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Letter of Direction #60-1

Date: **October 6, 2025**

To: **Turquoise Care Managed Care Organizations**

From: **Dana Flannery, Director, Medical Assistance Division**

Subject: **Primary Care Payment Reform Value-Based Payment (PCPR-VBP) Program Directed Payment. Repeal & Replace LOD# 60**

Title: **Calendar Year 2025 Primary Care Payment Reform Value-Based Payment (PCPR-VBP) Program Directed Payment**

This Letter of Direction (LOD) is intended to repeal and replace LOD #60 issued by the Health Care Authority/Medical Assistance Division (HCA/MAD) on July 14, 2025. The following updates are included in this revised LOD:

- Updated Calendar Year 2025 PCPR-VBP payment dates.
- In State, Border, and Out of State Provider eligibility

HCA/MAD has received approval from the Centers for Medicare & Medicaid Services (CMS) for the PCPR-VBP directed payment in accordance with 42 C.F.R. § 438.6(c) for the period of January 1, 2025 – December 31, 2025. With this LOD, HCA/MAD is providing directions on the PCPR-VBP Program directed payments for the quality incentive component of the program.

PCPR-VBP Program Background

In 2022, HCA/MAD began working with provider advocacy groups and MCOs to develop a primary care alternative payment model (APM), which eventually became the PCPR-VBP Program. The PCPR-VBP Program Directed Payment is structured as a uniform percentage increase for primary care services for each registered Primary Care Provider. The New Mexico HCA collaborated with the New Mexico Primary Care Council (PCC) and statewide stakeholders to create a payment reform specific to the needs of New Mexico. The NM PCC is a community body established through New Mexico Statute § 24-1K-3 in the 2021 New Mexico Legislature. The NM PCC's mission is to "revolutionize primary care into interprofessional, sustainable teams delivering high-quality, accessible, equitable health care across New Mexico through partnerships with patients, families, and communities." The NM PCC's Payment Strategies goal is to "develop and make recommendations regarding sustainable payment models and strategies to achieve high quality and equitable primary care for all New Mexicans."

HCA /MAD is implementing the PCPR-VBP Program to offer incentives for enhancing the role of primary care in the healthcare system and improving the quality and efficiency of care. This is a mandatory program for all eligible primary care practices. If Primary Care practices choose not to participate, then those practices will forego any quality bonus payments. Please refer to the Primary Care Provider Definition on the New Mexico PCPR website for eligibility information.

In-state and Border primary care clinicians and practices (PCP) providing services that are rendered within 100 miles of the New Mexico state border (Mexico excluded) are eligible to participate in the NM PCPR-VBP. Out-of-state PCP services that are rendered in an area more than 100 miles from the New Mexico border (Mexico excluded) are not eligible to participate. Telehealth PCPs that fit the PCPR-VBP eligibility criteria and are an in-state or border provider, can be included.

The Medicaid PCPR-VBP Program is designed to increase compensation for primary care clinicians and practices to help these providers retain their current workforce and attract new team members, to improve access to primary care services for patients, to increase health equity, to manage healthcare costs carefully to ensure the system is sustainable, and to enable clinicians to devote the necessary time to their patients and thereby increase their job satisfaction and reduce burnout.

Quality Payment

For the quality payment, primary care provider groups/Tax Identification Numbers (TINs) are all included in one provider class (hereinafter "PCPR-VBP provider"). PCPR-VBP providers are identified by a combination of provider type and provider specialty at both a practice and affiliate level. Please refer to the Primary Care Provider Definition (https://drive.google.com/file/d/1sOA5QdFiKNhpM-ysEui_yexrJAzzWY71/view) on the New Mexico PCPR website (https://www.hca.nm.gov/primary-care-council/primary-care-payment-reform/) for a detailed description. PCPR-VBP providers will have access to dashboards to monitor their quarterly incentive payments. The dashboards will be managed through the Data Intermediary.

Payment to the MCO

To support the PCPR-VBP Program, funding will be allocated to the MCOs and subsequently paid by the MCOs to the PCPR-VBP provider based on actual utilization. This directed payment arrangement is paid on a separate payment term to the MCOs outside of the monthly capitation rates. The separate payment term payment is made on a quarterly basis for primary care services utilization per MCO for that quarter for distribution. Based on the CMS approval date, the January 1, 2025 – December 31, 2025, quality payments will be paid on the schedule provided within this LOD. All services provided by the eligible provider will receive the same uniform increase.

Distribution of Data Intermediary Payment

The PCPR-VBP Program requires the use of an HCA/MAD selected Data Intermediary to calculate the quality metrics for participating PCPR-VBP providers. The MCOs entered into an agreement with a Data Intermediary for this program and provided the cost to HCA/MAD which incorporated it into the MCO capitation amount. The Data Intermediary's total fees for its performance of the program are prorated proportionately among the participating Turquoise Care MCOs.

Payment Distribution

The PCPR-VBP providers can earn quality payments based on submitting data for the following quality metrics: Patient Experience of Care; Third Next Available Appointment (TNAA); Screening, Brief Intervention, and Referral to Treatment (SBIRT); and patient visits (used to calculate Encounter Completion Rate). Successful administration of the program depends on the PCPR-VBP providers' timely and appropriate submission of claims data to the MCOs, TNAA and patient visits data to the Data Intermediary, attestations to structural measure requirements, data submission to CMS as applicable, and review of PCPR-VBP provider specific information within required timeframes. Quality payments depend on the timely finality of quality metrics; the payments will be calculated quarterly. Once the quarterly payment is finalized with the Data Intermediary, the Data Intermediary will provide quality dashboards to the providers and the MCOs. These quality dashboards will determine for each MCO how much to pay for the PCPR-VBP Program based on each MCO's distribution of membership. The MCO is to make the payment in accordance with participating PCPR-VBP providers. This separate payment term quality payment is tied to the provider base reimbursement. HCA/MAD approves of a MCO unilateral contracting approach that deems the provider into the program, and that does not require signatures. MCOs may still want to consider if this method allows for provider awareness of program participation and may want to have primary care providers confirm they have received and understand the PCPR-VBP program amendment deemed in some way.

Data Sharing and Reporting

As part of the agreement, the Data Intermediary will be sharing PCPR-VBP provider performance information with the providers, MCOs, HCA/MAD and Health Management Associates (HMA). The MCOs are also required to submit their PCPR-VBP Program payments and supporting documentation to HCA/MAD on the following quarterly HCA VBP FIN report after payments have been submitted to the PCPR-VBP provider. Payments are reported cumulatively throughout the year on the "PCPR-VBP" work tab and finalized on the Annual Supplemental report.

PCPR-VBP Program Payments

HCA/MAD will inform the MCOs to make a payment to all eligible PCPR-VBP providers based on HCA/MAD's calculations of amounts owed to each PCPR-VBP provider for the period of

January 1, 2025 – December 31, 2025, and through MCO contract consistent with the CMS-approved Directed Payment. MCOs must make electronic deposits, for the PCPR-VBP Directed Payment program to PCPR-VBP providers based on HCA/MAD's calculations and the payment must be received by the provider as directed by HCA/MAD. MCOs may make quarterly check payments if requested by the PCPR-VBP provider. Based on CMS annual approval, the PCPR-VBP payment will be paid on a quarterly cadence. Quality payments cannot be made until CMS has approved the PCPR-VBP directed payment.

Table 1. CY25 PCPR-VBP Payment Dates

Period	Quarter	Payment Date
Q1 2025	1/1/2025 - 3/31/2025	December 2025
Q2 2025	4/1/2025 - 6/30/2025	January 2026
Q3 2025	7/1/2025 – 9/30/2025	March 2026
Q4 2025	10/1/2025– 12/31/2025	June 2026

Evaluation Plan Metrics

PCPR-VBP providers will be evaluated on meeting data submission requirements for five quality measures for the period of January 1, 2025 – December 31, 2025, as shown in Table 2 below. These include two structural measures and two process measures: SBIRT structural measure, Patient Experience of Care structural measure, Third Next Available Appointment (TNAA), Encounter Acceptance Rate, and Encounter Completion Rate. MCOs will submit data for Encounter Acceptance Rate and Encounter Completion Rate. Note that the PCPs' performance against the performance measures does not impact eligibility for the uniform percentage increase on utilization during the January 1, 2025 – December 31, 2025, rating period.

Table 2. Group 1 Quality Measures

Measure Name	Measure Steward/Developer	Measure Specifications	State Baseline
Encounter Acceptance Rate Measure	State-Specific New Mexico	The percentage of claims/encounters that are accepted by the MCO's claims adjudication system. **Numerator (MCO):** Number of accepted claims/encounters (claims that were not rejected or denied and include "paid" claims, as well as claims that resulted in $0 payment, e.g. services rendered with claims submitted for informational purposes). **Denominator (MCO):** Number of accepted and rejected claims/encounters (synonymous with "denied claims").	CY 2024

Encounter Completion Rate Measure	State-Specific New Mexico	The percentage of practice-reported volume that is captured by accepted encounters from claim submissions. **Numerator (MCO):** Number of accepted claims/encounters (claims that were not rejected or denied and include "paid" claims, as well as claims that resulted in $0 payment, e.g. services rendered with claims submitted for informational purposes). **Denominator (Provider):** Number of patient visits for provider rendered services reported by the primary care practice for the MCO's members.	CY 2024
Third Next Available Appointment (TNAA) Measure	Institute for Healthcare Improvement (IHI)	Provider: As defined in the Data Intermediary's technical specifications	CY 2024
Screening, Brief Intervention, and Referral to Treatment (SBIRT) Measure	State-Specific New Mexico	Provider: As defined in the Data Intermediary's technical specifications	CY 2024
Patient Experience Measure	State-Specific New Mexico	Provider: As defined in the Data Intermediary's technical specifications	CY 2024

PCPR-VBP Program Directed Payment Operational and Reporting Requirements

This section provides information about operational, and reporting requirements associated with the directed payment.

- The directed payments are classified as revenue attributed to medical expenses and therefore classified as "premium". The payment will include gross-up amounts to account for underwriting gain, premium and surtax taxes.
    - HCA/MAD will provide each MCO with the amount of the directed payment and break out the gross-up amounts for each rate cohort.
- The directed payments will be included in the MCOs Medical Loss Ratio and Underwriting Gain calculations outlined in the MEDICAID MANAGED CARE SERVICES AGREEMENT.

    - HCA/MAD directs each MCO to report the revenue received for the directed payment in the quarterly and annual Financial Reporting package as "other revenue". The amounts recorded in the financial reporting package must match the total payment made by HCA/MAD to the MCO by rate cohort.
    - HCA/MAD directs each MCO to report the amount paid by the MCO to PCPR-VBP providers for the directed payment in the quarterly and annual Financial Reporting package as "other services". The amounts recorded in the financial reporting package must match the total payment made by HCA/MAD to the MCO by rate cohort.
    - HCA/MAD directs the MCOs to support PCPR-VBP providers by providing support to Medicaid beneficiaries to improve quality of care outcomes
- Amounts paid by the MCO to PCPR-VBP providers for the directed payment should also be reported in FIN-Report #5 for "Other Services" in the Shared Risk/Incentive Arrangements (All programs – Line 42). This will ensure that the FIN-Report Check Totals tab does not identify submission errors.
- The PCPR-VBP separate payment term directed payment revenues should be reported in the Directed Payment Revenue worksheet, "Primary Care VBP Directed Payment" column in FIN Report #23.
- The PCPR-VBP Shared Risk Arrangements, including Separate Payment Term Directed Payments should be reported in the "PCPR-VBP Directed Payment" column on the SRA Expense Detail worksheet in FIN Report #23.
- Reconciliations performed as part of the MCO contract (Retroactive Period, and Patient Liability) will not include the directed payment revenue or expense.
- The directed payment amount paid by the MCO to PCPR-VBP providers should not be included in encounter data submissions.

If you have additional questions related to this Letter of Direction (LOD) please contact Trisstin Maroney, Innovation Project Manager (Trisstin.Maroney@hca.nm.gov).

This LOD will sunset when direction is provided in one or more of the following: Turquoise Care Managed Care Services Agreement, Managed Care Policy Manual, NMAC, Systems Manual, or BHSD Billing and Systems Manual. The LOD may also sunset upon HCA/MAD notification or completion of the Turquoise Care Program.