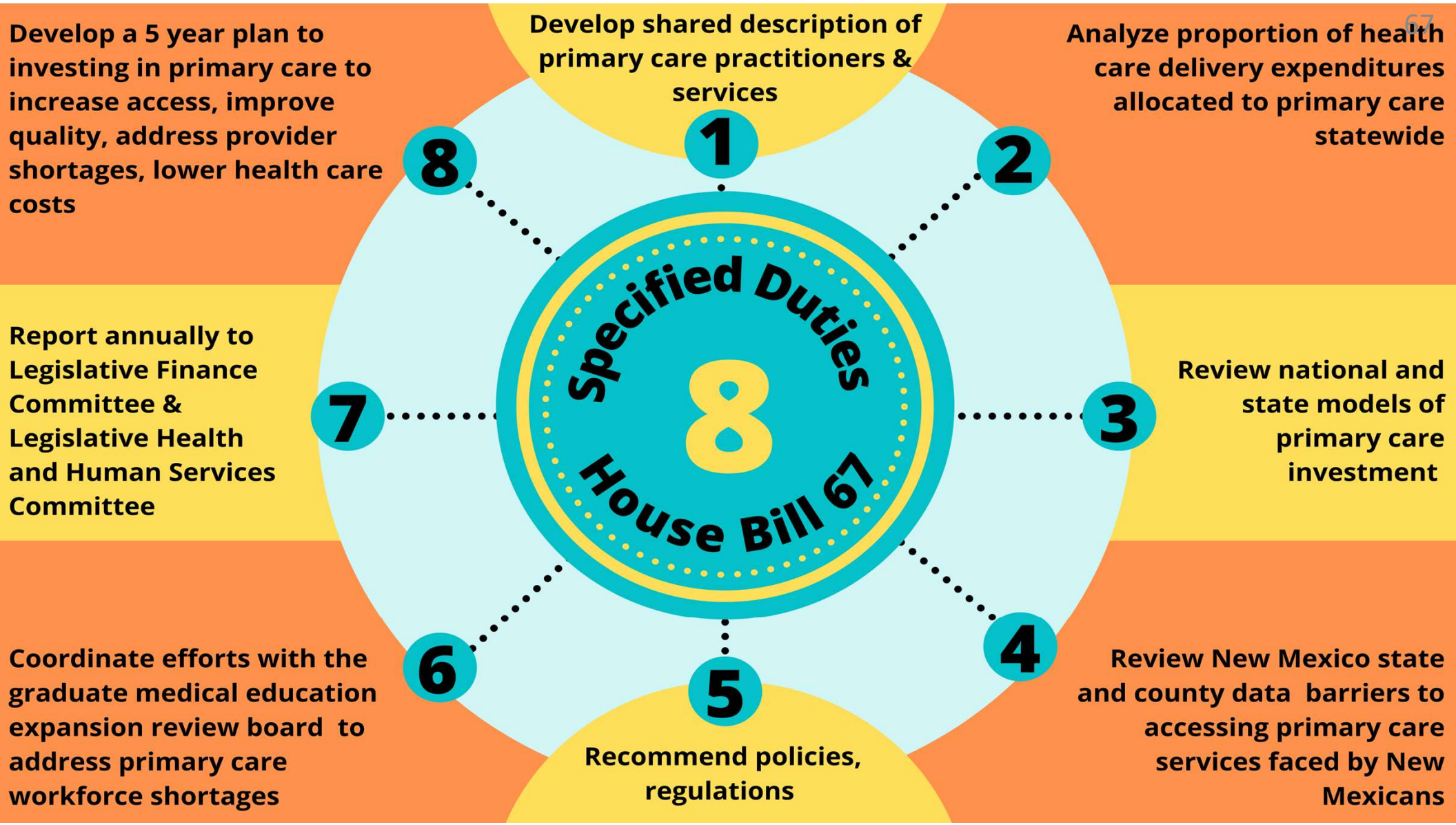
THE NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, & MEDICINE (NASEM)

Implementation Goals ("Objectives")

1. Pay for primary care teams to care for people, not doctors to deliver services.
2. Ensure high-quality primary care is available to every individual and family in every community.
3. Train primary care teams where people live and work.
4. Design information technology that serves patient, family, and interprofessional care team.
5. Ensure that high-quality primary care is implemented in the United States.



Source: https://www.nap.edu/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health


Specified Duties
8
House Bill 67
1
Develop shared description of primary care practitioners & services
2
Analyze proportion of health care delivery expenditures allocated to primary care statewide
3
Review national and state models of primary care investment
4
Review New Mexico state and county data barriers to accessing primary care services faced by New Mexicans
5
Recommend policies, regulations
6
Coordinate efforts with the graduate medical education expansion review board to address primary care workforce shortages
7
Report annually to Legislative Finance Committee & Legislative Health and Human Services Committee
8
Develop a 5 year plan to investing in primary care to increase access, improve quality, address provider shortages, lower health care costs

NEW MEXICO ON THE NATIONAL STAGE

Center for Health Care Strategies
New Mexico applied and was accepted for the Medicaid Primary Care Population-Based Payments & Learning cohort for states advancing primary care reform.

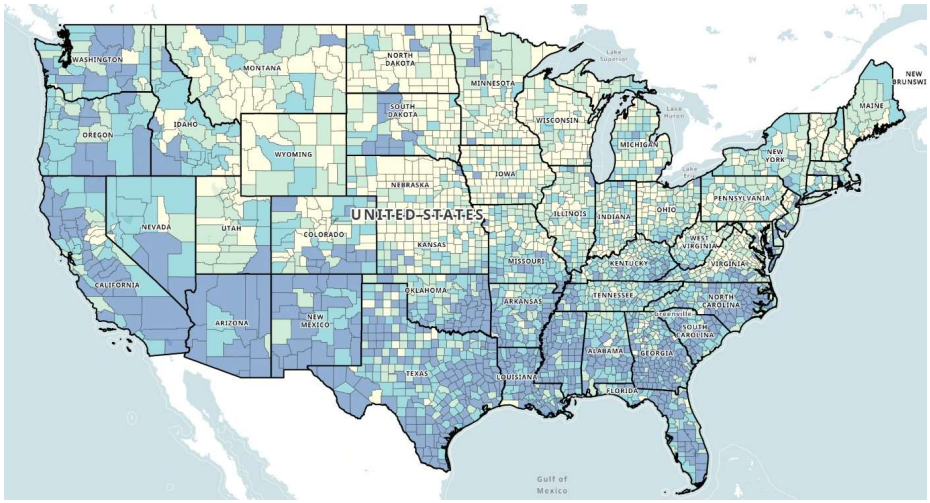
CMS Innovation Center
The CMS Innovation Center sought out a partnership with NM Medicaid because of the advancements we are making in primary care payment reform.

- New Mexico signed a letter of intent for the partnership which will begin June 2023 which will help align payment strategies across both payers.

Primary Care Coalition
New Mexico has joined a multi-state workgroup led by the Primary Care Collaborative on increasing primary care investment.

Milbank Memorial Fund
New Mexico was invited to join a multi-state Primary Care Investment Network.

U.S. Social Vulnerability, 2020



Level of Vulnerability

Low	Low-Medium	Medium-High	High	No Data

Source: CDC/ATSDR Social Vulnerability Index

HUMAN SERVICES DEPARTMENT

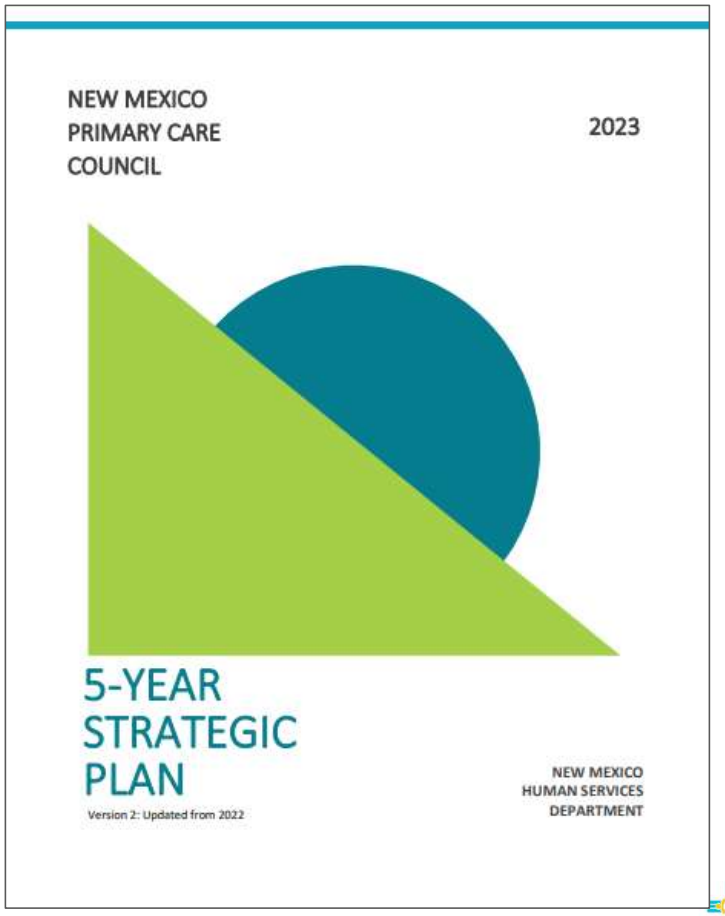
Investing for tomorrow, delivering today.

PCC RESOURCES AND STRATEGIC PLAN

PCC Website:

https://www.hsd.state.nm.us/primary-care-council/ to learn more about:

- PCC's 5-Year Strategic Plan
- Medicaid Primary Care Payment Reforms
  - Payment Reform FAQ
  - Video Overview
  - Webinars & Events
- PCC Quarterly Meetings



HUMAN SERVICES DEPARTMENT

Investing for tomorrow, delivering today.

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]

The Road to Value: NMBHPA Data Collection and APM Development Project

PCC Quarterly Meeting

Tuesday, December 5th, 2023

Agenda

- **Project Purpose, Goals, and Benefits to New Mexico**
- **Year 1:** Pilot Organization Selection, Metric Development, and Establishing a Data Collection/Reporting Platform
- **Year 2:** Implementation, Collaboration, Data Monitoring, and Preparing for Expansion
- **Proposed Years 3, 4, and 5**

HMA Pilot Project Team

Maggie McCowan

Gaurav Nagrath

Autumn Carparelli

Rachel Bembas

Margot Swift

Berkley Powell

Project Purpose, Goals, and Benefits to New Mexico

Project Purpose

Encourage behavioral health participation in innovative payment arrangements and, in the long term, develop a successful alternative payment model that can be implemented for behavioral health providers across the state.

- Built on a common set of meaningful, provider-driven behavioral health metrics.
- Support behavioral health organizations in developing infrastructure and capabilities to submit reliable quality data.
- Develop leadership activities necessary to transition from fee-for-service to value-based pay-for-performance reimbursement.
- Support New Mexico's vision for integrated behavioral health and primary care.

Benefits to New Mexico Behavioral Health

The project addresses a gap in the current measurement approach and its impact on behavioral health quality, patient experience, and other measures of patient care improvement.

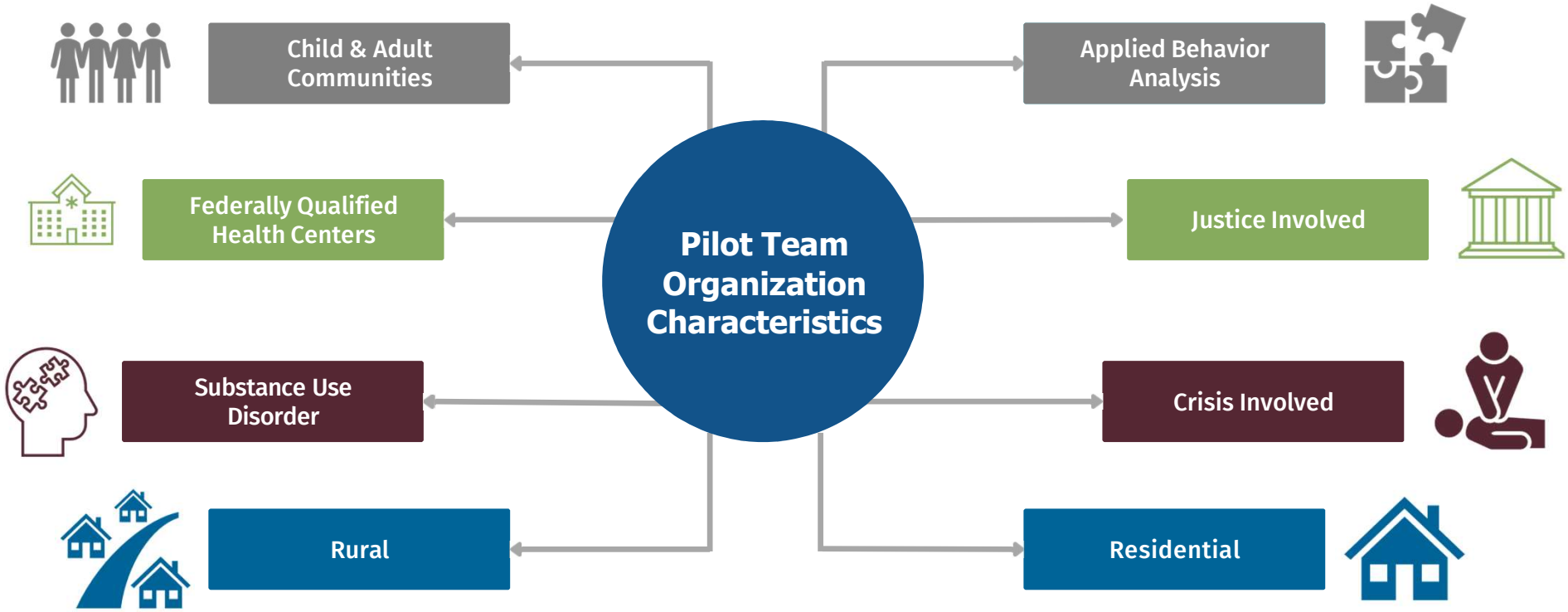
Behavioral health has trailed behind physical health in establishing evidence-based quality measures that can be empirically correlated to improved outcomes for the population.

The project lays the groundwork for behavioral health providers to be meaningfully incentivized to demonstrate quality and value.

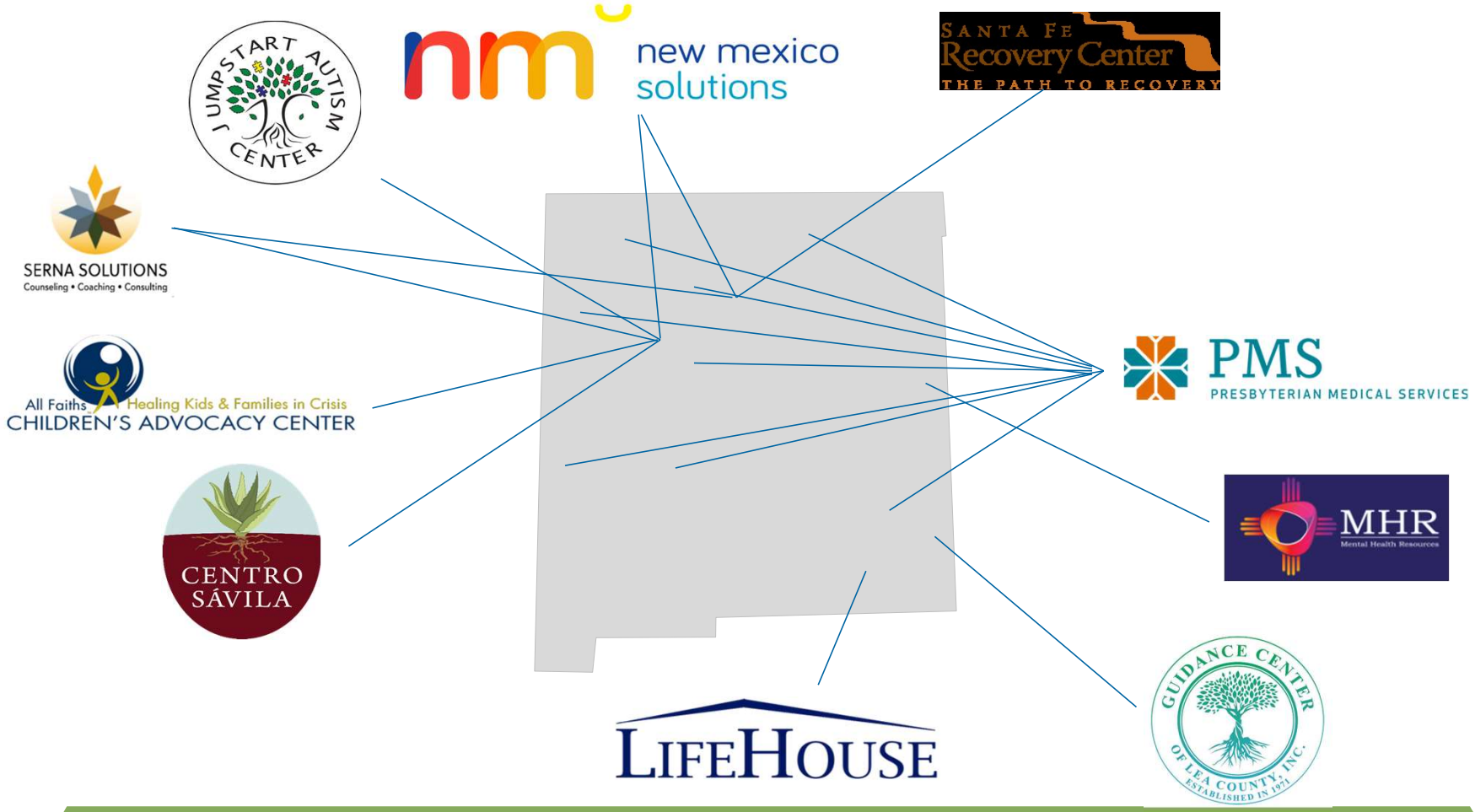
Year 1: Pilot Organization Selection, Metric Development, and Establishing a Data Collection/Reporting Platform

November 1st, 2022-June 30th, 2023

Pilot Organization Characteristics



Pilot Organizations



Behavioral Healthcare Payment Models

Behavioral healthcare payments as a key part of the entire healthcare delivery and payment system

Intended to:

- Reduce the administrative burden of behavioral health providers
- Encourage team-based approaches to care and coordination
- Allow for flexibility and innovation of value-based delivery approaches

Considerations for Meaningful Measurement for Behavioral Health Quality

Analytic Sophistication & Maturity

Metric Sophistication & Maturity

Standard	Complete Patient Record Data	Readmissions & Hospitalizations	Total Cost of Care
Good	Follow-Up Measures (HEDIS)	Medication Adherence & Co-Occurring Disorder Management	SMI Population Measures & Depression Remission Response
Better	Social Need & REAL (race, ethnicity, and language) Data Collection Reporting	CCBHC Metrics	High Acuity Events for Patient Panel
Best	Patient Panel Specific Disparity identification	Collaborative Processes to address patient needs (including social needs)	Health Outcome Improvement, Measurement Based Care, Morbidity & Mortality

Pilot Metric Development Was Provider-Driven

inform development of metrics

representatives provided input on what metrics are meaningful

menu of behavioral health metrics

- Can be tailored to different provider organization types

assessment identified organizational strengths and gaps in value-

with primary care

Metric Menu for Pilot Year

Mandatory Metrics *All must report*	Level I Metrics (Outcomes) *Choose 2*	Level II Metrics (Process) *Choose 2*
1. Measurement Based Care – PHQ-9 (APA)	❑ ASD Set of Patient-Centered Outcome Measure (ICHOM)	❑ Comprehensive Care for ABA Patients (Org-specific)
2. Social Needs Assessment (Org-specific)	❑ Functional Assessment Score Change (ICHOM)	❑ Improving Language Access (Org-specific)
3. Patient Experience of Care Survey (SAMHSA)	❑ Measurement Based Care – Other (Anxiety, SUD, etc.) (APA)	❑ Measure of Financial Burden to Patient (Org-specific)
4. % of Patients with Regular Engagement in Services (Org-specific)	❑ % of Patients with Successful Discharges (treatment goals achieved) (Org-specific)	❑ Depression Remission at 12 Months (MNCM)
5. Time to Initial Appointment for Diagnostic & Treatment Planning/Evaluation (SAMHSA)	❑ Net Promoter Score (Bain & Co)	❑ Emergency Department Utilization (Health Plan/State/Org)
6. Readmissions within 30 Days (NCQA)	❑ Deaths by Suicide (SAMHSA)	

Traditional Behavioral Health Metrics vs. NMBHPA Pilot Project Metrics

Sample of Traditional Behavioral Health Metrics	Sample of NMBHPA Pilot Project Metrics
• Follow-up after Hospitalization for Mental Illness – 7 days, 30 days • Follow-up after Emergency Department Visit for Mental Illness – 7 days, 30 days • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication • Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c • Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia • Metabolic Monitoring for Children and Adolescents on Antipsychotics • Use of Opioids at High Dosage	• Measurement Based Care • Social Needs Assessment • Patient Experience of Care • Regular Engagement in Care • Time to Initial Appointment for Diagnostic & Treatment Planning/Evaluation • Readmissions within 30 Days • ASD Set of Patient-Centered Outcome Measure • % of Patients with Successful Discharges • Deaths by Suicide • Improving Language Access • Measure of Financial Burden to Patient • Depression Remission at 12 Months • Emergency Department Utilization

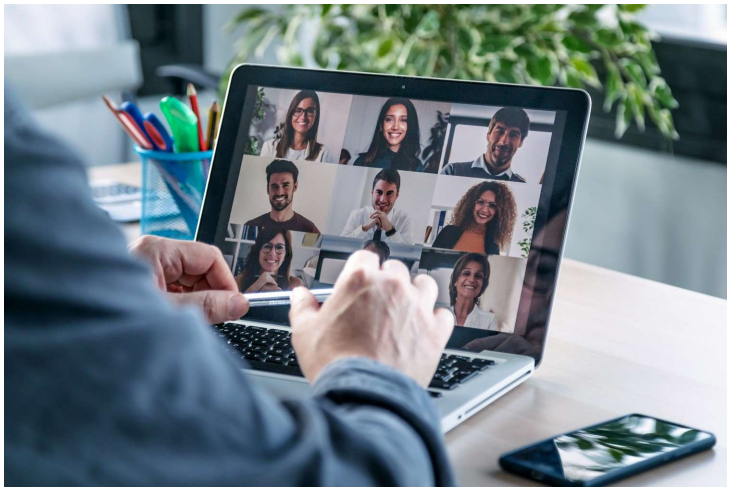
Year 2: Implementation, Collaboration, Data Monitoring, and Preparing for Expansion

July 1st, 2023-June 30th, 2024

Implementation: Data Collection and Provider Supports

Pilot organizations successfully submit quality data and receive corrective support

- Monthly office hours provide structured, learning collaborative setting for problem solving and discussing best practices
- Regular calls with pilot organizations allow for troubleshooting individual issues



Measure Baselines

The baseline represents the starting point. The target represents the realistic goal of where you want to end up. Combined, they are the key points needed to quantify progress over time.

- Baseline: July-October rate across pilot (cumulative numerator / cumulative denominator)
  - Only includes organizations that selected each addt'l measure
- Floor: Minimum of range calculated by taking the lower 95% confidence interval
- Ceiling: Maximum of range calculated by taking higher of the 95% confidence interval

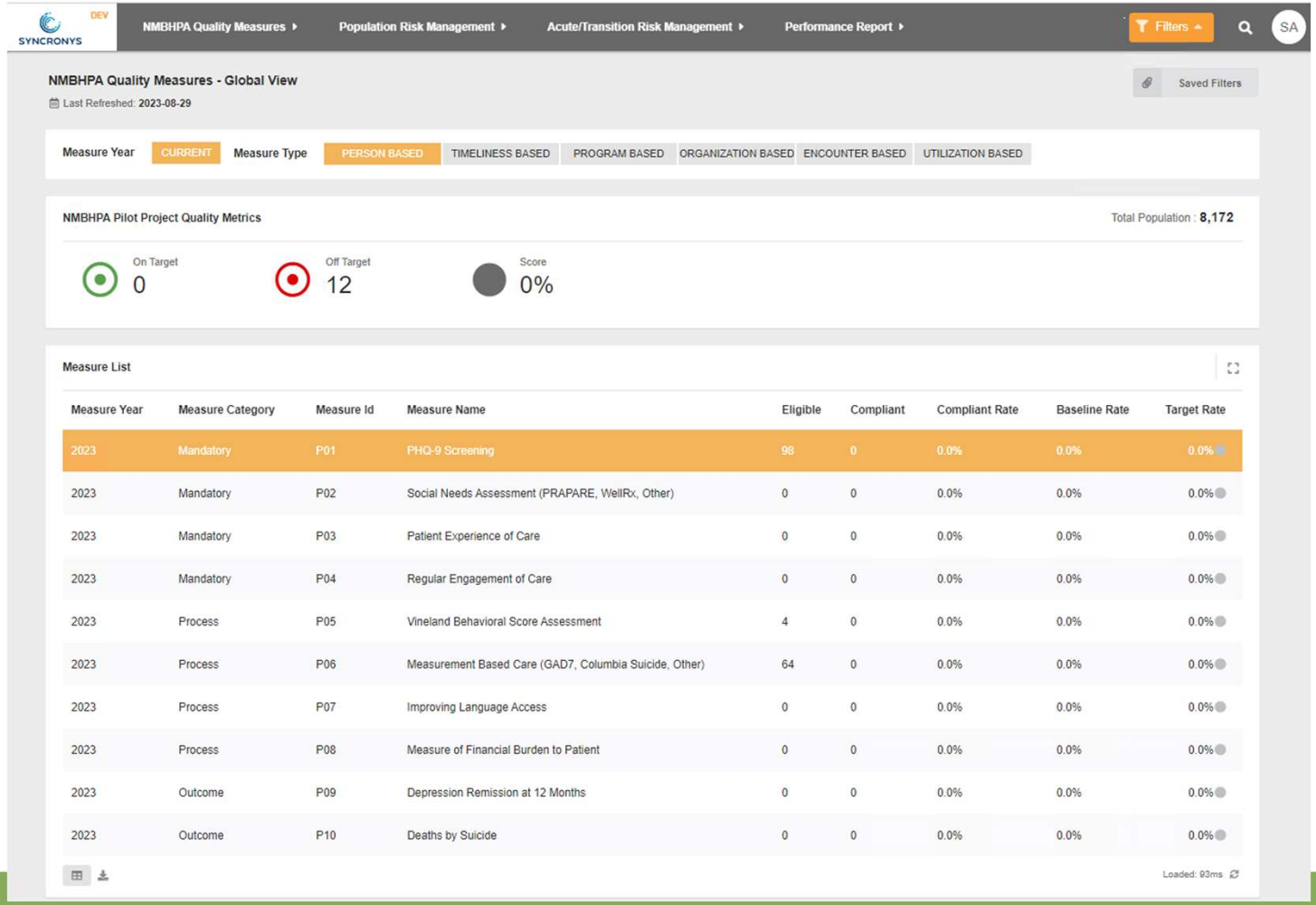
	Measure	Baseline	Floor	Ceiling
Mandatory	PHQ-9 Screening	**1.0%**	0.0%	3.0%
	Social Needs Assessment	**9.4%**	0.0%	34.8%
	Patient Experience of Care	**2.0%**	0.0%	25.2%
	Regular Engagement of Care	**67.0%**	40.4%	100%
	Days from Intake to Eval	**1.2**	0.0	13.0
	Days from Intake to Eval-Treat First	**18.8**	6.2	36.9
	All Cause Readmission	**12.4%**	6.9%	19.8%
Process	Vineland	**0.0%**	0.0%	0.0%
	Measurement Based Care (GAD-7)	**1.0%**	0.0%	1.4%
	Measurement Based Care (Columbia)	**22.7%**	0.0%	39.3%
	Improving Language Access	**9.3%**	0.0%	38.1%
	Measure of Financial Burden to Patient	**17.6%**	0.0%	44.5%
Outcome	Depression Remission	**0.0%**	0.0%	0.0%
	Deaths by Suicide	**0.0%**	0.0%	0.0%
	Percent of Successful Discharges	**32.8%**	0.0%	74.1%
	ED Visits per 100	**4.4**	0.1	9.9

Collaboration: SYNCRONYS & EHR Vendors

SYNCRONYS is engaged to support collecting data from provider organization and create actionable behavioral health dashboards

Pilot organizations' EHR vendors are engaged to facilitate streamlined and accurate data collection

Dashboard Snapshot



The aggregate view, showing compiled results from all organizations

Develop a Behavioral Health Pay-for-Performance Payment Framework

Refine quality measures as needed to ensure they are meaningful to providers, align with other reporting requirements, and accurately measure quality and access

Build from baseline performance and benchmarks to develop a pay-for-performance alternative payment model (APM)

Select 20 new pilot organizations to participate in project Year 3, with particular consideration given to adding small and rural sites

Proposed Years 3, 4 and 5

July 1st, 2024-June 30th, 2027

Proposed Year 3

July 1st, 2024-June 30th, 2025

Grow the Data Ecosystem

- 20 new pilot organizations begin submitting quality measures
- 10 continuing pilot organizations become key champions as payment reform expands

Collaboratively Design and Refine an Alternative Payment Model

- Providers, State representatives (BHSD and Medicaid), and MCOs provide input to finalize the APM
- APM tested and evaluated for efficacy
- APM broadly socialized with behavioral health providers statewide

Proposed Years 4 and 5

Year 4
July 1st, 2025-June 30th, 2026

- Entry-level APM, based on fee-for-service reimbursement, launches statewide

Year 5
July 1st, 2026-June 30th, 2027

- Enhanced APM tiers (e.g., shared savings/risk) launch statewide
- Comprehensive APM supports strong integration between behavioral health and primary care

Questions?

Maggie McCowen
mrmccowen@nmbhpa.org

Gaurav Nagrath
gnagrath@healthmanagement.com

HEALTH MANAGEMENT ASSOCIATES

WORKFORCE STRATEGIC INITIATIVES

INITIATIVE NAME	OWNER	DETAILS	STATUS
Health Professional Loan Repayment Program	HED	HSD is working with HED to extend the fund to additional degree types and increase the amount available for awards. •$14.6 million was available for the program	Enrollment is closed for FY24 HSD is having conversations with HED for FY25
Health Worker Burnout	HSD/PCC	Implement recommendations provided by the US Surgeon General on Addressing Health Worker Burnout and implement programs relevant needs in NM.	The PCC Workforce Workgroup will review recommendations and propose how we can adopt in NM.
Workforce Wellness	HSD/PCC	Reducing the stigma around mental and substance use treatment for health workers is a priority of the PCC.	Generating ideas on how to support
Workplace Violence	PCC/HSD	The PCC Workforce is researching ways we can help reduce and prevent health care workplace violence	Generating ideas on how to support
Workforce Analysis	PCC/HSD/NMHA	HSD & PCC are working on solutions in partnership with the NMHA on a high-quality and accurate workforce analysis to be included in a detailed dashboard and scorecard.	Developing plans

WORKFORCE STRATEGIC INITIATIVES

INITIATIVE NAME	OWNER	DETAILS	STATUS
Primary Care Payment Reforms	PCC/HSD	Primary Care value-based payments will begin January 2025. The Medicaid PC VBP will support the workforce by: 1.Reduce Workforce Administrative Burden 2.Pay for and incentivize patient health outcomes 3.Prospective payments that provide a more stable financial environment	Tier 1 of the model will roll out 7/1/24, Tiers 2 & 3 will roll out 1/1/2026
Multi-Payer Alignment	PCC/HSD/OSI/ CMS	NM Medicaid is partnering with CMS on the Making Care Primary Initiative. This is bringing Primary Care VBP alignments to NM that will help reduce provider burden. CMS OSI and HSD/PCC will work together in early CY2025 to begin conversations about commercial insurance alignment.	Medicaid & Medicare payment alignments will begin when both models roll out. Conversations on commercial insurance alignment will begin CY25.
Prior Authorizations	HSD/OSI	Updating Prior Authorization practices will reduce provider burden. Two changes to prior authorizations policy are being considered. 1. Gold-Carding for providers exempts physicians from prior authorization requirements so long as 90% of the doctors' requests were approved in the preceding 12 months. 2. Implement automatic external medical reviews of upheld MCO prior authorization denials.	PCC and OSI are discussing feasibility of these options

WORKFORCE STRATEGIC INITIATIVES

INITIATIVE NAME	OWNER	DETAILS	STATUS
Claims Process	HSD/OSI	Claims denials should be reviewed and audited to ensure compliance. Ensure clean payment standards are being adhered to.	OSI and HSD working together on ideas to improve standards.
PBM Contracts	HSD/OSI	Review issues with PBM related provider burdens.	PCC to review and make recommendations to reduce provider burdens related to PBM contracts.
Medicaid Provider Enrollment/MCO Credentialling Process	HSD/PCC/OSI	Track timeframes for Medicaid provider enrollment, simplify enrollment process and develop a manual on how to enroll. Propose updates to the current MCO credentialing process to make the process more streamlined. Recommend Medicaid to audit MCO Credentialling Standards.	OSI has provided data on enrollment times. OSI is also considering solutions to overall insurance enrollment processes. I need to talk with Medicaid to determine how to simplify. MCOs were recently fined for not meeting standards
"Workforce Cascade"	PCC	The PCC Workforce Workgroup is developing a state-wide strategic approach to supporting health care workforce development opportunities beginning in elementary education. The PCC is also working on ideas for workforce recruitment and retention.	Discussing Strategy

WORKFORCE STRATEGIC INITIATIVES

INITIATIVE NAME	OWNER	DETAILS	STATUS
Residency / Workforce Expansion	PCC/HSD/NMHA/NMPCTC	Exploring ways to sustain current rural residency programs, providing support for other professions that require post-graduate training, and increasing preceptorship.	NMPCTC is exploring sustainability for current rural residency programs. PCC is collaborating with NMPCTC, NMHA and others to expand to other professions and how to offer incentives for preceptors.
State-wide EHR	HSD/DOH	A state-wide Electronic Health Record is established for Medicaid and other state-agencies. Will allow for purchasing power and potentially can offer discounted or sliding scale fees for independent and rural practices.	DOH and HSD are collaborating to develop a 2025 legislative request.
RPHCA Program	DOH	The Rural Primary Health Care Act (RPHCA) Program provides funding to sustain a minimum level of delivery of primary care services in healthcare underserved areas of New Mexico.	DOH will continue to provide updates to HSD.
J1-Visa Waiver (federal program)	DOH	Recommends to extend residency in the US for workforce to practice in rural areas (up to 30 per federal fiscal year).	DOH will continue to provide updates to HSD.

WORKFORCE STRATEGIC INITIATIVES

INITIATIVE NAME	OWNER	DETAILS	STATUS
NM Health Services Program	DOH	Supporting students who commit to working in rural communities.	DOH to continue to provide updates to HSD.
Rural Health Care Tax Program	DOH	Income tax credit for providers who are in rural areas	Potential for additional provider types (line item vetoed by the Gov. in the 2023 session).
BH Supervision Requirements	Bill at Dept of Higher Ed	$3-4million in support so that BH providers can get their licensure	HED to update HSD on progress.
Youth pipeline programs	PCC & Others	There are several pipeline programs happening across New Mexico.	PCC will review programs and make recommendation on how to support and/or expand.