
September 7, 2023

Lorelei Kellog
Acting Director
Medical Assistance Division
Bew Mexico Department of Human Services
PO Box 2348
Santa Fe, NM 87504-2348

Dear Lorelei Kellog:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving New Mexico's submission of an amendment for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The amendment was received by CMS on March 1, 2023 and has a control name of NM_Proposal B 2021_Amendment.

Specifically, the following proposal amendment for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- A value-based purchasing and uniform percent increase arrangement established by the state to increase nursing facility per diem rates by the market basket index (MBI) factor and to provide quality incentive payments for nursing facilities under contract that meet performance requirements on specified quality metrics for the rating period covering January 1, 2021 through December 31, 2021, incorporated in the capitation rates through a separate payment term of up to \$80.3 million.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period(s), or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and implementing regulations, including by initiating separate deferrals and/or disallowances of federal financial participation. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Therefore, CMS strongly recommends that states share this approval letter and the final approved preprint with the certifying actuary. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the [Medicaid Managed Care Rate Development Guide](#). The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is

included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must certify the aggregate amount of the separate payment term and an estimate of the magnitude of the payment on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

The total dollar amount approved for the separate payment term for this state directed payment is \$80.3 million within the New Mexico Centennial Care managed care program. If the total amount of the separate payment term is exceeded from what was approved under this preprint or, the payment methodology is changed from the approved preprint, CMS requires the state to submit a state directed payment preprint amendment. Please note that if the separate payment term amount documented within the rate certification exceeds the separate payment term amount approved under the preprint, then the state will be required to submit a rate certification amendment to address the inconsistencies between the rate certification and the approved preprint.

If you have questions concerning this approval or state directed payments in general, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

Alexis Gibson
Acting Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

Section 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts. Section 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract – paragraph (c)(1)(i) provides that States may specify in the contract that managed care plans adopt value-based purchasing models for provider reimbursement; paragraph (c)(1)(ii) provides that States have the flexibility to require managed care plan participation in broad-ranging delivery system reform or performance improvement initiatives; and paragraph (c)(1)(iii) provides that States may require certain payment levels for MCOs, PIHPs, and PAHPs to support State practices critical to ensuring timely access to high-quality care.

Under section 438.6(c)(2), contract arrangements that direct the MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in section 438.6(c)(1)(i) through (iii).

Standard Questions for All Payment Arrangements

In accordance with §438.6(c)(2)(i), the following questions must be completed.

DATE AND TIMING INFORMATION:

1. Identify the State's managed care contract rating period for which this payment arrangement will apply (for example, July 1, 2017 through June 30, 2018):

January 1, 2021-December 31, 2021

2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2018):

January 1, 2021

3. Identify the State's expected duration for this payment arrangement (for example, 1 year, 3 years, or 5 years):

At least 5 years. NM acknowledges directed payments are generally subject to annual approval.

STATE DIRECTED VALUE-BASED PURCHASING:

4. In accordance with §438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative. *Check all that apply; if none are checked, proceed to Question 6.*

- Quality Payments / Pay for Performance (Category 2 APM, or similar)
- Bundled Payments / Episode-Based Payments (Category 3 APM, or similar)
- Population-Based Payments / Accountable Care Organization (ACO) (Category 4 APM, or similar)
- Multi-Payer Delivery System Reform
- Medicaid-Specific Delivery System Reform
- Performance Improvement Initiative
- Other Value-Based Purchasing Model

5. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services (the State may also provide an attachment). If “other” was checked above, identify the payment model. If this payment arrangement is designed to be a multi-year effort, describe how this application’s payment arrangement fits into the larger multi-year effort. If this is a multi-year effort, identify which year of the effort is addressed in this application.

For state fiscal year 2021, HCQS will include **four long term stay quality** components that are provided in response to question 17. The quality metrics will be equally weighted for payment each quarter. The nursing facilities' improvement in quality will be evaluated by comparing the nursing facilities scores to CMS cut points. Based on the amount of points a facility earns, a quality payment will be paid to the facility. The quality payment will not affect a facility's per diem rate. The HCQS differs from the NF VBP program as the NF VBP program is a voluntary program and HCQS is required of all Nursing Facilities per statute. The NF VBP program also differs as it incentivizes High-Acuity and Telemedicine. The NF VBP program also has different quality measures that include LS Antipsychotic, UTI, PointRight LS Hospitalization, LS High Risk Pressure Ulcers.

STATE DIRECTED FEE SCHEDULES:

6. In accordance with §438.6(c)(1)(iii), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. *Check all that apply; if none are checked, proceed to Question 10.*

- Minimum Fee Schedule
- Maximum Fee Schedule
- Uniform Dollar or Percentage Increase

7. Use the checkboxes below to identify whether the State is proposing to use §438.6(c)(1)(iii) to establish any of the following fee schedules:

- The State is proposing to use an approved State plan fee schedule
- The State is proposing to use a Medicare fee schedule
- The State is proposing to use an alternative fee schedule established by the State

8. If the State is proposing to use an alternative fee schedule established by the State, provide a brief summary or description of the required fee schedule and describe how the fee schedule was developed, including why the fee schedule is appropriate for network providers that provide a particular service under the contract (the State may also provide an attachment).

Amendment: There was no change to the below payment methodology for this directed payment. A change to total computable and non-federal share (as noted below) is based on the difference in estimating the quality payment based on data available prior to CY2021 and the actual quality payment amount paid during CY2021 utilizing the surcharge and available bed day data. The total computable payment amount for CY2021 is \$80.3 million with a non-federal share estimate of \$16.2 million.

The State of New Mexico plans to use §438.6(c)(1)(iii)(B) to implement the Healthcare Quality Surcharge (HCQS) Act to provide a uniform dollar increase to Nursing facility per diem rates for the market basket index (MBI) factor and per diem add-on for each respective class of Nursing Facility as defined by the statute and to provide quality incentive payments to Nursing Facilities that meet performance requirements on specified quality metrics. All New Mexico Medicaid Nursing Facilities qualify for these increases except for Out-of-State Nursing facilities.

Nursing Facility Classes:

- Class 1 - A health care facility with less than sixty beds;
- Class 2 - A health care facility with sixty or more beds and less than ninety thousand annual Medicaid bed days;
- Class 3 - A health care facility with sixty or more beds and ninety thousand or more annual Medicaid bed days

The uniform dollar increase to Nursing Facilities is based the annual per Medicaid bed day unit rate based on quarterly nursing facility assessment revenue in accordance with 42 CFR 433.68 and approved by CMS. New Mexico estimates that one-third of the annual revenue will be directed towards the uniform dollar per diem increase and two-thirds of the annual

9. If using a maximum fee schedule, use the checkbox below to make the following assurance:

In accordance with §438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

N/A

APPROVAL CRITERIA FOR ALL PAYMENT ARRANGEMENTS:

10. In accordance with §438.6(c)(2)(i)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract (the State may also provide an attachment).

All MCOs will be directed to increase contracted Nursing Facility per diem rates by the uniform percentage MBI factor and the uniform per diem add-on for utilization incurred by Medicaid managed care enrollees. The base capitation rates will be revised to incorporate the per diem and MBI increases and the quality payment will be incorporated in the rate certification as a separate payment term.

11. In accordance with §438.6(c)(2)(i)(B), identify the class or classes of providers that will participate in this payment arrangement.

The uniform dollar per diem add-on varies by Nursing Facility class, the uniform MBI factor increase is the same across Nursing Facility classes, and both apply to all New Mexico Medicaid Nursing Facilities (excluding for Out-of-State Nursing Facilities). The quality payment is available to all New Mexico Nursing Facilities that meet the quality metrics.

Nursing Facility Classes:

- Class 1 - A health care facility with less than sixty beds;
- Class 2 - A health care facility with greater than sixty beds and less than ninety thousand annual Medicaid bed days;
- Class 3 - A health care facility with more than ninety thousand annual Medicaid bed days

12. In accordance with §438.6(c)(2)(i)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract (the State may also provide an attachment).

The program only has three class of facilities. The payment arrangement is incorporated into the capitation rates and the contract via a letter of direction issued to all MCOs to increase contracted rates with Nursing Facilities by the specified uniform dollar increase for the MBI factor and per diem add-on.

QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #52). The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

13. Use the checkbox below to make the following assurance (and complete the following additional questions):

In accordance with §438.6(c)(2)(i)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per §438.340.

a. Hyperlink to State’s quality strategy (consistent with §438.340(d), States must post the final quality strategy online beginning July 1, 2018; if a hyperlink is not available, please attach the State’s quality strategy):

Draft Quality Strategy pending CMS comment:
<https://www.hsd.state.nm.us/uploads/files/Public%20Information/Public%20Notices%2C%20Proposed%20Rule%20and%20Waiver%20Changes/QS%20-%20Draft.pdf>

b. Date of quality strategy (month, year):

January 2019

c. In the table below, identify the goal(s) and objective(s) (including page number references) this payment arrangement is expected to advance:

Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives		
Goal(s)	Objective(s)	Quality strategy page
Assure that Medicaid recipients receive the right amount of care, at the right time, and in the right setting.		3
Ensuring that expenditures for care and services being provided are measured in terms of quality and not solely by quantity		3

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #52). The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

- d. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Question 13(c). If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and that of the multi-year payment arrangement.

The increased reimbursement for Nursing Facilities will support the operations of these facilities and aid these facilities to invest in the health of their local communities. The payment increase supports the adequacy of the rates for these services to continue to participate in the Centennial Care program as vital partners in providing statewide access to nursing facility level of care and skilled nursing services. New Mexico is focused on ensuring that expenditures for care and services being provided are measured in terms of quality and not solely by quantity. The quality measures were identified as areas where New Mexico's quality could improve.

14. Use the checkbox below to make the following assurance (and complete the following additional questions):

In accordance with §438.6(c)(2)(i)(D), the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goal(s) and objective(s) in the quality strategy required per §438.340.

- a. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 13(c). If this is any year other than year 1 of a multi-year effort, describe prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. If the State has an evaluation plan or design for this payment arrangement, or evaluation findings or reports, please attach.

The evaluation will occur annually after the end of the year, in conjunction with the quality reporting by the provider and the determination of the earned bonus payments. The state will determine the extent to which the quality payment arrangement has driven performance improvement and will be able to evaluate the use of the chosen nationally recognized standards.

- b. Indicate if the payment arrangement targets all enrollees or a specific subset of enrollees. If the payment arrangement targets a specific population, provide a brief description of the payment arrangement's target population (for example, demographic information such as age and gender; clinical information such as most prevalent health conditions; enrollment size in each of the managed care plans; attribution to each provider; etc.).

This payment arrangement will be applied to all members enrolled in an MCO who receive covered services from the Nursing Facilities.

- c. Describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

No data or measure stratifications are planned.

- d. Provide additional criteria (if any) that will be used to measure the success of the payment arrangement.

No additional criteria will be used.

REQUIRED ASSURANCES FOR ALL PAYMENT ARRANGEMENTS:

15. Use the checkboxes below to make the following assurances:

- In accordance with §438.6(c)(2)(i)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.
- In accordance with §438.6(c)(2)(i)(F), the payment arrangement is not renewed automatically.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #52). The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

In accordance with §438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with §438.4, the standards specified in §438.5, and generally accepted actuarial principles and practices.

Additional Questions for Value-Based Payment Arrangements

In accordance with §438.6(c)(2)(ii), if a checkbox has been marked for Question 4, the following questions must also be completed.

APPROVAL CRITERIA FOR VALUE-BASED PAYMENT ARRANGEMENTS:

16. In accordance with §438.6(c)(2)(ii)(A), describe how the payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified above) providing services under the contract related to the reform or improvement initiative (the State may also provide an attachment).

The same quality metrics are used to evaluate performance and receipt of the quality incentive payment across the Nursing Facility class of providers.

QUALITY CRITERIA AND FRAMEWORK FOR VALUE-BASED PAYMENT ARRANGEMENTS:

17. Use the checkbox below to make the following assurance (and complete the following additional questions):

In accordance with §438.6(c)(2)(ii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

a. In the table below, identify the measure(s) that the State will tie to provider performance under this payment arrangement (provider performance measures). To the extent practicable, CMS encourages States to utilize existing validated performance measures to evaluate the payment arrangement.

TABLE 17(a): Payment Arrangement Provider Performance Measures					
Provider Performance Measure Number	Measure Name and NQF # (if applicable)	Measure Steward/ Developer (if State-developed measure, list State name)	State Baseline (if available)	VBP Reporting Years*	Notes**
1.	Percentage of LS residents experiencing one or more falls with major injury	CMS	SFY2020	CY2021	
2.	Percentage of LS residents who have symptoms of depression	CMS	SFY2020	CY2021	
3.	Percentage of LS residents who needed and got a flu shot for the current flu season	CMS	SFY2020	CY2021	
4.	Percentage of LS residents who needed and got a vaccine to prevent pneumonia	CMS	SFY2020	CY2021	

*If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement the measure will be collected in.

**If the State will deviate from the measure specification, please describe here. Additionally, if a State-specific measure will be used, please define the numerator and denominator here.

- b. Describe the methodology used by the State to set performance targets for each of the provider performance measures identified in Question 17(a).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #52). The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

The quality metrics will be reviewed yearly for appropriateness and to ensure quality outcomes are met. Performance targets are based on CMS cut points, where applicable. Each cut point is allocated a set amount of points. Facilities earn points based on these cut points.

Each measure has 100 points associated with it. The 100 points are divided by cut points in 20 point increments. A Tier Percentage is associated with the summation of points for the quarter in question. The tier percentage are as follows: In recognition of the COVID emergency, during the data periods of July 2020 – December 2020, and the negative impact to quality scores the CY2021 Q1 and CY2021 Q2 will be given a COVID adjustment point total equaling 320 points.

Tier 1	320 points or more
Tier 2	319 to 260 points
Tier 3	259 to 200 points
Tier 4	199 to 140 points
Tier 5	139 points or less

Interim evaluation findings for Quarters 1-3 for the CY20 period of this directed payment is provided as an attachment. The findings for Quarter 4 will be provided to CMS by April 30, 2021.

REQUIRED ASSURANCES FOR VALUE-BASED PAYMENT ARRANGEMENTS:

18. Use the checkboxes below to make the following assurances:

- In accordance with §438.6(c)(2)(ii)(C), the payment arrangement does not set the amount or frequency of the expenditures.
- In accordance with §438.6(c)(2)(ii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #52). The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.