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

September 6, 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_VBP_IPH.OPH_Amendment_20210101-20211231.

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

- The uniform increase for inpatient and outpatient hospital services and performance-based quality payments established by the state for hospitals that provide guaranteed access to care for Native Americans through the Indian Health Service 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 $86.4 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 $86.4 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: 2023.09.06 14:53:21 -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):

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|---|
| January 1, 2021 through December 31, 2021 |

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

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|---|
| January 1, 2021 (continuation from CY2020 UNM Hospital directed payment) |

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

HSD acknowledges this directed payment is subject to annual approval unless the requirements for multi-year approvals are met.

**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.

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 performance on quality measures by the provider class. The total directed payment opportunity attributable to quality measures was $9.0 million and the provider class earned a quality payment of $5.4 million.

The state proposes to establish a directed payment for a hospital that (as defined in response to Question 11) provides guaranteed access to care for Native Americans. The directed payment will be structured as a rate increase for inpatient and outpatient hospital services, but a portion of it will be at risk for meeting specified performance metrics.

Most of the rate increase (90 percent) will be paid out on a quarterly basis, separately from the monthly capitation payments. The state will withhold 10 percent ($9.0 million). Each payment will be allocated among the MCOs based on each MCO's share of total utilization by the eligible provider during the payment period. The MCO's will be directed to pay the rate increase to the provider on a lump sum basis, separately from the claims payments.

Payment of the 10 percent withheld amount will be contingent on meeting agreed-upon quality improvement targets (described in response to Question 13). Ten measures have been chosen. The state will release 10 percent of the total withhold for each measure for which the target has been met. After the end of the year, the provider will report to the state on its performance on the quality metrics. Based on the number of targets met, the state will approve payment of the relevant portion of the withheld amount to be paid out as a bonus payment. The bonus payment will be allocated among the MCOs based on their proportional share of utilization by the eligible provider, and they will be directed to make payments to the provider accordingly.

The total $90 million payment increase, including the withhold, is projected to equal 46% based on actuarial projections, but the actual rate increase will vary depending on actual utilization during the year.

The non-federal share for this payment arrangement will be paid by University of New Mexico Hospital, which is an integral part of the state institution, in the form of an IGT. University of New Mexico Hospital will transfer the non-federal share required to fund this payment arrangement to the New Mexico Human Services Department using local sources of revenue. The New Mexico Human Service Department and the University of New Mexico Hospital will enter into a Memorandum of Understanding outlining the IGT obligations generated under this program as well as existing IGT arrangements between University of New Mexico Hospital and the state.

## 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).

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|---|
| N/A |

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).

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| Both the quarterly payment increases and the withhold payment (to the extent earned) will be allocated to the MCOs and (subsequently paid by the MCOs to the provider) based on actual utilization of the provider by each MCO. While the total pool of funds available for this payment arrangement is fixed at $90 million, the payment of that amount will be tied directly to the delivery of services to MCO enrollees by the eligible provider during the payment period. |

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 eligible class of providers is defined as a hospital that, pursuant to a lease agreement, has assumed a New Mexico county's perpetual contractual obligation to the United States government, through the Indian Health Service, to provide guaranteed access to care for Native Americans. The University of New Mexico Hospital would qualify. While eligibility would be tied to the provider's unique role in providing access to care for this population, the payment increase would be tied to all services provided by the eligible provider to all MCO enrollees.

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).

All services provided by the eligible provider will receive the same percentage rate increase and bonus payment.

**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):

https://www.hsd.state.nm.us/wp-content/uploads/2020-Quality-Strategy-Final.pdf
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:

Please note: The numbering below places the goals in priority order relative to the payment arrangement, not the numbering in the Quality Strategy.

| **Table 13(c): Payment Arrangement Quality Strategy Goals and Objectives** | | |
|---|---|---|
| **Goal(s)** | **Objective(s)** | **Quality strategy page** |
| Ensuring that expenditures for care and services being provided are measured in terms of quality and not solely by quantity | Continue use of nationally recognized protocols, standards of care and benchmarks | 13 |
| | | |
| | | |
| If additional rows are required, please attach. | | |

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

| |
|---|
| The payment arrangement will put a portion of the MCO payments to the provider at risk for meeting several key quality measures, utilizing nationally recognized benchmarks. Specifically, the chosen quality measures (detailed in the table responding to Question 17a) are consistent with State quality priorities and the quality reporting requirements for the MCOs. By providing a meaningful bonus payment arrangement, the state intends for this arrangement to drive performance improvement within the hospital with a direct impact on quality of care, helping to shift overall payments to an increasing focus on quality rather than quantity. |

this both in terms of this year's payment arrangement and that of the multi-year payment arrangement.

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 quality program data will be collected on the identified measures for 2021. Data from 2019 will be used to establish the baseline and performance targets. Quality performance review 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/withhold payments. The state will determine the extent to which the value-based payment arrangement has driven performance improvement and will be able to evaluate the use of the chosen nationally recognized standards. The quality measures specified in Question 17a are also the evaluation plan measures

As of the date of this preprint, Year 1 quality data is not yet available as the contract year is not yet complete. [*The state will submit Year 1 results in July 2021.*]

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 payment arrangement targets all enrollees.

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

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|---|
| 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.

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|---|
| 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.

☒ 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).

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| Although there is only one hospital that is within the eligible class, the payment arrangement will be available on the same terms of performance for all hospital services (inpatient and outpatient) provided by the eligible provider pursuant to a contract with an MCO. |

## 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**** Data Source |
|---|---|---|---|---|---|
| 1. | Deaths Among patients with serious treatable complications after surgery | AHRQ | 2019 | 2021-2023 | Claims |
| 2. | Percentage of outpatients CT Scans of the abdomen that were "combination" (double scans) | AHRQ | 2019 | 2021-2023 | Claims |
| 3. | Serious complications that patients experienced during a hospital stay or after having certain inpatient procedures (lower is better) | AHRQ | 2019 | 2021-2023 | Claims |
| 4. | Patients with alcohol abuse who received a brief intervention during their hospital stay. | TJC | 2019 | 2021-2023 | Supplemental |
| 5. | HCAHPs Survey Communication with Doctors | AHRQ | 2019 | 2021-2023 | HCAHPs |
| 6. | HCAHPs Survey Communication with Nurses | AHRQ | 2019 | 2021-2023 | HCAHPs |

| | | | | | |
|---|---|---|---|---|---|
| 7. | Follow up after ED visit for Mental Health (7 day) | NCQA | 2019 | 2021-2023 | Claims |
| 8. | Follow up after ED visit for Mental Health (30 day) | NCQA | 2019 | 2021-2023 | Claims |
| 9. | Follow up after Hospitalization for Mental Health (7 day) | NCQA | 2019 | 2021-2023 | Claims |
| 10. | Follow up after Hospitalization for Mental Health (30 day) | NCQA | 2019 | 2021-2023 | Claims |

*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).

The performance targets will be determined in conjunction with the provider based on a review of CY2021 performance by the provider, setting reasonably achievable goals for performance improvement.

**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.