DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

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 D 2021_Amendment.

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

- The uniform percentage increase established by the state for qualified practitioners who are members of a practice plan under contract to provide professional services at a state-owned academic medical center 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 $49.9 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 $49.9 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 E. Gibson -S

Digitally signed by Alexis E. Gibson -S
Date: 2023.09.07 11:54:28 -04'00'

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 (continuation from CY2020 UNMMG directed payment)

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

1 year. NM HSD acknowledges this type of directed payment is subject to annual review and approval by CMS.

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.

N/A

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 an increase in actual utilization incurred during CY2021 compared to the historical utilization used for developing the cost estimate.

The state plans to use §438.6(c)(1)(iii)(B) to provide a uniform percentage increase of approximately 96% of contracted rates between the practice plans and the Medicaid Managed Care Organizations. The increase will align Medicaid payments for professional services with levels that are consistent with efficiency, economy, and quality of care and are commensurate with the average commercial rate. As the payment arrangement will be structured using a separate payment term, the exact uniform percentage rate increase may vary from the intended level. For each quarter, payments will be calculated using the uniform percentage increase (as noted above) times the actual utilization from the prior quarter in order to arrive at the supplemental payment. The total computable for CY2021 is $49.9 million with a non-federal share estimate of $ 8.2 million.

Qualified Practitioners are individual provider types enumerated in response to Question 11 who are members of a practice plan under contract to provide professional services at a State-owned academic medical center or employed by such academic medical centers as determined by the Department. The increase will apply for all professional services delivered by a qualified practitioner, excluding anesthesia.

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.

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).

An annual pool of funds will be established in a separate payment term by applying the uniform percentage increase commensurate with the average commercial rate to anticipated utilization and associated base Medicaid payments, not to exceed 100% of ACR. The distribution of funds from the pool to the managed care plans will be made quarterly.

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

Qualified Practitioners are individual provider types enumerated below who are members of a practice plan under contract to provide professional services at a State-owned academic medical center as determined by the Department.

In this contract year, the eligible practice plan is the University of New Mexico Health Sciences Center clinical delivery system including: UNM Medical Group, UNM Sandoval Regional Medical Center, UNM Hospitals, and associated clinics and programs.

Qualified Practitioners include:

- Doctors of Medicine (excluding anesthesiologists)

- Doctors of Osteopathy
- Doctors of Podiatry
- Doctors of Dentistry
- Certified Registered Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Clinical Social Workers
- Clinical Psychologists
- Optometrists
- Clinical Nurse Specialist
- Board Certified Behavioral Analyst
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Audiologists
- Licensed Professional Counselors

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 payment arrangement sets a pool that is built using a uniform percentage increase, utilization and associated base Medicaid payments. The same uniform percentage increase will apply across the eligible class of providers. The MCOs will receive quarterly payments from the pool based on actual expenditures for providers who meet the eligibility criteria for the class of participating providers.

QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS:

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/quality-strategy-2/

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
Assuring that Medicaid recipients in the program receive the right amount of care, delivered at the right time, in the right setting	Develop collaborative strategies and initiatives with state agencies and other external partners	3
Ensuring that expenditures for care and services are measured in terms of quality and not quantity	Continue use of nationally recognized protocols, standards of care and benchmarks	3

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 resource gains from the payment arrangement will support the Qualified Practitioners' efforts to align with New Mexico's quality strategy goals and objectives by supporting improvement initiatives that achieve the traits of high quality, high value healthcare for the attributed population. Such initiatives will target performance improvement in the areas of appropriateness of care, efficient and coordinated care, member-centered care, timeliness, equality of appropriate of care, and prevention and early detection. The Qualified Practitioners will collaborate with New Mexico Medicaid

and Centennial Care 2.0 managed care plans (MCPs) to develop Medicaid performance improvement strategies that result in high quality, high value healthcare.

The annual performance measures for the program's evaluation plan will be in alignment with the HEDIS measures currently used to assess performance in the state's managed care program. The use of common performance measures across evaluation plans is another strategy to improve collaboration between the MCPs and Qualified Practitioners and to align on performance goals.

A periodic review will be undertaken to ensure the percentage increase and subsequent funds are appropriate to support the professional services provided by these integral Qualified Practitioners.

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 State will collect metrics annually pertaining to the quality of and access to care in alignment with the state's goals and objectives and existing measurement processes. The below table features the metrics, baselines and improvement targets for the program:

Measure	Baseline (Prior 12-month average through August 2020)	Performance Target (CY2021)
Well Child Visits – First 15 Months (W15)	58%	63%
Antidepressant medication management (AMM) Continuous Phase	28%	33%
Childhood Immunization Status (CIS) Combo 3	49%	54%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	2%	7%
Comprehensive diabetes care HbA1c poor control >9	30%	29%

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.).

The uniform percentage increase will be applied to all Centennial Care 2.0 members enrolled in an MCO who receive covered state-plan services (excluding anesthesia) from a Qualified Practitioner. This includes all populations covered under managed care including legacy (non-expansion), adult expansion and long-term services and supports programs.

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

N/A

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

N/A

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.

☒ 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).

N/A

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. N/A					
2.					

*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).

N/A

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.