Michelle Lujan Grisham, Governor
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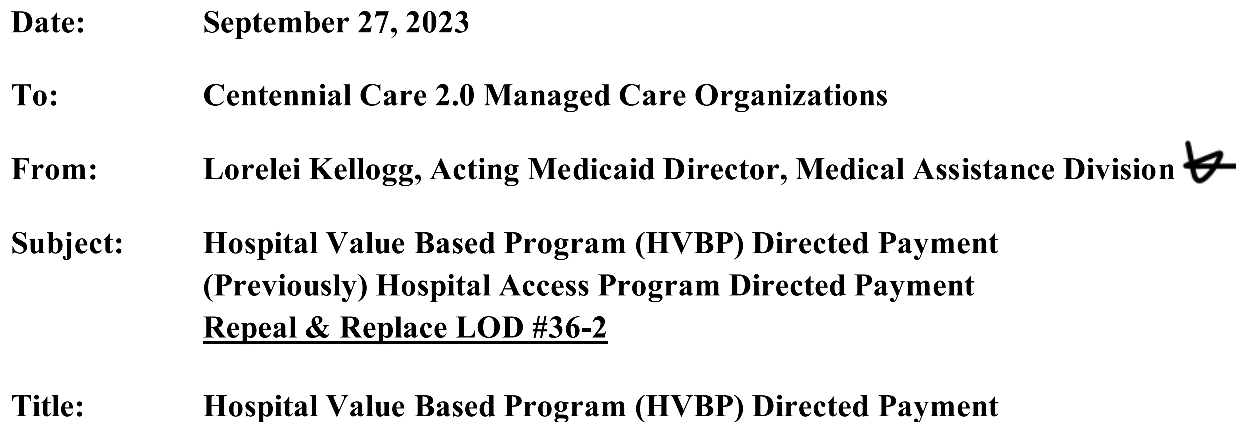
Letter of Direction #36-3



Date:	**September 27, 2023**
To:	**Centennial Care 2.0 Managed Care Organizations**
From:	**Lorelei Kellogg, Acting Medicaid Director, Medical Assistance Division**
Subject:	**Hospital Value Based Program (HVBP) Directed Payment** **(Previously) Hospital Access Program Directed Payment** **<u>Repeal & Replace LOD #36-2</u>**
Title:	**Hospital Value Based Program (HVBP) Directed Payment**

This Letter of Direction (LOD) is intended to repeal and replace LOD #36-2 Hospital Access Program Directed Payment, issued by the Human Services Department Medical Assistance Division (HSD/MAD) on June 2, 2022.

HSD/MAD has worked with the Centennial Care Managed Care Organizations (MCOs) and provider advocacy groups in the development of the Hospital Value Based Program (HVBP). The purpose of this LOD is to provide instructions to the MCOs for implementing the HVBP. The Centers for Medicare & Medicaid Services (CMS) has approved this directed payment in accordance with 42 CFR 438.6(c) for calendar year 2023 (CY2023). With this LOD, HSD is updating the previous Hospital Access Program (HAP) directed payment to include additional quality measures included in the design of the HVBP directed payment. HSD established the HVBP directed payment with the pool of funding previously used for the HAP directed payment in CY2022.

Hospital Value Based Program Directed Payment Background

In CY2020, HSD established the Hospital Access Program (HAP) Directed Payment with the pool of dollars previously allocated to the Safety Net Care Pool (SNCP) Hospital Uncompensated Care (UC) which CMS required HSD to sunset December 31, 2019. In CY2022, HSD began working with provider advocacy groups and MCOs in the development and transition into the Hospital Value Based Program (HVBP).

The HVBP Directed Payment is structured as a uniform dollar increase for inpatient and outpatient hospital services for each respective class of SNCP hospitals. The payment increases 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. All services provided by the eligible provider within each respective class will

receive the same uniform increase. The payment arrangement will be paid on separate payment terms outside of the monthly capitation rates.

Safety Net Care Pool Class Payment

The inpatient and outpatient services subject to this directed payment are authorized in the State plan and the managed care delivery system for these services is authorized under the Centennial Care 2.0 section 1115 demonstration authority. SNCP hospitals are defined in the Centennial Care 2.0 1115 demonstration effective January 1, 2019, through December 2023. The list of impacted hospitals is included in the Standard Terms and Conditions – Attachment E for the 1115 waiver. These include the following SNCP classes:

- Smallest - 30 or fewer hospital beds;
- Small - 31-100 hospital beds;
- Medium - 101-200 hospital beds;
- Large hospitals - 201-300 hospital beds;
- Largest hospitals - 301 or more hospital beds.

Quality Payment

For the Quality payment, SNCP hospitals are divided into three hospital groups: Frontier, Rural, and Urban with different quality assessment and payment calculation methodologies for Frontier and Rural/Urban. The quality score will utilize CMS reported outcomes and New Mexico Medicaid State Specific MMIS data for the Data Vendor to calculate the quality scores. The SNCP Hospital will have access to dashboards to monitor their potential quarterly payout. The dashboards will be managed through the Data Vendor.

Payment to the MCO

To support the HVBP, funding will be allocated to the MCOs and subsequently paid by the MCOs to the providers based on actual utilization during CY2023. This directed payment arrangement is paid on a separate payment term to the MCOs outside of the monthly capitation rates.

Distribution of Data Vendor Payment

The HVBP requires the use of a Data Vendor to calculate the quality metrics for participating hospitals. The MCOs entered into an agreement with a Data Vendor for this program and provided the cost to HSD which incorporated it into the capitation amount. Data Vendor's total fees for its performance of the program is prorated proportionately among the participating MCOs by the following percentages: Western Sky Community Care (WSCC) 10%, Blue Cross Blue Shield of New Mexico (BCBSNM) 36%, and Presbyterian Health Plan (PHP) 54%.

Payment Distribution

The SNCP Hospitals can earn Hospital Quality Performance and Residual Funds payments based on their Medicaid inpatient and outpatient utilization and their quality scores. Successful administration of the program depends on the hospital's timely and appropriate submission of claims data to the MCOs, attestations to structural measure requirements, data submission to CMS as applicable, and review of hospital specific information within required timeframes. Quality Payments, based on each hospital's performance, are dependent on timely finality of Quality Payments; the payments will be calculated quarterly. Once the quarterly payment is finalized with the Data Vendor, the Data Vendor will provide

quality dashboards to the facilities and the MCOs. These quality dashboards will determine for each MCO how much to pay for the HVBP program based on each MCOs distribution of membership. The MCO is to make the payment in accordance with the contract that the participating SNCP Hospital signed.

Data Sharing and Reporting

As part of the agreement the Data Vendor will be sharing hospital performance information with the hospitals, MCOs, and HSD. The MCOs are also required to submit their HVBP payments and supporting documentation to HSD on the following quarterly HSD VBP FIN report after payments have been submitted to the Hospitals. Payments are reported cumulatively throughout the year on the "HVBP" work tab and finalized on the Annual Supplemental report.

Hospital Value Based Program Payments

HSD will inform the MCOs to make payments to all contracted hospitals based on HSD's calculations of amounts owed to each hospital for the period of January 1 through – December 31, 2023, and through MCO contract consistent with the CMS-approved Directed Payment. Quarterly Payments will be made retrospectively for CY2023 as the MCOs must make electronic deposits for the HVBP Directed Payment program to contracted hospitals based on HSD's calculations and the payment must be received by the provider as directed by HSD quarterly.

All dollars for the HVBP Directed Payments will be made on a separate payment term basis outside of the monthly capitation rates and the MCOs will distribute the separate payment term amount to contracted hospitals as directed by HSD.

Evaluation Plan Metrics

CY2023 HVBP Directed Payment was approved by CMS without an evaluation plan during the initial process. CMS indicated future approvals would depend on an evaluation for CY2023. The evaluation will be conducted by HSD staff.

HSD will review the pre and post comparisons results of the measures indicated for this preprint to determine performance outcomes. Note that the providers' performance against the performance measures do not impact eligibility for the uniform dollar increase on utilization during the CY2023 rating period. The below table features the metrics and baselines for the program for CY2023:

Measure Name	Measure Steward/Developer	State Baseline
RURAL/URBAN Hospital Performance Measures		
1. Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) [NQF #1789]	CMS	CY 2019
2. Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite (serious complications that patients experience during a hospital stay or certain inpatient procedures) [NQF #0531]	CMS	CY 2019

3. Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) [NQF #0500]	CMS	CY 2019
4. HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Hospital Inpatient Survey: Communication with Doctors [NQF #0166]	CMS	CY 2019
5. HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Hospital Inpatient Survey: Communication with Nurses [NQF #0166]	CMS	CY 2019
6. Screening, Brief Intervention, and Referral to Treatment (SBIRT) Process Measure [SAMHSA]	State-Specific New Mexico	TBD
7. Early Elective Delivery [Percentage of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary]	CMS	CY 2019
8. Care Coordination for Mental Health Emergency Department Visit Follow-Up – structural measure with attestation	State-Specific New Mexico	TBD
FRONTIER Hospital Performance Measures		
1. Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training – structural measures with attestation	State-Specific New Mexico	TBD
2. Care Coordination for Mental Health Emergency Department Visit Follow-Up – structural measure with attestation	State-Specific New Mexico	TBD

HVBP Directed Payment Operational and Reporting Requirements

The HVBP Directed Payments are classified as revenue attributed to medical expenses and are therefore classified as "premium". The quarterly payments will include gross-up amounts to reflect applicable underwriting gain and premium taxes. The directed payments will be included in the MCOs medical loss ratio and underwriting gain calculations outlined in the Centennial Care 2.0 Contract Amendment #6 (Section 7.2).

For the Care Coordination Structural Measure it is the responsibility of the MCOs and hospitals to work collaboratively on the coordination of quarterly meetings that MCOs will facilitate.

Reporting requirements for the HVBP Directed Payments are set forth below:

- Each MCO is directed 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 MAD to the MCO by rate cohort.
- Each MCO is directed to report the amount paid by the MCO to hospitals 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 MAD to the MCO by rate cohort.

- Amounts paid by the MCO to hospitals 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 do not trigger submission errors.
- The HVBP separate payment term directed payment can be reported in the "HAP Directed Payment" column on the SRA Expense Detail worksheet in FIN Report #23.
- The directed payments are classified as revenue attributed to medical expenses and therefore classified as "premium". The quarterly payments will include gross-up amounts to reflect applicable risk/margin and premium taxes.
    - MAD will provide each MCO with the amount of the directed payment and break out the gross-up amounts for each rate cohort.
- Reconciliations performed as part of the Centennial Care 2.0 MCO contract (Retroactive Period, and Patient Liability) will not include the HVBP Directed Payment revenue or expense.
- The directed payment amount paid by the MCO to hospitals should not be included in encounter data submissions.

If you have additional questions related to this Letter of Direction (LOD) please email Rayna L. Fagus, Bureau Chief, Financial Management Bureau at rayna.fagus@hsd.nm.gov or 505-699-5566.

This LOD will sunset upon termination of the Centennial Care 2.0 Medicaid Managed Care Services Agreement.