HUMAN SERVICES DEPARTMENT

NEW MEXICO PRIMARY CARE COUNCIL MEETING
NOVEMBER 9, 2022

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.

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.

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.

Time	Agenda Item	Facilitator(s)	Desired Outcome
9:00	Welcome	Elisa	Frame meeting and objectives, review agenda, and establish quorum.
9:05	Opening Remarks	Jen	
9:10	We're growing! Primary Care Council Updates	Elisa & Alex	Update members on Council activities and developments.
9:25	PC Alternative Payment Model (APM) Development Update	Elisa	Shared understanding of PC APM vision and expected outcomes, and the stakeholder engagement processes driving APM development.
10:25	PCC Strategic Priorities	Elisa	Develop a list of new PCC strategic objectives and tactics across the Council's four goals.
11:45	Closing Remarks	HSD & Council Members	
12:00	*Adjourn*		

NORMS FOR TODAY'S MEETING

- Listen actively and speak respectfully to and about others.
- Take space, make space.
- If you wonder, ask.
- Take breaks when needed.
- Raise your hand using zoom to make a comment/ask a question.
- During discussion, engage in popcorn style facilitation and call on the next speaker when hand is up.
- **Revolutionize, revolutionize, revolutionize!**

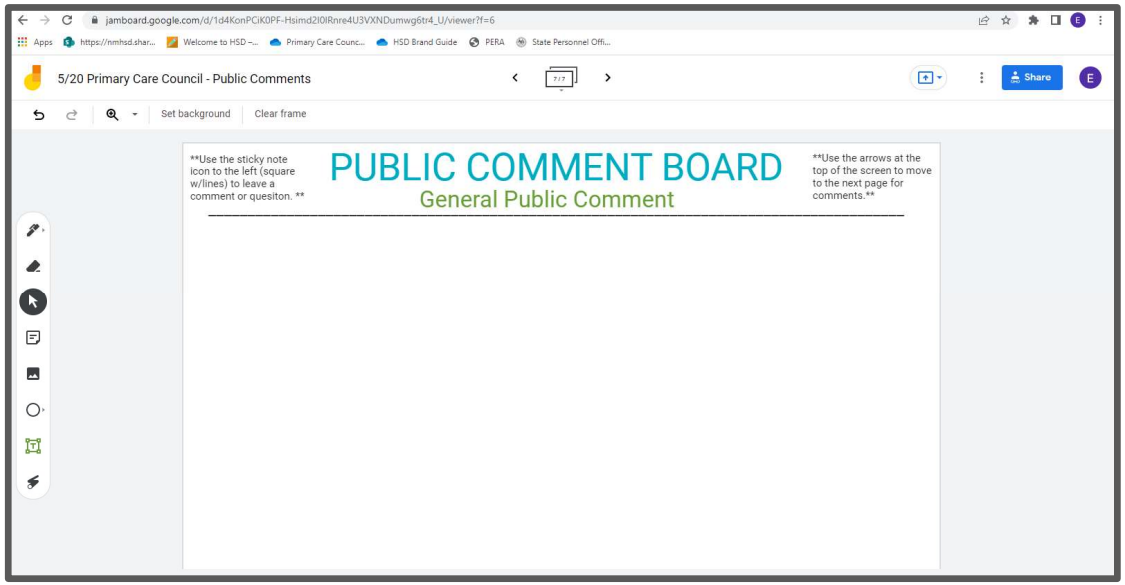
Raincloud Medicine, Rebecca Lee Kunz

Source: Tree of Life Studio

WE WANT TO HEAR FROM YOU

PCC Members:

- Comments will be taken on Jamboard. Link has been emailed to you.
- Please provide your availability for the next quarterly meeting using Rally Poll for March quarterly meeting
- Please provide your availability for the following quarterly meeting using Rally Poll for June meeting
- Zoom poll for in-person meeting



Community Members:

- Comments will be taken on Jamboard.
- Link has been shared in the Zoom chat.

HUMAN SERVICES DEPARTMENT

KUDOS

Congratulations to ***Val Wangler*** on the opening of Gallup Community Health!!

Thanks for being a champion for Primary Care in New Mexico!

THE TRUTH WELL TOLD

Independent

ALCS Page 9

GALLUP, NEW MEXICO 87301

Getting healthcare back on track

2022 E Aztec Ave • Gallup,

William C. Weaver IV/Independent

Dr. Valory Wangler poses in front of Gallup Community Health after the ribbon-cutting ceremony Wednesday.

Local healthcare champion opens non-profit center

By Cassidy Morgan
Staff writer
cmorgan@gallupindependent.com

GALLUP — McKinley County has the largest shortage of primary care providers in the state of New Mexico. The impacts of this shortage have serious consequences on the accessibility and quality of healthcare available to members of the community – particularly for underserved demographics such as women, low-income individuals, and minorities.

Gallup, home to about 22,000 people, has only two major medical facilities that serve the city's population in addition to thousands more who come in from surrounding tribal communities. These facilities have a combined total of less than 200 beds and are often understaffed with limited resources.

Even if healthcare was more available in the area, there is still a significant demographic that would not have the means to pay for even the most basic of treatment. So then, what is there to be done and who will do it?

Champions for healthcare

Dr. Valory Wangler, founder and Executive Director of Gallup Community Health, has been a champion for healthcare in the region for the past 12 years. Hailing originally from Texas, she has served as the Chief of

See Gallup Community Health, Page 5

William C. Weaver IV/Independent

Gallup Community Health patient Kelly Arendsen helps her son cut the ribbon during the Gallup Community health grand opening Wednesday in Gallup.

HUMAN SERVICES DEPARTMENT

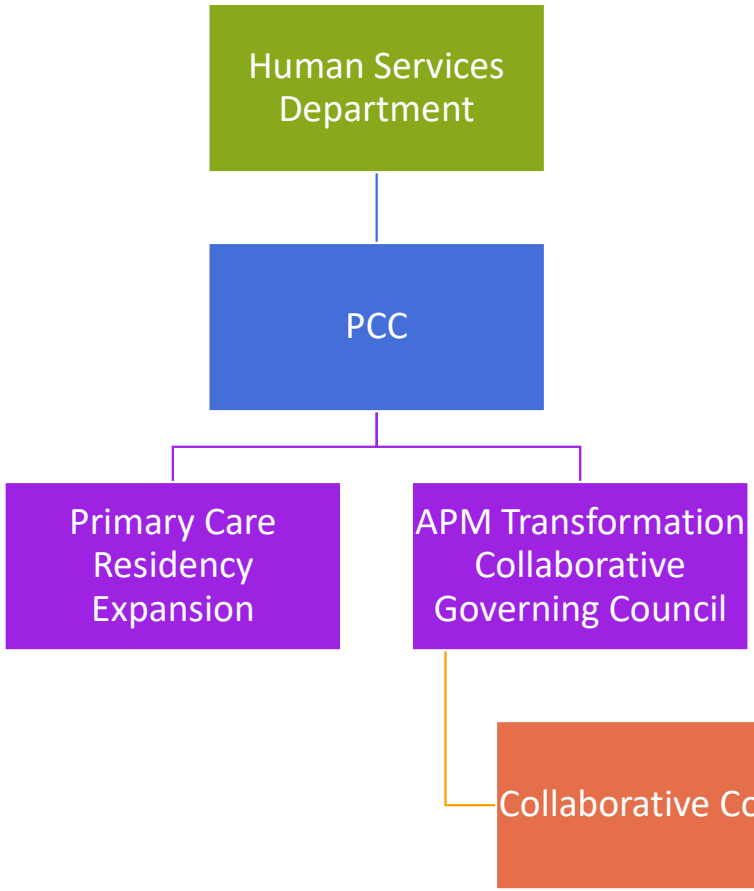
Investing for tomorrow, delivering today.

OPENING COMMENTS

Jen Phillips, M.D.
PCC Chair

PRIMARY CARE COUNCIL IS GROWING!

- To help meet PCC duties outlined in House Bill 67, HSD is strengthening PCC capacity by:
  - Integrating Primary Care Residency Expansion partners with the PCC.
  - Launching Alternative Payment Model (APM) Transformation Collaborative Governing Council & Cohort.



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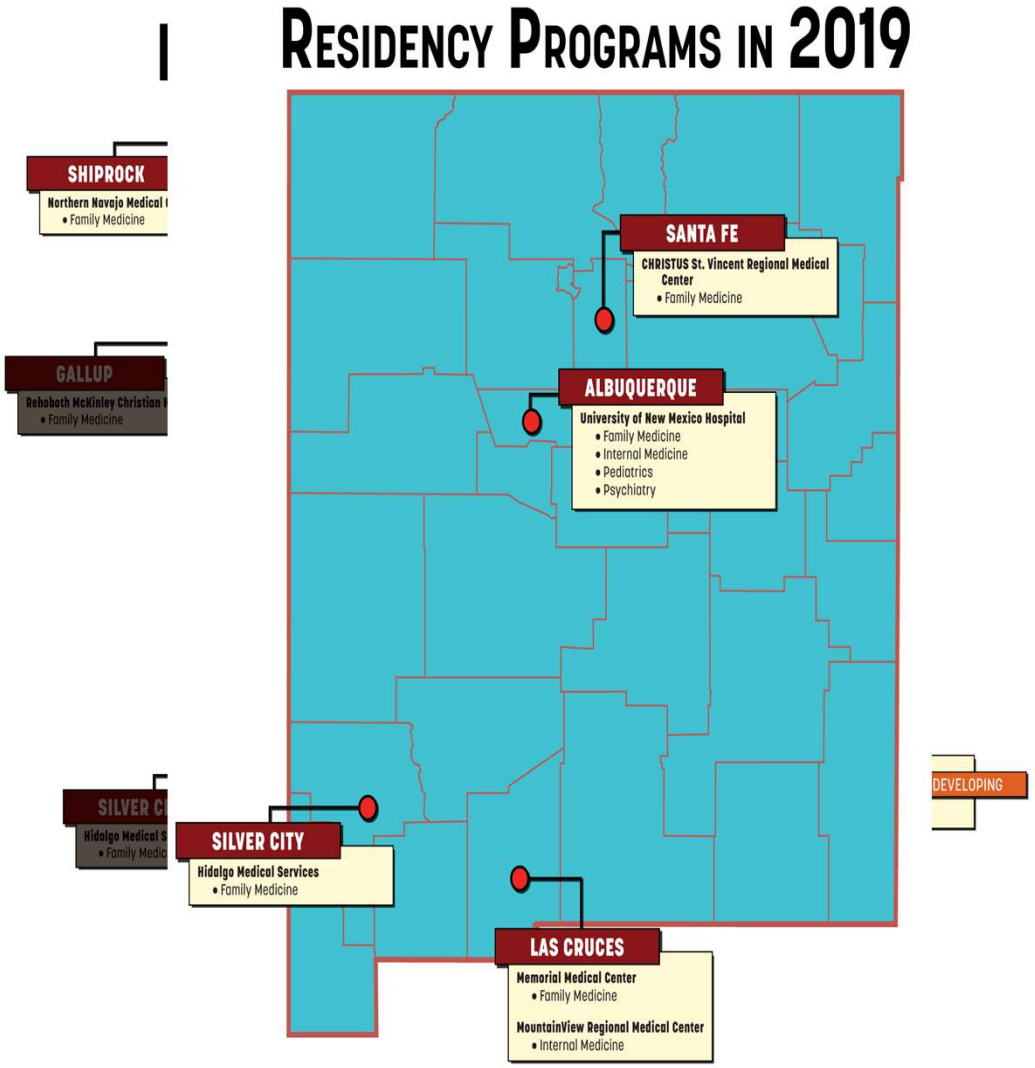
PRIMARY CARE COUNCIL IS GROWING: RESIDENCY EXPANSION

- PCC statute calls on PCC to coordinate with members of Residency Expansion.
- 2019 House Bill 480 established Primary Care Graduate Medical Education Expansion Program to grow residency programs in NM.
- Primary Care Residency Expansion members have met since Fall 2019 to award funding to programs and promote financial and academic sustainability.
- Deadline for next round of program funding is early 2023.
- Many PCC members are also active in Residency Expansion.



RESIDENCY EXPANSION SUPPORT SINCE 2019

Program	Specialty	Location	Funding	New or Expanding Program	First Year Residents	Anticipated Residency Start Date
El Centro Family Health/CHRISTUS St. Vincent	Family Medicine	Española	$487,339	New	4	2024
Burrell College of Osteopathic Medicine (BCOM)	Family Medicine	Las Cruces	$236,640	Expansion	4	Summer 2021
BCOM	General Psychiatry	Hobbs	$122,373	New	2	Summer 2024
BCOM	Family Medicine	Hobbs	$122,373	New	6	Summer 2024
Doña Ana	Gen. Psychiatry	Las Cruces	$546,308	New	3	Summer 2024
CHRISTUS St. Vincent Regional Medical Center	Family Medicine	Santa Fe	$374,950	Expansion	6	2021
TOTAL			**$1,889,983**		**25**	

FINANCIAL SUSTAINABILITY FOR RESIDENCY EXPANSION

- Medicaid has implemented several actions since 2019 to incentivize primary care GME expansion.
- Additionally, each recipient of GME support must certify all funding will go directly to GME program. →

Area	ion
1. Raise state annu limit to reflect full needed for expansi	e Plan SPA) al limit.
2. Address FTE lir full amount neede and anticipated ex	FTE cap.
3. Increase payme to incentivize new Care resident posit	w Primary $100,000. FTE ,000.
4. Make payments resident FTE posit equitable.	existing (regardless qually at
5. Amend provide eligible for Medic payments.	eligibility d Rural s.

subject to the total resident FTE described below.

2) Existing GME Positions
   i. GME payment amount per current resident FTE; the annual Medicaid payment amount per resident FTE in state fiscal year 2021 for 510 FTE residents counted as of the end of state fiscal year 2019 is as follows:
      - Primary Care and General Psychiatry resident $50,000
      - Other resident $50,000
   ii. The per resident amounts will be inflated for state fiscal years beginning on or after July 1, 2021 using the annual inflation update factor described in paragraph e.1.

3) Expansion GME payment amount per resident FTE
   i. Expansion positions are new ACGME-approved positions that begin training on or after July 1, 2020;
   ii. The annual Medicaid payment amount per resident FTE beginning with state fiscal year 2021 is as follows:
      - Primary Care and General Psychiatry resident $100,000
      - Other resident $50,000
   iii. "Other" resident FTE will be equal to or less than the number of eligible new/expanded Primary Care and Psychiatric Residents in any prior fiscal year.
   iv. The total number of expansion residents of hospitals, FQHCs and RHCs will be limited to the number of Primary Care and Psychiatric resident FTEs approved in the annually updated state GME Expansion Strategic plan and shall not exceed 101.
      - SFY 2021 - 2 FTE
      - SFY 2022 - 21 FTE
      - SFY 2023 - 31 FTE
      - SFY 2024 - 32 FTE
      - SFY 2025 - 15 FTE
      - Each year after shall be limited by 10 FTE per year or

The annual Medicaid payment amount per resident FTE as set forth in paragraph c.3(ii) above is contingent upon the certification of each participating GME program director that increased GME funding will go directly to the GME program.

d. State Academic Medical Center:

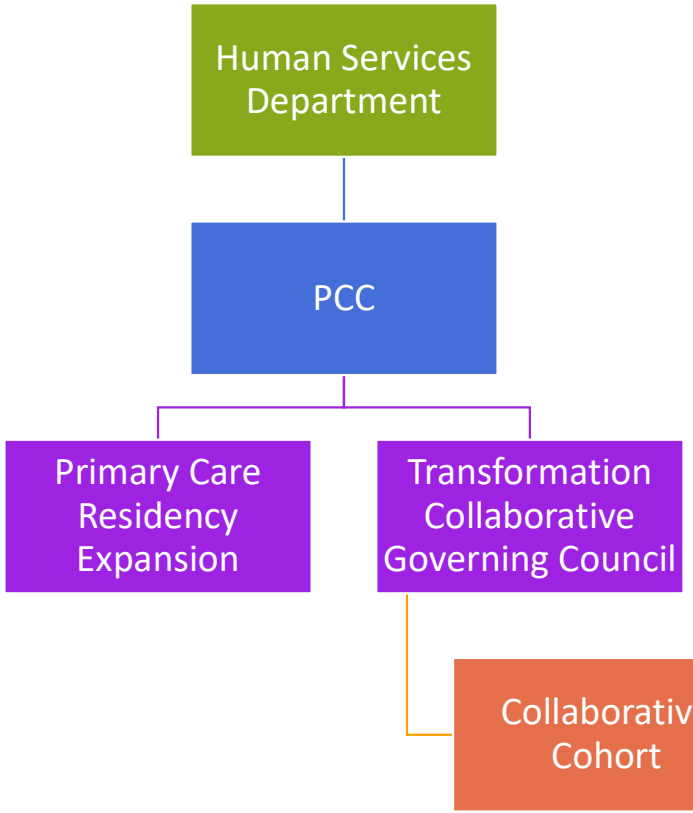
1) The State Academic Medical Center shall provide the state share of the general fund needed to support its number of GME FTEs through an intergovernmental transfer (IGT). FTEs for the State Academic Medical Center shall only be limited by the IGT the State Academic Medical Center makes available.

TN No. 20-0019 Approval Date 5/25/21

Supersedes TN. No. 16-008 Effective Date July 1, 2020

PRIMARY CARE COUNCIL IS GROWING! CLINICIAN & PROVIDER TRANSFORMATION COLLABORATIVE

- Significant factor in successful APM adoption is provider and clinician buy-in and support.
- Collaborative composed of primary care clinicians and providers as well as representatives from payors and community organizations and organized into 2 groups:
  - Governing Council will provide strategic direction to PCC on successful APM provider and clinician adoption.
  - Cohort will provide feedback on APM technical assistance implementation, and relay information from PCC to their networks.



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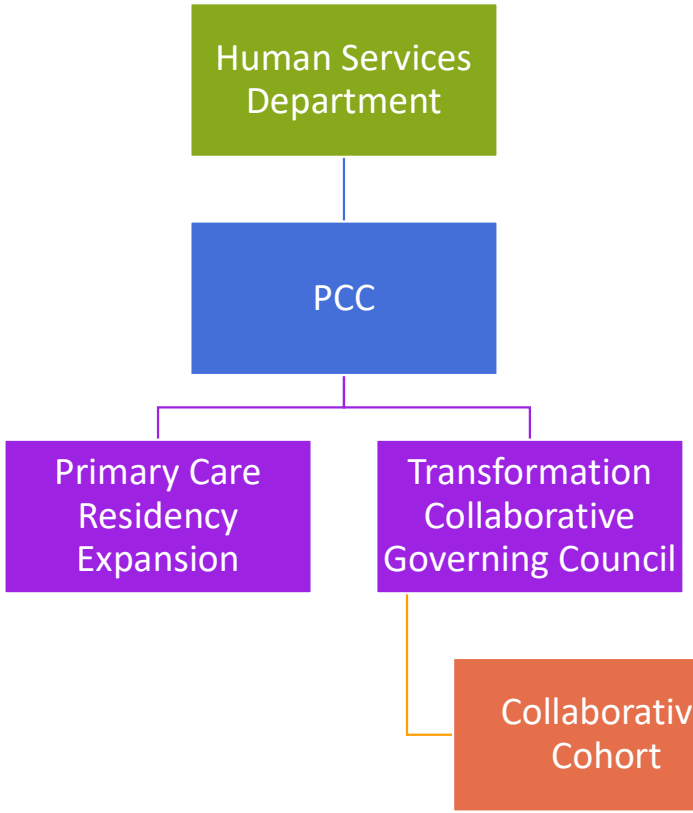
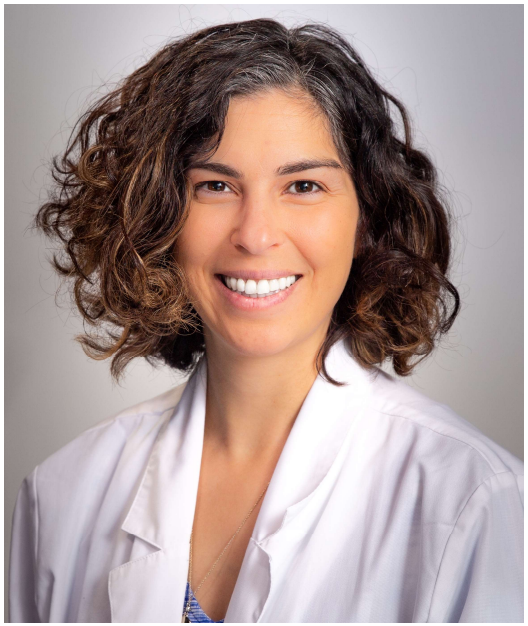
PRIMARY CARE COUNCIL IS GROWING! CLINICIAN & PROVIDER TRANSFORMATION COLLABORATIVE

- PCC Member Jon Helm serves on Governing Council.
- Collaborative will not advise on design of APM itself; this will remain role of PCC.
- Proposed Transformation Collaborative Purpose Statement: *Revolutionize primary care team payment by influencing, adopting, and championing alternative payment models to achieve health equity and transform the health of New Mexicans.*



Voting members: please use the zoom poll to ratify.

HSD OPENING COMMENTS



Alanna Dancis, MSN, CNP
Medical Director, HSD-MAD
HSD PCC Representative

New Mexico Medicaid Primary Care Alternative Payment Models will Address

HEALTH EQUITY | WORKFORCE SUSTAINABILITY | HEALTH TECHNOLOGY

Human Services Department is partnering and collaborating with New Mexicans to provide feedback and provide technical assistance. Our aim is to provide High Quality, Equitable Primary Care to all New Mexicans.

Benefits for Patients & Families

Increased health equity
Increased access
Better health care quality
Whole-person, team-based care
Integrated Behavioral Health, Dental, & Vision
Connection to Social Services & Community
Reduced health care costs

Benefits for Clinicians & Providers

Sustainable workforce & improve workplace wellness
Payment for care of patents
Increased flexibility and administrative efficiency
Team-based care approach
Increased patient care time
Sustainable financial models
Improved technology resources

Benefits for Communities

Increased public and population health focus
Relationships between social services, providers, and community members
Improved health outcomes

Benefits for Payors

Ability to measure health outcomes
Payment for quality and health outcomes
Reduction in hospital utilization
Incentives for efficient use of health care dollars

HUMAN SERVICES DEPARTMENT

HMA

New Mexico Primary Care Alternative Payment Model

Primary Care Council Quarterly Meeting

Wednesday, November 9, 2022

Agenda

I. **Work To Date**
    a. **Preliminary Provider Readiness Survey High-Level Results**
    b. **Themes from Focus Groups and Ongoing Stakeholder Engagement**
II. **Primary Care Alternative Payment Model (APM) Framework**
III. **Breakout Room Feedback Discussions**
IV. **Breakout Room Report-Outs**
V. **Next Steps for APM Development and Stakeholder Engagement**

Work To Date

Transformation Collaborative:

- Held first Transformation Collaborative Governing Council meeting on 10/28 and drafted the group's Purpose Statement.
- Next meeting is on 11/29 and will include the full Collaborative (Governing Council + Collaborative Cohort).

Ongoing Stakeholder Engagement:

- Meeting with the PCC Payment Strategies and Health Data Equity Workgroups monthly.
- Conducted discussions with NATAC, the New Mexico Medical Society, and SYNCRONYS users.

APM Design:

- Received and summarized NM Medicaid managed care encounters and FFS data. Currently reviewing data for gaps in care to inform quality metrics and baseline delivery system structure.
- Outlined the APM framework (to be shared today) and quality metric framework.

Provider Readiness Assessment:

- Conducted provider readiness survey in September and received 70 responses.
- Conducted four focus groups in October and November: small/medium practices, hospitals, FQHCs and interprofessional teams.

PC APM Readiness Survey Respondents

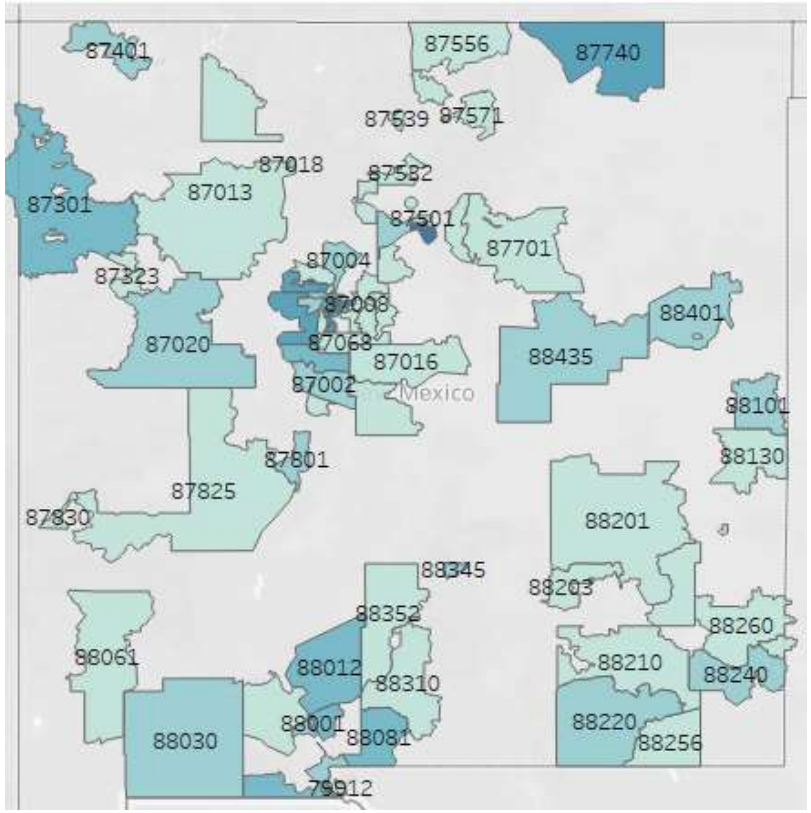
Practice Size

	Count	Percent
Individual Provider	13	19%
2-20 Providers	39	57%
21-100 Providers	9	13%
More than 100 providers	7	10%

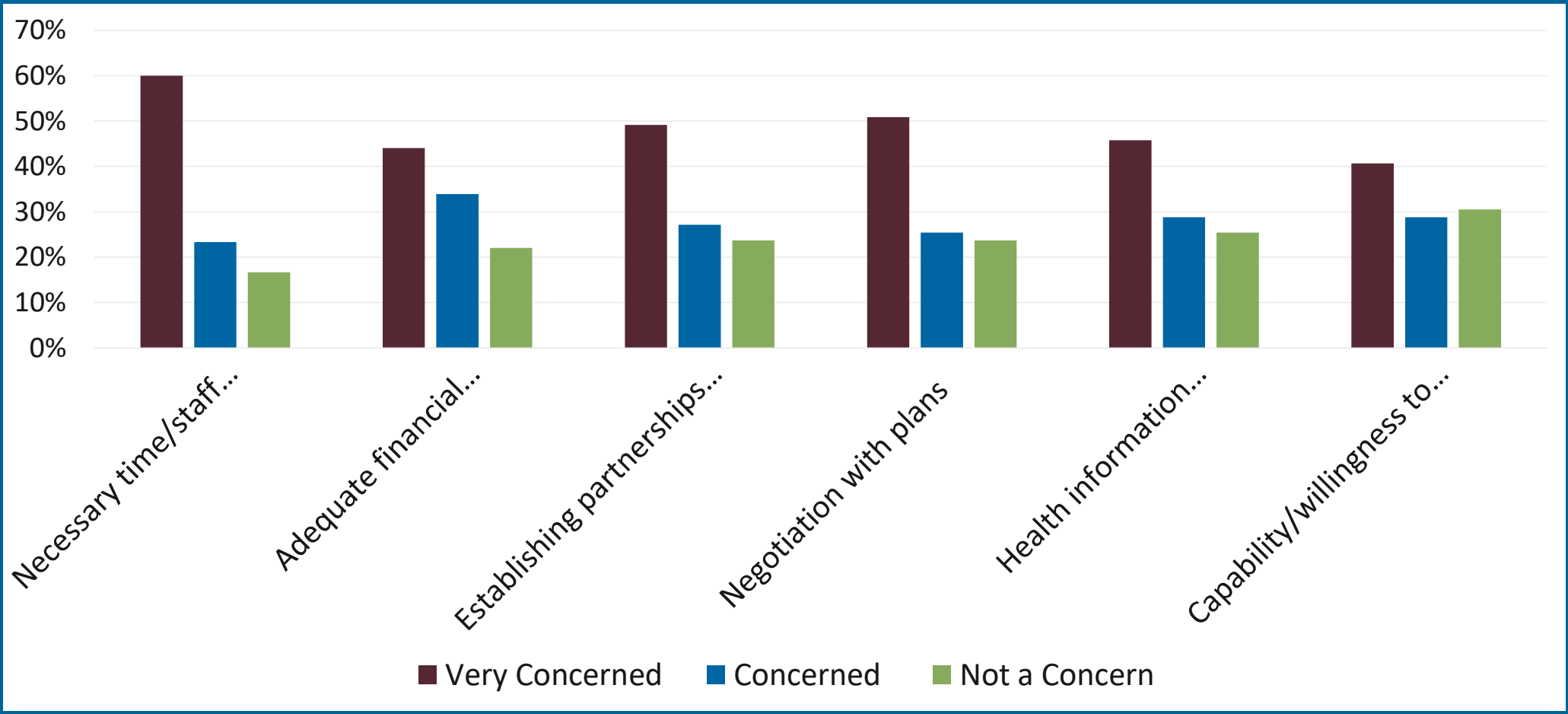
FQHC Status

	Count	Percent
Yes	16	24%
No	52	76%

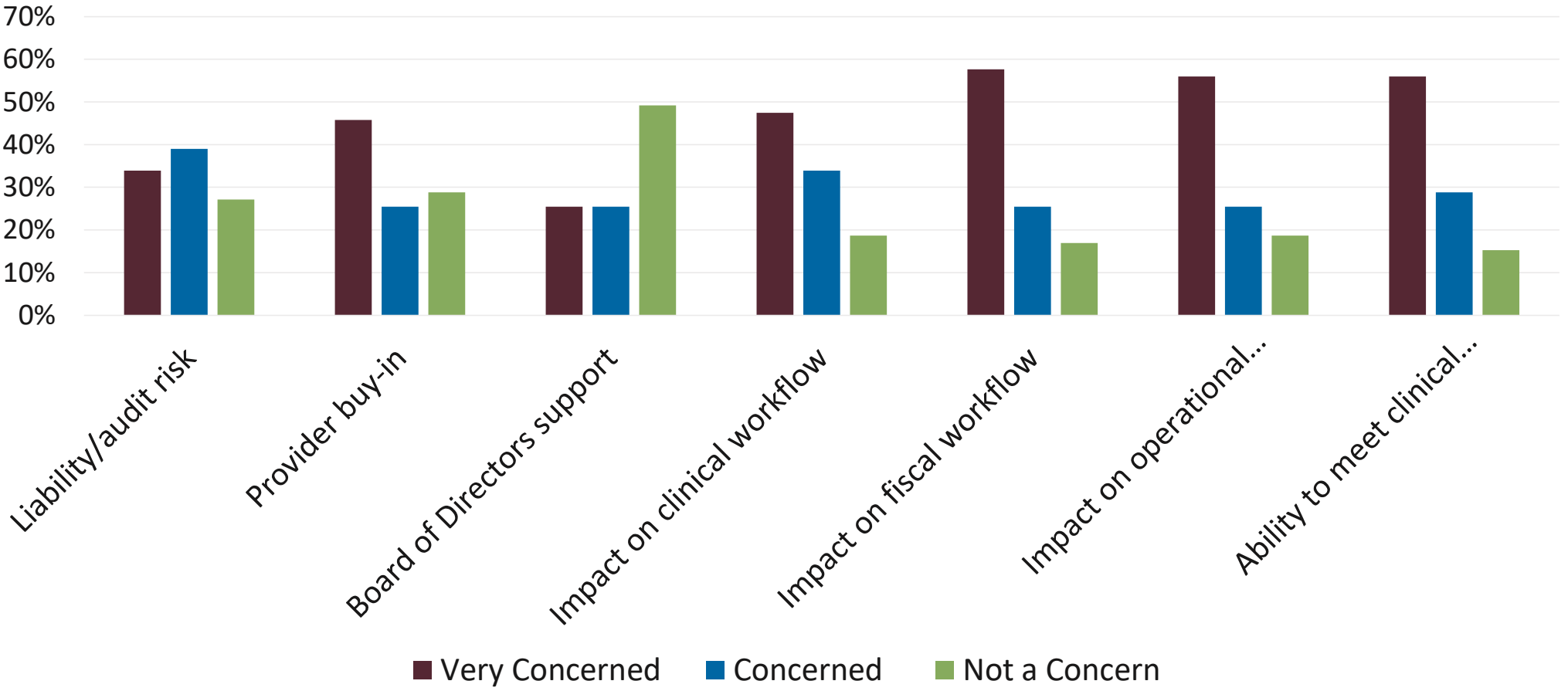
Practice ZIP Code(s)



Areas of Concern in PC APM Preparation



Areas of Concern in PC APM Preparation



Preliminary Themes from Focus Groups and Ongoing Stakeholder Engagement

- Health equity and holistic patient care
  - Foundational element in APM development
  - Metrics focused on equity and patient experience, not just clinical or process measures
  - Excitement about potential to be creative and innovative with patient care
- Integrated and interprofessional team-based care
  - Increasing and leveraging support staff – CHW/CHRs, MAs, peers, care coordinators
  - Team-based care will reduce provider burnout, “the right person is doing the right work”
  - Concerns about lack of available options for community referral (especially in rural communities) and not having financial resources to hire additional support staff

Preliminary Themes from Focus Groups and Ongoing Stakeholder Engagement

- Many primary care practices can't transition to APMs without support
  - Continuum of options to meet providers where they are
  - Provide a "glide path" to enable increasing risk and accountability over time
  - Concerns about administrative burden – quality metric alignment needed across MCOs and other payers
- Access to data is key to success
  - Actionable data empowers practitioners to provide high quality patient care
  - Concerns about financial investment and logistics of accessing data – consider the role of payers in data aggregation and analysis

Primary Care Alternative Payment Model (APM) Framework

Addressing Primary Care APM Concerns

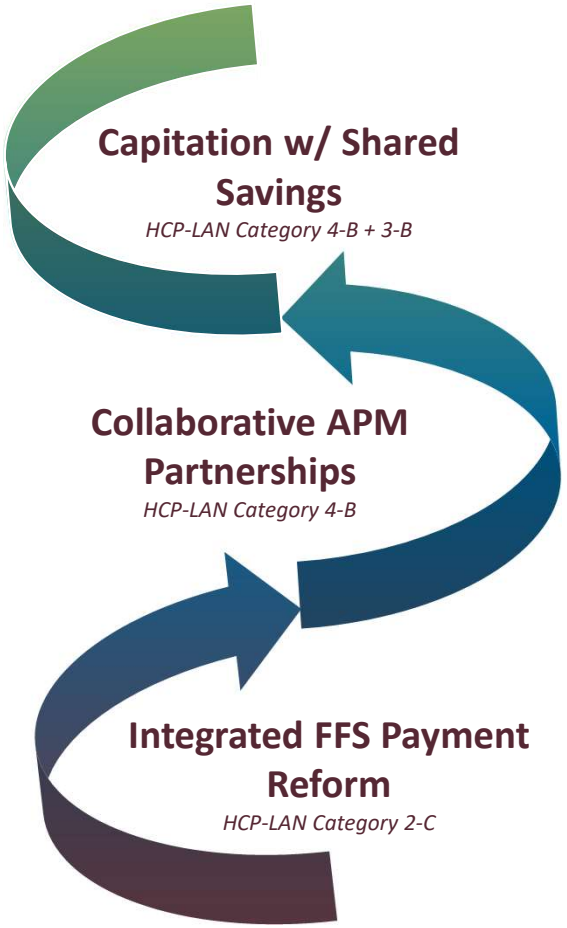
CONCERNS

1. The APM will punish smaller primary care providers in New Mexico.
2. The APM will focus on process measures, largely ignoring metrics focused on equity and patient experience.
3. The APM will increase provider administrative burden.
4. Primary care practices do not have enough financial resources to hire additional staff needed for a team-based approach to care.
5. Primary care practices do not have IT resources to aggregate and analyze data as needed to succeed in the APM.

ADDRESSING CONCERNS

1. We are designing the APM so there are multiple ways to participate, and PC clinicians and providers can succeed and implement innovative approaches to care delivery.
2. APM will focus on actionable performance measures and be transparent to clinicians, providers, and patients. Health equity and patient experience measures are part of the design.
3. We are sensitive to concerns about provider burden and are striving to reduce burden through the APM.
4. APM will directly incentivize and support healthcare workforce investment and partnerships to support interprofessional, team-based care.
5. APM will is designed to develop necessary infrastructure for data collection, analysis, and reporting for clinicians and providers to succeed in the APM and improve patient care.

Primary Care APM Framework



Capitation w/ Shared Savings

HCP-LAN Category 4-B + 3-B

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

Collaborative APM Partnerships

HCP-LAN Category 4-B

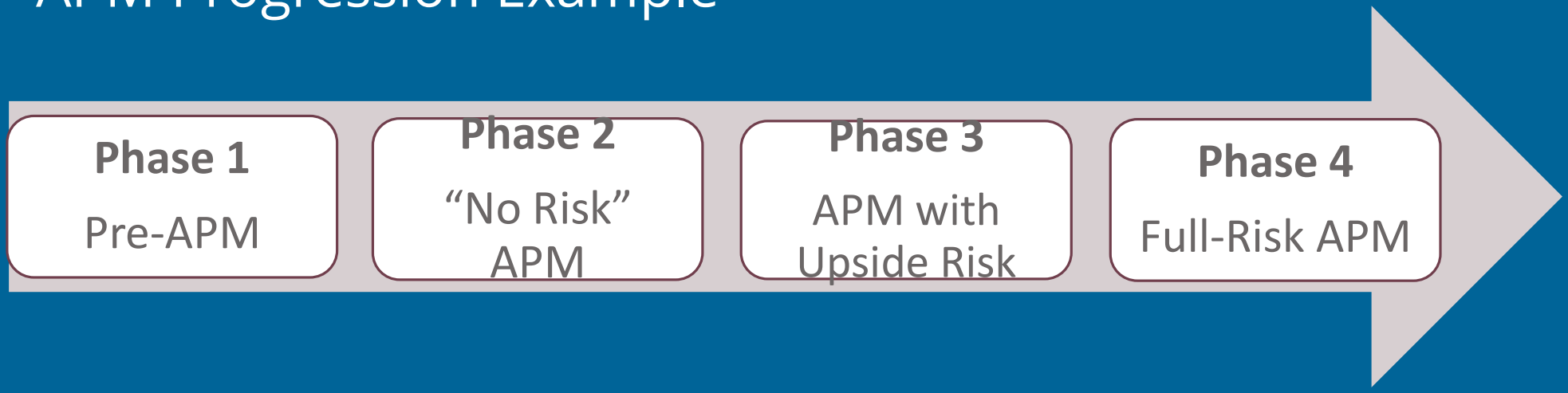
- Provider-specific PCP capitation payments with reconciliation and quality metric benchmarking
- Providers are "met where they are" and supported by partnerships among Providers/MCOs/administrative entities
- "Menu" approach to APM participation allowing appropriate calibration of risk and operational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

Integrated FFS Payment Reform

HCP-LAN Category 2-C

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

APM Progression Example



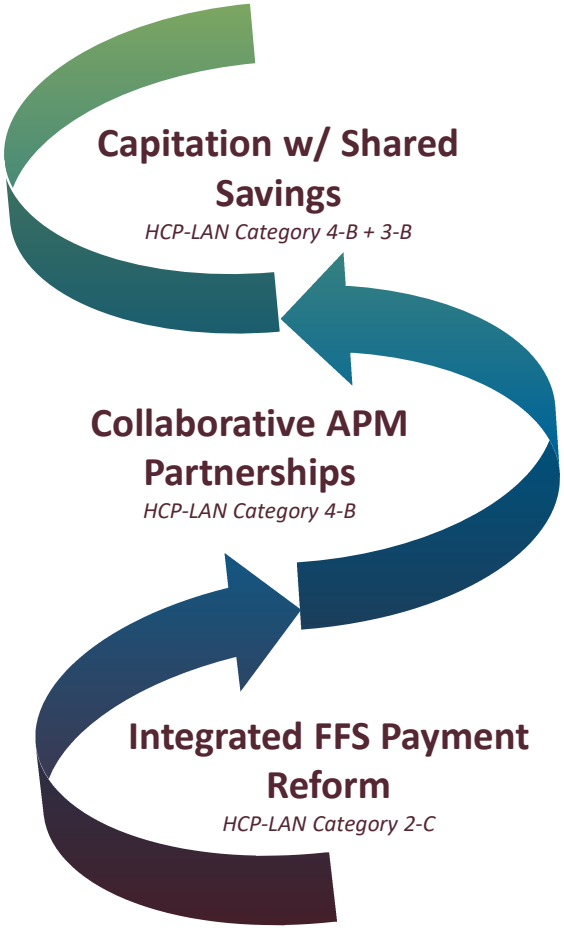
- Fee-for-service payments
- Targeted quality programs and incentives

- "No-risk" capitation payment
- Baseline quality and outcome reporting
- Infrastructure incentives

- Capitation payment with upside gain
- Incentives rewarding operational integrity and reporting

- Capitation payment with two-sided risk
- Incentives rewarding performance

Stakeholder Considerations



Benefits to Patients	Benefits to Providers	Considerations	Requirements
• Improved patient outcomes as incentives align towards quality of care • Patients have access to additional non-medical service providers (e.g., CHWs) • Increased access to comprehensive and flexible services based on patient needs, reinforcing equity • Additional benefits offered to patients under flexible payment arrangements • Enhanced PCP reimbursement incentivizes more preventive care • Detachment from procedure codes limits "encounter chasing", allows for culturally competent care	• Maximum provider flexibility due to secure revenue streams • Reduction in provider burden and encounter reporting • Allows for multiple avenues of MCO competition (shared savings, cap rates, etc.)	• PCP/dental/behavioral health bundles • Administered by MCO(s) and/or HSD • Promote competition while retaining access	• Attribution logic and leakage process • Data sharing for all services for assigned members • Actuarial soundness and CMS approval
	• Promotes flexibility for non-traditional services & providers • Allows providers of all capabilities to participate • Reinforces partnership with other providers and MCOs	• Clear expectations for progression across time • Potential for duplication of administrative efforts • Data sharing across entities could introduce challenges	• Similar requirements to full APM described above • Introduces operational partnerships and contracting logistics
	• Leverages existing policies and programs • Available to support ALL providers currently billing Medicaid services • Customizable to target areas	• Could favor traditionally billed providers and services • Requires review to avoid duplication across programs	• Understand and coordinate with existing policies • Potential need for additional funding • May require SPA/waiver approval

HEALTH MANAGEMENT ASSOCIATES

Breakout Room Discussions

In each breakout room, use the Jamboard to document your discussion.

01 What are your initial reactions to the APM framework?

02 What do you think are the benefits of this framework? What concerns do you have with this framework?

03 Many of your peers have expressed hesitation and/or concern about the APM. What do you think the State needs to do to alleviate this concern? How can we better communicate the APM to primary care stakeholders? What would you say to your peers about the APM?

Breakout Room Report-Outs

01 What are your initial reactions to the APM framework?

02 What do you think are the benefits of this framework? What concerns do you have with this framework?

03 Many of your peers have expressed hesitation and/or concern about the APM. What do you think the State needs to do to alleviate this concern? How can we better communicate the APM to primary care stakeholders? What would you say to your peers about the APM?

Next Steps

01 Draft provider readiness assessment based on findings from the survey and focus groups. Continue preparing for training and APM socialization activities in 2023.

02 Conduct full Transformation Collaborative meeting in late November, agenda to include sharing the purpose statement, a discussion of the group's charge and measures of success, and a presentation of the APM framework.

03 Continue to develop the APM and quality metric frameworks with guidance from PCC and Payment Strategies and Health Data Equity Workgroups.

Thank You

Contact Us

gnagrath@healthmanagement.com
mswift@healthmanagement.com

YOUR FEEDBACK: PCC STRATEGIC PRIORITIES

- HSD updating PCC 5-year strategic plan for January 2023 release.
- We would like your feedback on strategic priorities.
  - 4 workgroups will focus on each of the 4 PCC Goals.
  - 30-40 minutes to draft objectives and tactics using a spreadsheet.
  - 15-20 minutes for debrief.
- Draft plan will be emailed in December for PCC review.

PCC Goal 3: Develop and drive health information technology improvements and investments that make high quality primary care seamless and easy for Interprofessional Primary Care Teams, patients, families, and communities.				
EXAMPLE				
Objective	**Activity / Tactic**	**HB67 Duty**	**Lead**	**Timeframe**
Develop sustainable Medicaid PC Alternative Payment Models (APM) that supports each goal of the PCC for January 1, 2024 implementation.	1. Design new PC APM aligning with HCP-LAN framework that incentivizes performance and population-level heath outcomes, aligns with core features and principles adopted by HSD and PCC, and applies to a variety of settings.	2, 3, 4, 5, 8	HSD	FY23-FY27
Objectives	**Activity / Tactic**	**HB67 Duty**	**Lead**	**Timeframe**
TBD	TBD	TBD	TBD	TBD

NEW MEXICO PRIMARY CARE COUNCIL

MISSION

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VISION

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

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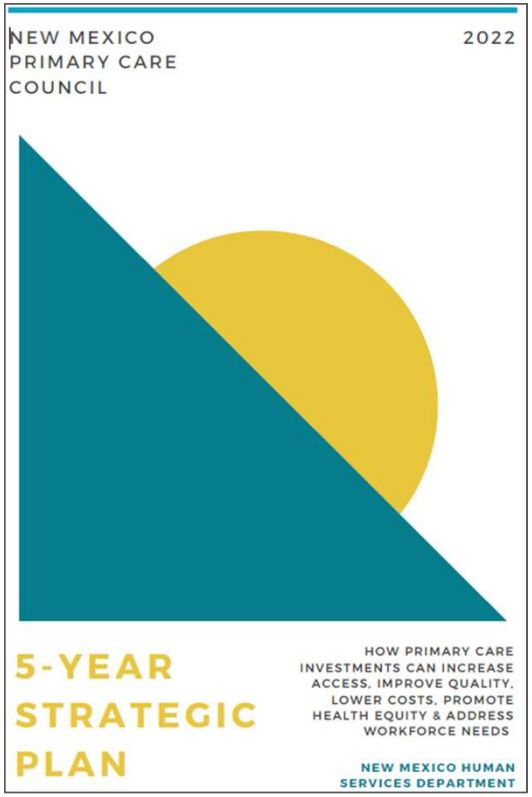
Workforce Sustainability

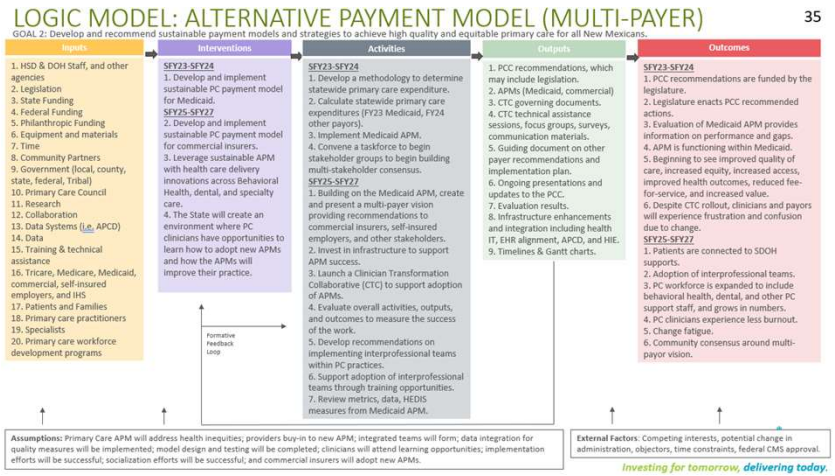
Create a sustainable workforce, financial model, and budget to support our mission and secure necessary state and federal funding.

RESOURCES FOR BREAKOUT GROUPS

2022 PCC Strategic Plan (Pgs. 7-11)



PCC Logic Models (Appendix slides 50-59)



Strategic Planning Overview (Appendix slides 61-65)

HUMAN SERVICES DEPARTMENT

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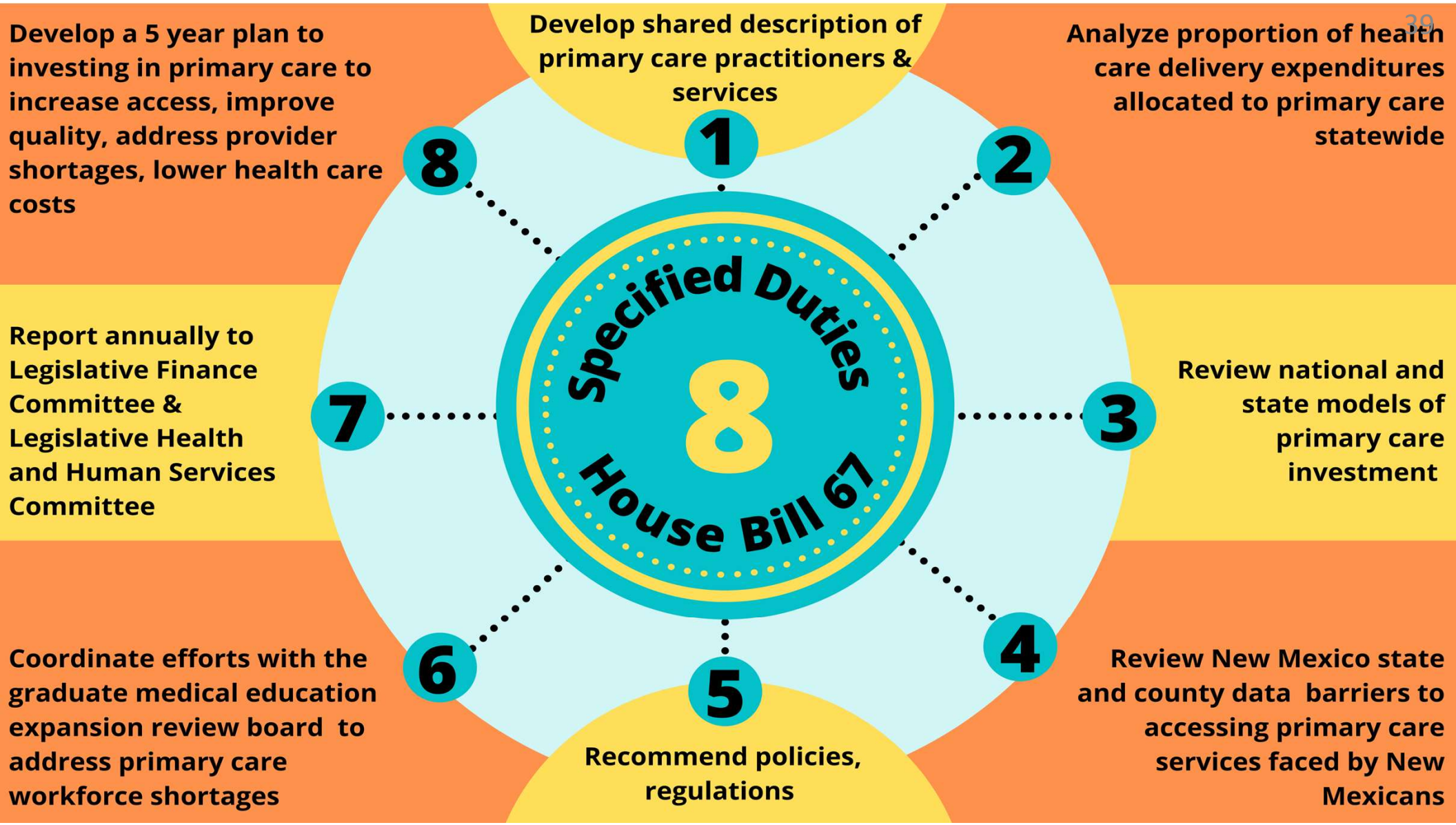
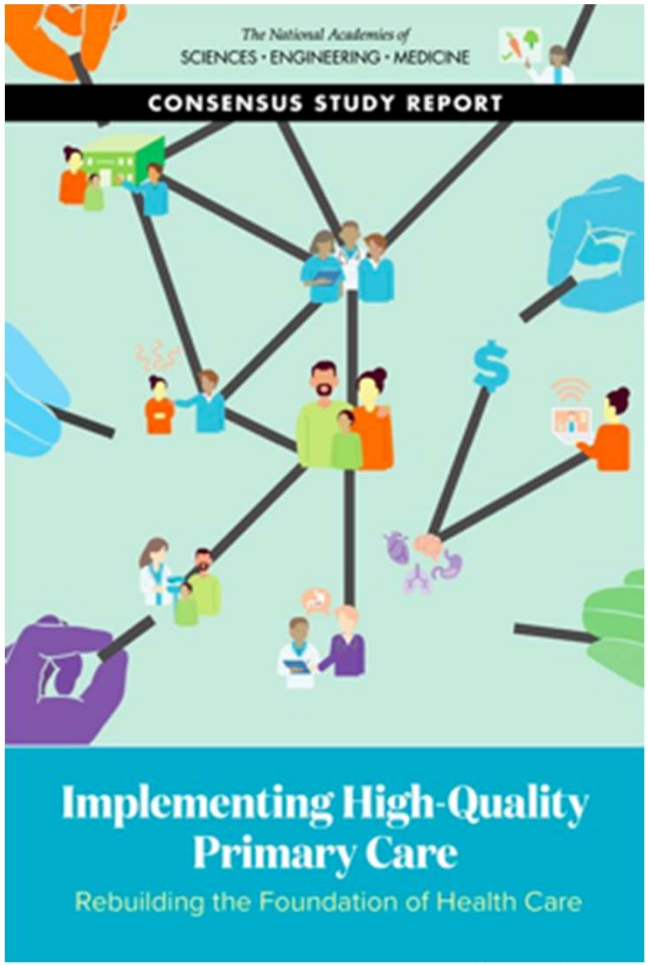

Specified Duties
8
House Bill 67
1
Develop shared description of primary care practitioners & services
2
Analyze proportion of health care delivery expenditures allocated to primary care statewide
3
Review national and state models of primary care investment
4
Review New Mexico state and county data 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

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

Implementation Goals ("Objectives")

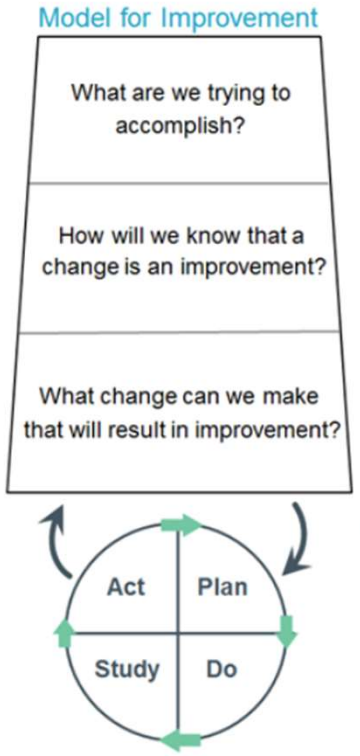
1. Pay for primary care teams to care for people, not doctors to deliver services.
2. Ensure high-quality primary care is available to every individual and family in every community.
3. Train primary care teams where people live and work.
4. Design information technology that serves patient, family,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

MODEL FOR IMPROVEMENT: RECOMMENDATIONS TO IMPROVE PRIMARY CARE

NASEM Recommendation to Improve Primary Care	What are we trying to accomplish? (Goal)	What are we already doing?	How will we know a change is an improvement? (Outcome)	What change can we make that will result in improvement? (Metrics)
(1) Pay for primary care teams to care for people, not doctors to deliver services.	Achieve high-quality primary care as a common good	Payers evaluate payment models based on their ability to deliver high-quality PC	Observe a shift away from fee-for-service and towards hybrid payment models	Facilitate multi-payer collaboration and increase health care spending on PC
(2) Ensure that high-quality primary care is available to every individual and family in every community.	A community-oriented model that places patients, families, and community members at the center	COVID-era rule revisions and interpretations of Medicaid and Medicare benefits	New health centers, rural health clinics, and Indian Health Services in areas with shortage of PC	Permanently support COVID-era rule revisions and interpretations
(3) Train primary care teams where people live and work.	Expand and diversify the PC workforce. Ensure that care delivered is culturally appropriate.	Research areas that are medically underserved and have a shortage of health professionals	Augment funding to support interprofessional training in community-based environments	Adopt alternative financing sources for HRSA-developed PC training
(4) Design information technology that serves the patient, family, and interprofessional care team.	Adopt a comprehensive aggregate patient data system to enable PC clinicians to access patient data and provide whole-person care	Understand that current certification requirements are a barrier to high-quality PC	Electronic health record certification standards ensure health systems are interoperable and hold HIT vendors, state, and national support agencies financially responsible	Collaborate with vendors, state, and national support agencies to implement new policies and authorizations
(5) Ensure that high-quality primary care is implemented in the United States.	Every New Mexican can receive high-quality PC by their primary care team, and within 48 hours when needed.	Establishing a Primary Care Council to achieve the vision of high-quality PC	Prioritize funding for PC research	Serve as the unified voice to organize PC stakeholders, assess implementation, hold actors accountable, and catalyze a common agenda



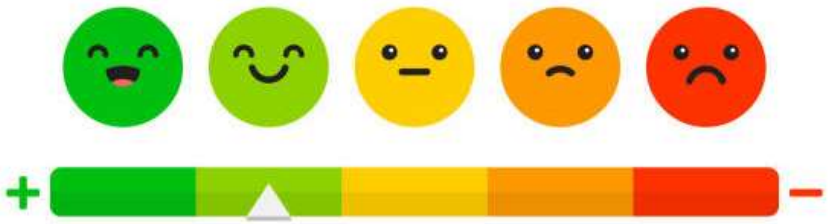
MARCH 2023 PCC MEETING DRAFT AGENDA

- Primary Care APM Development Update
- FY25 Primary Care Pitches for the People
- Strategic Plan Review & Update

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

CLOSING COMMENTS

INVESTING FOR TOMORROW, DELIVERING TODAY.

HUMAN SERVICES DEPARTMENT

APPENDIX

INVESTING FOR TOMORROW, DELIVERING TODAY.

APPENDIX TABLE OF CONTENTS

- Transformation Collaborative Governing Council Roster
- PCC Strategic Plan Logic Models
- Strategic Planning Overview
- Link to the 2022 Primary Care Council 5-Year Strategic Plan
- PC APM Project Team Bios

TRANSFORMATION COLLABORATIVE GOVERNING COUNCIL ROSTER

PC CLINICIAN & PROVIDER TRANSFORMATION COLLABORATIVE GOVERNING COUNCIL MEMBERS

1. Jon Helm, RN: Nurse Flow Manager, First Choice Community Healthcare
2. Sarah Yue, FNP: Covenant Family Medical Group
3. William "Mac" Bowen, MD: Program Director and Family Physician, Christus St. Vincent, UNM Santa Fe Family Medicine Residency
4. Diana Weber, MD, CPE: Medicaid Chief Medical Officer, Blue Cross Blue Shield of New Mexico (ex-officio)
5. Matt Misleh: Chief Operating Officer, New Mexico Primary Care Association
6. Nathan Cogburn, RN: Vice President of Network Development and Value-Based Care, Western Sky Community Care (ex-officio)
7. Kate Kollars, MD, MPH: Resident Physician, UNM Family and Community Medicine
8. Darcie Robran-Marquez, MD, MBA, FAAFP: Chief Innovations Officer, IMPACT Pop Health, LLC
9. Jeanette Lara, DO: Physician, Presbyterian Medical Services Chaparral Family Health Center (ex-officio)
10. Linda Son-Stone: Chief Executive Officer, First Nations Community HealthSource
11. Bridget Lynch, MD: Physician and Board Chair, New Mexico Academy of Family Physicians
12. Elizabeth Lacouture: Vice President, Population Health and Quality, Presbyterian Health Plan
13. Robert "Bob" Longstreet: Chief Information Officer, New Mexico Primary Care Association
14. Arturo Gonzales, PhD: Consultant: Administration, Governance, Implementation and Evaluation, National Latino Behavioral Health Association
15. Neal Bowen, PhD, Director: HSD Behavioral Health Services Division (ex-officio)
16. Bryce Pittenger, LPCC: CEO of Behavioral Health Collaborative, HSD

HUMAN SERVICES DEPARTMENT

NM PCC STRATEGIC PLAN LOGIC MODELS

LOGIC MODEL: HEALTH EQUITY

GOAL 1: Develop and drive investments in health equity across New Mexico to improve the health of New Mexicans.

Current State	Future State (Long-term Outcomes)
1. Longstanding, systemic, structural, social inequities, and racism have existed in health care for many decades. 2. Some of the health challenges specific to New Mexico include: a. 25% of New Mexicans live at or below the federal poverty level. b. 1 in 3 of New Mexicans live in rural areas. c. New Mexico has a health care provider shortage which negatively impacts preventative care and access to treatment. d. Obesity and diabetes among New Mexico youth are disproportionately higher in Native and Hispanic populations. e. Diseases of despair are highest among Native Americans, with NM ranking highest for alcohol related deaths in the nation. f. LGBT youth are more likely to suffer depression and anxiety and to have attempted suicide. g. Teen pregnancy rates among Hispanic and Latino females are higher than any other racial or ethnic group. h. Infant mortality and poor maternal health outcomes are highest among Black and African American women. i. 35% of New Mexicans speak a language other than English. j. NM's minority-majority population has suffered root shock, generational/historical trauma and the effects of colonization leading to systemic racism and social injustices. 3. Many New Mexicans live in rural and frontier areas and have limited access to healthcare and lack the transportation necessary to for in-person visits. 4. Access to broadband internet is limited in many areas of New Mexico therefore limiting access to telehealth and other health care technology. 5. Some areas of New Mexico are without running water and other infrastructure that promote health and wellbeing. 6. Current health care pay structures including fee-for-service do not incentivize patient wellness, but rather incentivize treatment of illness resulting in less-than-optimal health outcomes.	1. Continual efforts to improve structural and social determinants of health greatly increase health equity for all New Mexicans. 2. All New Mexicans will have access to equitable, sustainable, and culturally appropriate health care. 3. Whole-person, team-based primary care increases the likelihood individuals are connected to behavioral health, dental, and vision treatment. 4. An increased focus on patient health outcomes reduces rates of obesity and diabetes. 5. Integrated behavioral health helps to reduce stigma in seeking treatment, increases access, reduces alcohol related deaths, and improves services for LGBT youth. 6. Improved partnerships across the state support informed decision-making that centers the voices of those most affected.

Reference: NMDOH Office of Health Equity: https://www.nmhealth.org/about/asd/ohe/

LOGIC MODEL: HEALTH EQUITY

GOAL 1: Develop and drive investments in health equity across New Mexico to improve the health of New Mexicans.

Inputs	Interventions	Activities	Outputs	Outcomes
1. HSD & DOH Staff, and other agencies 2. Legislation 3. State Funding 4. Federal Funding 5. Philanthropic Funding 6. Equipment and materials 7. Time 8. Community Partners 9. Government (local, county, state, federal, Tribal) 10. Primary Care Council 11. Research 12. Collaboration 13. Data 14. Data Systems 15. Training & technical assistance 16. Tricare, Medicare, Medicaid, commercial, self-insured employers, and IHS 17. Patients and Families 18. Primary care practitioners 19. Specialists 20. Primary care workforce development programs	1. By 2026, integrate public health, primary care, and behavioral health. 2. By 2026, create meaningful partnerships between governmental agencies, nonprofit organizations, businesses and academic centers to support health equity. 3. By 2026, increase sustained investment in historically marginalized and divested populations.	1a. Develop NM models of public health, primary care and behavioral health integration. 1b. Create a network of community health workers (CHW), Community Health Resource (CHR), and Community Peer Support Workers (CPSW) who are integrated with PC. 1c. Implement CCBHCs to support behavioral heath access, and primary care integration. 1d. Implement a State Plan Agreement for Medicaid to pay for CHWs, CPSWs, and other peer support workers who play an important in primary care teams. 2a. Partner with the Social Determinants of Health Coalition in their vision for all New Mexicans [to] live in communities with equitable access to adequate community-based resources. 2b. Inventory NM Department of Health (NMDOH) services across primary care. 2c. Partner with NMDOH Office of Health Equity (OHE) to collaborate on strategies addressing disparities. 2d. Align NMDOH State Health Improvement Plan with PCC Strategic plan activities. 3a. Place primary care at the center of Medicaid and propose initiatives for Turquoise Care that will support the five populations designated as historically and intentionally disenfranchised (a. Prenatal, postpartum, and members parenting children, including children in state custody (CISC); b. Seniors and members with LTSS needs; c. Members with behavioral health conditions; d. Native American members; and e. Justice-involved individuals.) 3b. Invest in and expand Medicaid's non-emergency transportation (NEMT) program to improve access to care particularly for those in rural areas. 3c. Increase enrollment and eligibility in Medicaid's Supportive Housing Program and expand support activity eligibility. 3d. Request approval from CMS to continue telemedicine expansion after the Federal Public Health Emergency has ended. 3e. Work with DOH to improve access to reproductive health. 3f. Inventory state-wide supports using the community and resource data exchange to manage what is available for SDOH services. (DOH) to create a full state-wide assessment to support the closed loop resource.	1. List of NMDOH services across primary care. 2. Report on assets and needs within public health services. 3. Recommendations on NM models of public health, primary care, and behavioral health integration. 4. Catalog of linkages between public and private sector groups supporting SDOH and health equity. 5. Ccomprehensive literature review of the NMDOH State Health Assessments with Community Health and State agency assessments. 6. Networks of integrated CHWs, CHRs, and CPSWs. 7. Investments in historically marginalized and divested populations. 8. Meetings, focus groups, surveys, and site visits with community groups leading to community-led solutions that address health equity. 9. Creation of Alternative Payment Models that address health equity. 10. Online, real-time SDOH referral system. 11. Partnerships that ensure inadvertent adverse outcomes are avoided and that the voices of those most affected are included in decision-making. 12. Comprehensive plan that begins to address disparities related to language, food access, housing needs, and rural health care access.	1. PC teams begin to integrate. 2. Improved health for historically marginalized and divested communities. 3. High-quality primary care is accessible to all New Mexicans throughout the state. 4. Sustained investments in historically marginalized and divested populations begin to improve health outcomes. 5. Co-learning about institutional and structural determinants of health. 6. Improved health equity. 7. Patients begin to receive resources through the SDOH closed-loop, patient-provider referral system. 8. PC providers experience reduced burnout due to streamlined communications within health teams and online tools.

Assumptions: Primary Care APM will address health inequities; integrated teams will form; PC clinicians and community stakeholders will participate in meetings and focus groups; implementation efforts will be successful; socialization efforts will be successful; investments will be made; and online systems will be used.

External Factors: Competing interests, potential change in administration, objectors, time constraints, federal CMS approval.

LOGIC MODEL: ALTERNATIVE PAYMENT MODEL (MEDICAID)

GOAL 2, Objective 2: Implement Medicaid investment and payment strategies aligned with NM PCC Mission and Vision.

Current State	Future State (Long-term Outcomes)
1. As of June 2022, Medicaid and CHIP served 1,099,278 New Mexicans (52% of the population). NM has the highest percentage of people on Medicaid in the US. 2. High-quality and equitable Primary Care (PC) is not available to Medicaid customers. 3. NM Medicaid Primary Care is primarily reimbursed through managed care and is not linked to quality outcomes. 4. NM Medicaid does not pay prospectively for interprofessional, integrated, team-based care; 5. Is not risk adjusted for medical and social complexity; 6. Does not allow for investment in team development, practice transformation resources, and infrastructure to design, use, and maintain necessary digital technology; 7. Does not align with incentives for measuring and improving quality outcomes for patient populations assigned to interprofessional care teams; 8. Does not incorporate population and public health focus to promote health equity; 9. Does not integrate primary care behavioral health; 10. Does not address unique challenges in provision of care to children; 11. Does not incorporate regional assets and resources; 12. Does not have a multi-payor vision; 13. Does not fully empower patients and families to be partners in health care transformation. 14. Medicaid PC payment models have systemic structural inequities causing mistrust, lack of access, and increased health disparities. 15. For routine use in PC, technology has not fundamentally expanded beyond electronic health records, registration systems, and patient portals created two decades ago. 16. Technology is a leading cause of clinician burnout (add more details). 17. More information is needed about the extent to which providers have connected their EHRs to the HIE in New Mexico. 18. Need to understand more about what percentage of Tribal clinics are fee for service.	1. High-quality and equitable Primary Care is available to Medicaid customers. 2. NM Medicaid pays prospectively for interprofessional, integrated, team-based care, including incentives for incorporating non-clinician team members and for partnerships with community-based organizations; 3. Is risk-adjusted for medical and social complexity; 4. Allows for investment in team development, practice transformation resources, and infrastructure to design, use, and maintain necessary digital technology; 5. Aligns with incentives for measuring and improving quality outcomes for patient populations assigned to interprofessional care teams; 6. Incorporates population and public health focus to promote health equity; 7. Integrates primary care behavioral health; 8. Addresses unique challenges in provision of care to children; 9. Incorporates regional assets and resources; 10. Multi-payor, multi-stakeholder vision; 11. Empowering patients and families to be partners in health care transformation.

Reference: National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

LOGIC MODEL: NEW MEXICO MEDICAID ALTERNATIVE PAYMENT MODEL

GOAL 2, Objective 2: Implement Medicaid investment and payment strategies aligned with NM PCC Mission and Vision.

Inputs

1. HSD & DOH Staff, and other agencies
2. Legislation
3. State Funding
4. Federal Funding
5. Philanthropic Funding
6. Equipment and materials
7. Time
8. Community Partners
9. Government (local, county, state, federal, Tribal)
10. Primary Care Council
11. Research
12. Collaboration
13. Data Systems (i.e. APCD)
14. Data
15. Training & technical assistance
16. Tricare, Medicare, Medicaid, commercial, self-insured employers, and IHS
17. Patients and Families
18. Primary care practitioners
19. Specialists
20. Primary care workforce development programs

Assumptions: Primary Care APM will address health inequities; providers buy-in to new APM; integrated teams will form; data integration for quality measures will be implemented; model design and testing will be completed; clinicians will attend learning opportunities; implementation efforts will be successful; and socialization efforts will be successful.

Interventions

SFY23-24

1. By 2024, develop and implement sustainable PC payment model for Medicaid.
2. By 2024, engage with stakeholders to prepare for and promote adoption of the PC APMs.

SFY25-26

3. Provide supports for Medicaid PC clinicians and providers to reach HCP- LAN APM Category 4 by 2026.
4. The State will create an environment where PC clinicians have opportunities to learn how to adopt new APMs and how the APMs will improve their practice.

APM Activities SFY23-SFY24

1a. Design a new PC APM(s) aligning with the HCP-LAN framework that is designated to incentivize performance and population-level heath outcomes, aligns with the core features and principles adopted by HSD and PCC, and applies to a variety of settings.
1b. Test and evaluate APMs for efficacy and outcomes prior to start date of new MCO contracts (1/1/2024).
1c. Develop Medicaid MCO contract language for PC APMs in accordance with CFRs and other state/federal rules and regulations.
1d. Provide fiscal, policy, and/or programmatic implementation recommendations for the NM Medicaid program, including any legislation that may need to advance to support the APM; and multi-payor roll-out of a primary care APM, including any legislation that may need to advance to support the APM.

TC Activities SFY23-SFY24

1a. Conduct monthly meetings of the primary care transformation collaborative (TC), providing primary care practitioners supports related to NM Medicaid primary care APM implementation.
1b. Build relationships with stakeholders.
1c. Using survey findings, determine level of APM provider readiness adoption among NM providers.
1d. Conduct focus groups and provide regular, ongoing support indicated by assessment and designed to address common areas of need in adopting PC APMs and team-based care models.
1e. Identify underserved areas where TA is needed to support and/or to enhance provider APM adoption.
1f. Identify best and promising practice activities that enhance provider APM adoption.
1g. Include fiscal, policy, and/or programmatic implementation recommendations for the NM Medicaid program, and/or PC TC, including any legislation that may need to advance to support the collaborative.
1h. Develop a measurement instrument to evaluate success of TA services, and revise supports as needed.

APM & TC Activities SFY25-26

3a. Provide clinicians and providers incentive payments that advance their capacity to adopt increasingly more advanced PC APMs.
3b. Establish and provide technical assistance for the use of a value-based data intermediary to help evaluate and monitor health metrics.
3c. Work with legislature to sustainably fund continued PC APM growth and improvements.
3d. Engage with CMS to leverage federal funding and programs to support PC payment model success.
4a. Continuation of PC APM technical assistance to grow the number of providers participating and advance their level of adoption.

Outputs

1. State policy recommendations are presented, which may include legislative proposals.
2. APM for NM Medicaid program is finalized and integrated.
3. Transformation Collaborative workforce assessment drafted,
4. Governing body will develop documents
5. Medicaid MCO contract language drafted
6. Transformation Collaborative holds sessions on APM and Interprofessional Care Teams
7. White paper on other payer recommendations.
8. Ongoing presentations and updates to the PCC
9. Present results of evaluating activities, output, and outcomes to the PCC
10. Value-based methodology and tools for measuring and reporting performance and outcomes.
11. Closed-loop, real-time, patient-provider-SDOH referral system

Outcomes (SFY23-24)

1. State policy recommendations are funded by the legislature
2. A new PC APM is operationalized for Medicaid using the HCP-LAN category 4 (population-based payments); aligns with the core principles and features adopted by HSD and PCC; and applies to a variety of settings.
3. Interprofessional Care Teams begin supporting patients with whole-person care.
4. Reduced administrative burdens begin to increase patient time and improve provider wellness.
5. Medicare customers begin to receive improved quality of care, equity, access, and decreased health disparities.

External Factors: Competing interests, potential change in admiration, objectors, time constraints (i.e. MCO RFP).

LOGIC MODEL: ALTERNATIVE PAYMENT MODEL

GOAL 2: Develop and recommend sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.

Current State	Future State (Long-term Outcomes)
1. Primary Care (PC) practices are part of larger health care systems organized around administrative and reporting requirements, compensation based on relative value unit productivity, and pay-for-performance metrics. In 2016, practice revenue from fee-for-service in the US was 83.6. Also, across the US, more than 35% of patient visits are to PC physicians, yet PC receives only 5% of all health care related spending. 2. Financing health care is complex and PC practices receive revenue from multiple sources including public payers, commercial insurers, self-insured employers, and directly from patients. 3. There is a shortage of PC practitioners across all specialties and practices are not organized under an interprofessional team model and are not meaningfully connected to SDOH support organizations. 4. Current models have systemic structural inequities causing mistrust, lack of access, and increased health disparities. 5. For routine use in PC, technology has not fundamentally expanded beyond electronic health records, registration systems, and patient portals created two decades ago. 6. Technology is a leading cause of clinician burnout due to lack of interoperability between systems, poor system design, and amount of time spent with technology vs. patient time.	1. High quality and equitable primary care is available to all New Mexicans. 2. Primary Care (PC) pays prospectively for interprofessional, integrated, team-based care, including incentives for incorporating non-clinician team members and for partnerships with community-based organizations 3. PC is risk-adjusted for medical and social complexity. 4. PC allows for investment in team development, practice transformation resources, and infrastructure to design, use, and maintain necessary digital technology. 5. PC aligns with incentives for measuring and improving quality outcomes for patient populations assigned to interprofessional care teams. 6. PC incorporates population and public health focus to promote health equity. 7. PC Integrates behavioral health. 8. PC addresses unique challenges in provision of care to children. 9. PC incorporates regional assets and resources. 10. Interprofessional Care Teams are supporting patients with whole-person care. 11. Other payers adopt APMs. 12. Close alignment in models with commercial payers and Medicaid 13. Empowered patients and families become partners in healthcare transformation. 14. Digital health makes it easier for people to receive and clinicians to know how to deliver the right care at the right time, while also supporting relationships between individuals, families, clinicians, and communities. 15. Reduced administrative burden to allow for more patient time and reduce clinician burnout.

Reference: National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

LOGIC MODEL: ALTERNATIVE PAYMENT MODEL (MULTI-PAYOR)

GOAL 2: Develop and recommend sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans.

Inputs	Interventions	Activities	Outputs	Outcomes
1. HSD & DOH Staff, and other agencies 2. Legislation 3. State Funding 4. Federal Funding 5. Philanthropic Funding 6. Equipment and materials 7. Time 8. Community Partners 9. Government (local, county, state, federal, Tribal) 10. Primary Care Council 11. Research 12. Collaboration 13. Data Systems (i.e. APCD) 14. Data 15. Training & technical assistance 16. Tricare, Medicare, Medicaid, commercial, self-insured employers, and IHS 17. Patients and Families 18. Primary care practitioners 19. Specialists 20. Primary care workforce development programs	**SFY24-SFY26** 1. By FY 2026, develop and implement sustainable PC payment model for self-insured plans, commercial insurers, IBAC plans, and federal plans aligning with Medicaid models. 2. By 2026, create an environment of cross-collaboration across commercial, non-profit, public health, and state agencies to ensure broad success of PC APMs and interprofessional team-based care models.	**SFY24-SFY26** 1a. Building on the Medicaid APM, create and present a multi-payer vision providing recommendations to commercial insurers, self-insured employers, and other stakeholders. 1b. Invest in infrastructure, training, and capital to ensure the success of PC APM broadly across the state. 1c. Launch a multi-stakeholder initiative collaborating with NM health care payers and organizations to adopt standardized PC payment models, increase investments in advanced primary care, and provide technical assistance to primary care practices. 1d. OSI to issue rules and guidance for contracting using PC APM structures. 1e. Request legislature to allow specific authority for OSI to require PC APM structures and team-based care models. 1f. OSI to help convene carriers to build consensus and adopt PC APMs and team-based care models. 1g. Evaluate overall activities, outputs, and outcomes to measure the success of the work. 2a. Using data and experiences from Medicaid, create partnerships with commercial payors to build technical assistance, training, infrastructure, and capital to support and increase the adoption of advanced PC APMs and interprofessional teams state-wide.	1. PCC recommendations, which may include legislation. 2. APMs (Medicaid, commercial) 3. TC governing documents. 4. TC technical assistance sessions, focus groups, surveys, communication materials. 5. Guiding document on other payer recommendations and implementation plan. 6. Ongoing presentations and updates to the PCC. 7. Evaluation results. 8. Infrastructure enhancements and integration including health IT, EHR alignment, APCD, and HIE. 9. Timelines & Gantt charts.	**SFY24** 1. PCC recommendations are funded by the legislature. 2. Legislature enacts PCC recommended actions. 3. Evaluation of Medicaid APM provides information on performance and gaps. 4. APM is functioning within Medicaid. 5. Beginning to see improved quality of care, increased equity, increased access, improved health outcomes, reduced fee-for-service, and increased value. 6. Despite CTC rollout, clinicians and payors will experience frustration and confusion due to change. **SFY25-SFY26** 1. Patients are connected to SDOH supports. 2. Adoption of interprofessional teams. 3. PC workforce is expanded to include behavioral health, dental, and other PC support staff, and grows in numbers. 4. PC clinicians experience less burnout. 5. Change fatigue. 6. Community consensus around multi-payor vision.

Assumptions: Primary Care APM will address health inequities; providers buy-in to new APM; integrated teams will form; data integration for quality measures will be implemented; model design and testing will be completed; clinicians will attend learning opportunities; implementation efforts will be successful; socialization efforts will be successful; and commercial insurers will adopt new APMs.

External Factors: Competing interests, potential change in administration, objectors, time constraints, federal CMS approval.

LOGIC MODEL: HEALTH TECHNOLOGY

GOAL 3: Develop and drive health information technology improvements and investments that make high quality primary care seamless and easy for Interprofessional Primary Care Teams, patients, families, and communities.

Current State	Future State (Long-term Outcomes)
1. PC technology has not fundamentally expanded beyond electronic health records (EHRs), registration systems, and patent portals created two decades ago. 2. Technology is a leading cause of burnout for the workforce. 3. Digital Health is used for documenting care, collecting and storing information, delivering care, and communicating. 4. The COVID-19 pandemic has forced many primary care practices to rapidly transform their processes to make virtual care and population care the new norm. 5. Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996 to promote and support health information exchange. However, HIPAA has largely been a barrier to information exchange and is badly in need of updating. 6. There is a lack of interoperability between different technologies. In some cases, the lack of interoperability results in continued use of paper charts and fax machines. 7. Poorly designed systems introduce frustrating processes into the care delivery experience and even make the experience more difficult and error prone.	1. Digital health makes it easier for people to receive, and clinicians to know, how to deliver the right care at the right time, while also supporting relationships between individuals, families, clinicians, and communities. 2. Primary Care digital health tools include EHRs, patient portals, mobile applications, telemedicine platforms, electronic registries, analytic systems, remote monitoring, wearable technology, care-seeker and care team communication support, and geographical and population health displays. 3. Population health tools allow the State to be proactive in caring for communities through alerts, reminders, and quality or health maintenance tabs built into EHRs. 4. Health Information Technology (HIT) supports: a. Easy retrieval of accurate, timely and reliable native and imported data b. Simple and intuitive data displays c. Easy navigation d. Evidence at the point of care to aid decision making e. Enhancements to workflow, automating mundane tasks, and streamlining work, never increasing physical or cognitive workload f. Easy transfer of information to and from other organizations and clinicians g. No unanticipated downtime h. financing PC using data-driven decision making, paying teams for improved patient outcomes

Reference: National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

LOGIC MODEL: HEALTH TECHNOLOGY

GOAL 3: Develop and drive health information technology improvements and investments that make high quality primary care seamless and easy for Interprofessional Primary Care Teams, patients, families, and communities.

Inputs	Interventions	Activities	Outputs	Outcomes
1. HSD & DOH Staff, and other agencies 2. Legislation 3. State Funding 4. Federal Funding 5. Philanthropic Funding 6. Equipment and materials 7. Time 8. Community Partners 9. Government (local, county, state, federal, Tribal) 10. Primary Care Council 11. Research 12. Collaboration 13. Data Systems (i.e. APCD) 14. Data 15. Training & technical assistance 16. Tricare, Medicare, Medicaid, commercial, self-insured employers, and IHS 17. Patients and Families 18. Primary care practitioners 19. Specialists 20. Primary care workforce development programs	1. By 2026, develop, invest in, and implement health IT improvements to support advanced PC practice, payment, and interprofessional teams. 2. By 2026, provide technical assistance to support adoption of health IT infrastructures required for advanced PC APMs and adoption of interprofessional team-based care. 3. By 2026, recommend, develop, and implement health IT improvements to support population health, patients, families, communities to make high quality primary care seamless and easy.	1a. Assess the needs for providers to connect their EHRs to the HIE to advance PC APMs in their practice; and request GF subsidies for providers who need support (if applicable). 1b. Conduct a comprehensive assessment of current health IT resources, needs, and capabilities statewide that informs a plan and funding for current tool improvements, new technology implementation, and training that supports advanced PC practice, payment, and teams. 1c.Review the interoperability of data sharing tools that support advanced PC across the state and recommend policy to ensure systems are meeting requirements. 1d. Create a collaborative plan for implementation of health technologies across multi-payors to reduce administrative burdens, enable successful PC APM implementation, and team-based care models that include patient and provider identity management, attribution, care management and coordination, financial benchmarking and management, quality reporting, and feedback. 2a. Provide technical assistance to providers and clinicians to support the adoption of health IT that supports advanced PC practice, payment, and teams. 3a. Assess patient engagement tools and patient portals currently available and in use in NM Medicaid and develop recommendations for improvements and expansion. 3b. Request legislative funding to provide a closed-loop patient-provider online referral system to help providers and clinicians connect patients to SDOH supports. 3c. Assess decision support technologies being used by PC providers and identify gaps and opportunities for platforms to support population health issues (i.e. diabetes, substance use).	1. Improved implementation and funding support for health technology across the state. 2. Implement dashboards for access to real time data that addresses gaps in priority areas such as workforce and health equity. 3. Training programs for PC workforce. 4. Funding for providers to connect their EHRs to the HIE (if needed). 5. Funding and creation of a closed-loop patient-provider online referral system. 6. Written request from CMS seeking federal approval for telemedicine post-PHE. 7. Assessment and recommendation reports on patient engagement tools, patient portals, decision support technologies and heath equity. (one bullet for each) 8. Policy, guidance, or regulation. 9. Community outreach. 10. Infrastructure projects. 12. Investments in health IT.	1. More meaningful relationships that promote trust will begin. 2. Patients and their interprofessional teams will engage in co-created care plans. 3. Engagement with community resources through the closed-loop patient-provider referral system results in food, shelter, job, and other SDOH supports for patients. 4. Technology burnout by clinicians, providers, and patients. 5. Better access to health IT. 6. Providers and clinicians will begin to advance their practice. 7. Short-term increase in provider burden, followed by a decrease once technologies are implemented and learned.

Assumptions: Primary Care health IT will address health inequities and reduce administrative burden; providers and clinicians adopt new or existing technologies; integrated teams will adopt interprofessional team tools; funding will be available for system enhancements; clinicians will attend learning opportunities; implementation efforts will be successful; and socialization efforts will be successful.

External Factors: Competing priorities and interests, potential change in admiration, objectors, time constraints, prohibitive cost, availability of broadband, varying levels of computer/technology literacy.

LOGIC MODEL: WORKFORCE

GOAL 4: Create a sustainable workforce, financial model, and budget to support our mission and secure necessary state and federal funding.

Current State	Future State (Long-term Outcomes)
1. There is no real retention program for mid-career health professionals (other than the rural health provider income tax program). Employers see benefit packages as retention programs. 2. New Mexico has the highest population of physicians over 60 years old, and the lowest population of physicians under 40. Causing large waves of retirement among physicians. 3. Many professions show low tenures of working in healthcare positions. For example, nurses average only three years in active health care work. 4. Existing providers keep large patient panels, making it difficult for new providers to come in, especially in rural areas. 5. Rural communities are isolated from updated primary care practices. 6. Large out-of-state institutions are recruiting New Mexican physicians, offering better benefits and more pay, and no income taxes. 7. Lack of healthcare career secondary education including clinician rotations and continuing education, and affordable CME opportunities. 8. In rural areas, there is a lack of employment for significant others, and poor childcare/school options, leading many providers with families to stay in large cities or move out of state entirely. 9. Low adoption of interprofessional teams in non-FQHC settings. 10. The healthcare workforce is small to begin with, and New Mexico is currently suffering from a huge workforce shortage. 11. Early education healthcare career programs are found in some communities in New Mexico, but they are not offered state-wide. 12. Structural inequities in New Mexico, especially in rural areas are a deterrent to recruitment and retention of health care professionals. 13. Patient wait times to see clinicians are frequently 3 or more months resulting in higher hospital and urgent care utilization. 14. Current pay structures including fee-for-service and payments not linked to quality or outcomes are driving a culture of high-volume focus on illness treatment resulting in provider and clinician burnout and poor patient outcomes.	1. Sustainable models for recruitment and retention are resulting in a diverse workforce across urban and rural areas. 2. The population of physicians becomes more diverse in age range and less likely to be affected by large waves of retirement. 3. A robust focus on wellness for health care professionals improves reduces burnout, improves workplace satisfaction, increases tenure, and retains workers in the state. 4. Patient panels are sized appropriately improving quality of care, patient time, patient outcomes, and worker satisfaction. 5. Rural Primary Care clinics receive financial, technical, recruitment, and administrative supports resulting in increased health equity and sustainable clinics. 6. Consistent analysis of workforce pay and payment adjustments reduces the likelihood of a provider or clinician leaving the state for higher pay. 7. Robust secondary education training programs that provide continuing education, affordable CME opportunities, and graduate medical education increase the number of highly trained professionals. 8. The adoption of interprofessional teams reduces administrative burdens, increases patient time, and improves health outcomes. 9. Early education programs including STEAM-H are sustained through public and private partnerships and result in more youth having interest in health care careers. 10. Structural inequities are addressed in rural communities increasing the likelihood for recruitment and retention of health care professionals. 11. Increase in health care workforce improves patent times, health outcomes, and health care worker wellness. 12. Sustainable Primary Care Alternative Payment Models support a model of patient wellness that improves patient health outcomes, reduces provider clinician burnout, and pays prospectively for the care of patient wellness.

LOGIC MODEL: WORKFORCE SUSTAINABILITY

GOAL 4: Create a sustainable workforce, financial model, and budget to support our mission and secure necessary state and federal funding.

Inputs	Interventions	Activities	Outputs	Outcomes
1. HSD & DOH Staff, and other agencies 2. Legislation 3. State Funding 4. Federal Funding 5. Philanthropic Funding 6. Equipment and materials 7. Time 8. Community Partners 9. Government (local, county, state, federal, Tribal) 10. Primary Care Council 11. Research 12. Collaboration 13. Data 14. Data Systems 15. Training & technical assistance 16. Tricare, Medicare, Medicaid, commercial, self-insured employers, and IHS 17. Patients and Families 18. Primary care practitioners 19. Specialists 20. Primary care workforce development programs 21. Graduate Medical Expansion Programs 22. Recruiters	**SFY24** 1. By 2024, develop and conduct a benchmark study of the current primary care workforce in New Mexico to understand what needs addressed to increase and support PC providers, clinicians, and teams. 2. By 2024, implement sustainable Medicaid PC rate adjustments. 3. By 2024, develop plans to expand workforce capacity, expand and make improvements to current recruitment and retention efforts that have shown success, and make plans to implement new programs where needed. **SFY25-26** 4. By 2025, develop and implement strategies to create a sustainable and diverse primary care workforce that supports interprofessional teams, education, and residency programs; addresses barriers to recruitment; addresses burnout; and improves provider-to-population rations and access to care. 5. By 2026, perform reassessment of workforce using benchmark study to determine intervention outcomes.	**SFY24** 1a. Conduct a comprehensive, statewide primary care workforce analysis to determine the current provider-to-population rations, provider demographics, utilization of primary care interprofessional teams, understand effectiveness of loan repayment programs in recruitment/retention in rural areas, understand the current state of provider well-being, and healthcare career programs that will inform tactics to address workforce shortages and sustainability. 2a. Implement sustainable Medicaid rate adjustments to support current workforce and help with recruitment efforts. 3a. Inform a plan to expand the capacity of certified peer support workers (CPSWs) and community health workers (CHWs) 3b. Research and report on the effectiveness of state-led loan repayment and other primary care workforce recruitment/retention programs (especially in rural areas) and inform a plan to expand and improve and/or create new programs as needed. **SFY25-SFY26** 4a. Develop a comprehensive inventory and analysis of public-sponsored primary care recruitment/retainment programs state-wide 4b. Collaborate with primary care organizations to improve the primary care workforce through programs that have shown success. 4c. Coordinate with NM GME Expansion Review Board and Advisory Group. 4d. Develop cost-effective recruitment and retainment strategy that includes a plan for addressing structural inequities to improve recruitment/retention of providers from underrepresented communities. 4e. Make recommendations on national and state models for FTE benchmarks metrics, equity adjustments, and factoring complex care needs. 4f. Report on statewide FTE benchmarks based on recommendations and research. 4g. Implement strategies to improve efficiencies of practice, a culture of wellness, and provider resilience. 4h. Make recommendations to improve the credentialing processes in state and insurance requirements/ affordability for varying professions. 4i. Inform a plan for primary care telehealth expansion. 5a. Reassess statewide primary care workforce analysis using benchmark study tool.	1. Definition of the Interprofessional Primary Care Team as it applies to NM. 2. Report and recommendations for Primary care workforce, physician well-being, and current state of recruitment/retention programs. 3. Determine Primary Care service sufficiency standards. 4. Provide and sustain the Interprofessional Primary Care Team required to provide high-quality primary care for every community in NM. 5. Assess health system optimal staffing. 6. Partnership with GME expansion groups to reach stated goals. 7. Improved training programs for PC workforce.	1. Address the unique health and social vulnerability of New Mexicans. 2. Improve the integrated health care team experience. 3. Increased number and diversity of primary care residents trained and retained in NM. 3. Providers and clinicians begin to have improvements in their own well-being. 8. Physicians beginning to feel more professionally fulfilled and seek help (less stigma) when feeling burnout.

Assumptions: Complete understanding of the workforce; Improved GME, recruitment, and retention practices will sustain the workforce; Increased diversity of providers will reduce health disparities; Improved efficiency of practice, culture of wellness and resiliency will decrease burnout.

External Factors: Competing interests, potential change in administration, objectors, time constraints, federal CMS approval.

STRATEGIC PLANNING OVERVIEW

MISSION: WHAT IS OUR PURPOSE?

- Written declaration of an organization's core purpose and focus that normally remains unchanged over time.
- Properly crafted mission statements:
  - serve as filters to separate what is important from what is not,
  - clearly state which markets will be served and how,
  - communicate a sense of intended direction, and
  - Should be 25 words or less.

VISION: WHAT DO WE WANT THE FUTURE LOOK LIKE?

- Aspirational description of what an organization would like to achieve or accomplish in mid-term or long-term future.
- Intended to serves as clear guide for choosing current and future courses of action.

GOALS: WHAT ARE OUR DESIRED OUTCOMES?

- Goals are broad and highest-level outcomes towards which effort and actions are directed.
- They are "what's", not "how's" and we might have multiple goals to achieve.
- Normally contain a verb.
- There is no measurement, instead provides general direction of the work.
- Time frame: 2-5 years

OBJECTIVES: PLAN THAT TURNS WHAT WE *HAVE* INTO WHAT WE *WANT* TO GET WHAT WE *NEED*.

- Objectives differs from goals in that they are measurable and specific.
- Quantify and set target so strategy can be planned around it.
- For example, “increase the number of primary care practitioners by 15% in 2 years” or “develop a succession plan for retiring physicians” would be objectives.
- Time frame: 1-2 years.

TACTICS: TRANSLATE STRATEGY INTO ACTIONS THAT ARE LEARNED FROM AND BUILT UPON

- Tactics are actions or tools a work group takes to achieve their objectives.
- They are "how's," not "what's."
- Goals, objectives, and tactics must work in tandem.
  - Without tactics you're left with big thinking and no action.
- We need both big wings (strategies/goals) and feet (tactics).
- Time frame: 3-12 months.

HMA ADDITIONAL INFORMATION

HUMAN SERVICES DEPARTMENT

Primary Care Alternative Payment Model
Project Team Bios

HMA Health Management Associates

New Mexico Human Services Department, Office of the Secretary

Elisa Wrede (she/her) is the Primary Care Project Manager overseeing the work of the Primary Care Council (PCC). Established through House Bill 67, the New Mexico PCC is working to identify ways primary care investment could increase access to primary care, improve the quality of primary care services, address the shortage of primary care providers, and reduce overall health care costs.

Elisa has a Bachelor of Business Administration from the University of Northern Colorado. She has previously worked in community engagement and corporate social responsibility helping to connect communities with volunteers and financial resources through grants and sponsorship. Elisa enjoys engaging with community through volunteering, music, and art. She is passionate improving health equity in New Mexico through revolutionizing primary care.

Alex Castillo Smith (she/they) is the Special Projects Manager (she/they) is the Strategic Planning & Special Projects Manager for the New Mexico Human Services Department. She works in collaboration with her colleagues to establish and maintain an annual, consistent rhythm of activities necessary to achieving Departmental strategic priorities. The development, analysis, and evaluation of data and evidence is one of those strategic priorities.

Alex has a Master of Social Work and a Master of Public Health from the University of Washington, and previously worked in federal disability right and aging policy, non-profit education, Capitol Hill, and political campaigns. Alex is a proud past recipient of various safety net programs like SNAP and Medicaid, a first-generation low-income college graduate, and a mixed race child of an immigrant parent. She was born on Ais/Ays land.

Alanna Dancis (she/her) is the Medical Director for HSD-MAD. Alanna is a nurse practitioner with a specialty in gerontology. She went to Thomas Jefferson University in Philadelphia, PA for her nursing degree and graduated with her MSN from the University of Pennsylvania in 2014. She was a primary care provider in the Senior Health Clinic at the University of New Mexico Hospital from 2015-2022 and the Medical Director of that clinic from 2018-2022. She was the first non-physician Medical Director at UNM. While Medical Director of the clinic, she also started a home-based primary care program where clinicians saw frail patients in their homes or assisted living facilities. She also trained residents, nurse practitioner students, pharmacy students and PA-C students within the clinic. Her professional areas of interest have included frailty, palliative care, and home-based services.

Alanna lives in Albuquerque with her son, Forrest, and her 25 houseplants.

Health Management Associates

Gaurav Nagrath, ScD, MBA, is a Managing Principal at HMA and is the project director for HMA's engagement with the New Mexico Human Services Department. Dr. Nagrath has expertise in value-based care models and contract management. He has led significant projects that have impacted and advanced practice redesign, population modelling, return on investment and sustainability, data strategy, information governance and related policies, and outcomes-based performance analytics. In addition, Dr. Nagrath has completed extensive work with integrated delivery systems, patient-centered medical homes, and MCOs. Before joining HMA, he held various principal roles with Cerner Corporation, a multinational health care technology, population management, and payment consulting firm where he spearheaded value-based care and risk solution efforts. Dr. Nagrath earned a Doctor of Science degree in global health management and policy from the Tulane University School of Public Health and Tropical Medicine.

HUMAN SERVICES DEPARTMENT

Primary Care Alternative Payment Model
Project Team Bios

HMA Health Management Associates

Kyle Edrington, Kyle founded Edrington Health Consulting, an HMA Company, in 2014 and is responsible for the design, development, and communication of actuarial engagements. He is leading the work to design, test, and evaluate a primary care alternative payment model (APM) for the New Mexico Medicaid program. Kyle has experience working with State Medicaid Agencies, health plans, providers, and other stakeholders across 15 states. Kyle's experience includes the development of actuarially sound capitation rates and Alternate Payment Models as well as related quality-focused reimbursement strategies. This experience has created a unique perspective that allows him to most effectively strategize, develop, and implement cohesive solutions that enable success for all stakeholders within each Medicaid program and individuals it serves.

Chris Dickerson, ASA, MAAA is an Associate in the Society of Actuaries and Member of the American Academy of Actuaries and is supporting the work to design, test, and evaluate a primary care alternative payment model (APM) for the New Mexico Medicaid program. He has 14 years of experience focused on Medicaid service delivery and reforms. He has worked with all levels of Medicaid service delivery, including assisting state agencies with managed care rates and fee-for-service modifications; developing managed care plan operations including down streaming risk to providers; and working with providers to optimize population health and entering risk-bearing contracts.

Craig Schneider, Ph.D is a Principal at HMA and is leading the work to design, facilitate, and evaluate a Primary Care Clinician and Provider Transformation Collaborative component of the state of New Mexico. Dr. Schneider also leads and contributes to several projects that help community-based organizations and health plans qualify for Medicaid managed care and value-based payment programs. Prior to joining HMA, Dr. Schneider led learning collaborative projects for the Centers for Medicare & Medicaid Services (CMS) Innovation Center, including the Emergency Triage, Treat, and Transport Learning System; the Accountable Health Communities (connecting clinical care to social determinants of health) Implementation, Monitoring, and Learning Systems project; and the Learning Systems for [Medicare] Accountable Care Organizations contract. For 14 years, Dr. Schneider worked at the CMS Boston Regional Office on provider reimbursement, quality improvement, beneficiary services and outreach, and health care reform. Dr. Schneider earned a doctorate in health policy from the Brandeis University Heller School for Social Policy.

Margot Swift, MPH is a Consultant in HMA's Denver office and is supporting the Primary Care Clinician and Provider Transformation Collaborative component of the project, as well as leading project management. She joined HMA in February 2022 after serving with the New York City Department of Health and Mental Hygiene (NYC DOHMH), Bureau of Alcohol and Drug Use Prevention, Care and Treatment. Margot oversaw operations for the overdose prevention technical assistance team and provided programmatic guidance and capacity building support to community partners. Since joining HMA, Margot has worked on several payment reform projects, including a readiness assessment and robust stakeholder engagement around behavioral health payment reform. She earned a Master of Public Health in health policy and management from the State University of New York Downstate Medical Center School of Public Health.

Vision & Approach

Vision

HMA will support the development of VBP structures which appropriately incentivize and reward desired performance in the delivery of primary care benefits.

Approach

- Design, test, and evaluate a new primary care alternative payment model (APM) for the New Mexico Medicaid program
- Design, facilitate, and evaluate a Primary Care Clinician & Provider Transformation Collaborative

Vision & Approach – Key Pillars

- Improve healthcare quality and health status of New Mexicans
- Support team-based care (with a model the allows flexibility and is tied to quality)
- Use Medicaid market power to drive reform
- Collaborate with MCOs to drive innovation
- Reduce provider burden and strengthen workforce
- Learn from and leverage Medicare VBP efforts
- Leverage information sharing and HIE to connect providers