New Mexico Health Care Delivery and Access Act (HDAA) Value-Based Payment (VBP) Program

Effective July 1, 2024

V. 1.1 (4/2/2025)

Table of Contents

Executive Summary

The Health Care Delivery and Access Act (HDAA) represents the next iteration in expanding Medicaid payment reform in New Mexico, creating a state directed payment financed by tax assessments on participating HDAA hospitals. New Mexico Turquoise Care Managed Care Organizations (TC MCOs) and the New Mexico Health Care Authority (HCA) distribute the payments back to hospitals through the HDAA Medicaid-Directed Payment program. Payments are distributed in two ways: as an access payment through a uniform rate increase and as a value-based payment (VBP) that is based on quality performance outcomes.

With this VBP program, HCA aims to achieve expansion in hospital services, increased access to care, and improved quality with better health outcomes, incentivizing New Mexico Acute Care Hospitals, Long-Term Care Hospitals, Inpatient Rehabilitation Facilities, and Inpatient Psychiatric Facilities to improve the health of members and quality of services.

The remainder of this document details only the HDAA VBP program.

Stakeholders

1. New Mexico Health Care Authority (HCA)
2. New Mexico Hospital Association (NMHA)
3. Turquoise Care Managed Care Organizations (TC MCOs): Blue Cross Blue Shield of New Mexico, Molina Healthcare of New Mexico, Presbyterian Health Plan, and United Healthcare Community Plan of New Mexico
4. New Mexico Acute Care Hospitals, Long-Term Care Hospitals (LTCH), Inpatient Rehabilitation Facilities (IRFs), and Inpatient Psychiatric Facilities (IPFs)
5. Medicaid Beneficiaries

Foundational Framework

GOALS

The goals for the HDAA VBP program are:

- Incentivize participating providers to improve or maintain high-quality outcomes for Medicaid beneficiaries.
- Increase access to services for Medicaid beneficiaries.
- Provide better value for Medicaid funds spent on care.

GUIDING PRINCIPLES

- Align with state quality strategy, goals, and objectives.
- Minimize the administrative burden on healthcare providers.
- Leverage and build on existing processes and tools.
- Develop a program that will be transparent and simple to understand to influence behavior and outcomes.
- Provide actionable insights to help drive performance outcomes with no surprises.
- Account for variation across healthcare providers.
- Distribute payments based on performance relative to targets.
- Implement regular program reviews to evaluate effectiveness and make any changes needed.

Program Components

The HDAA quality-incentive payment program has five components:

- **Funding mechanism:** How incentive payments in the program are funded.
- **Quality measurement:** Specific metrics used to evaluate the performance of healthcare providers in the program.
- **Assessing performance:** Methodology used to evaluate provider performance on quality metrics, which may include comparisons to baselines and performance targets.
- **Linking performance to payment:** Methodology used to relate provider outcomes to an incentive payment, intended to align financial incentives with the quality strategy.
- **Ongoing evaluation and changes:** Systematic approaches to measure impact, maintain regulatory compliance, and ensure the effectiveness, sustainability, and relevance of the program.

Minimum Requirements for Provider Participation

To participate in the New Mexico HDAA VBP program, a hospital or specialty hospital must meet the following minimum requirements:

- Medicaid certified hospital or specialty hospital as follows:
    - Non-federal hospital licensed as a hospital by the New Mexico HCA, excluding a state university teaching hospital or a state-owned special hospital.
    - Long-term care hospital (LTCH) that provides long-term inpatient medical care for medically complex patients whose length of stay averages greater than 25 days.

    - Inpatient psychiatric facility (IPF) that primarily provides, by or under the supervision of a physician, psychological or psychiatric services for the diagnosis and treatment of mentally ill persons.
    - Inpatient rehabilitation facility (IRF) that primarily provides rehabilitative care to inpatients.
- Required contracts/agreements executed with MCOs
- Submit required data
- Have Medicaid utilization during the measurement period to receive payment

Funding Mechanism

The "HealthCare Delivery and Access Assessment" is imposed on eligible hospitals based on assessed inpatient net revenues excluding Medicare, and outpatient net revenue, excluding Medicare. Upon Centers for Medicare & Medicaid Services (CMS) approval, the non-federal share (HDAA assessments) is matched with federal funds; this establishes the HDAA fund. Forty percent (40%) of this fund is distributed to participating providers as an annual quality incentive payment through the VBP program.

HCA will send quality incentive VBP payment funding to the MCOs by May 15 of the subsequent calendar year. MCOs must make quality incentive payments to hospitals no more than 15 days after receiving payment from HCA.

Data Intermediary

Net Health serves as the Data Intermediary for the program, providing comprehensive analytics services, reporting, and software solutions to HCA, participating providers, and the MCOs. As a fiduciary data steward acting on behalf of data owners and adjudicating a fair and balanced payment mechanism, Net Health serves as an unbiased mediator in the appropriate use of data to ensure accurate payments and performance rewards.

Net Health engages Guidehouse as a subcontractor for advisory support and related services. Guidehouse is experienced in working with state health and human services agencies to develop, monitor, and improve Medicaid managed care programs, including the development of MCO and provider value-based payment models and directed payment programs.

Workgroup

A stakeholder workgroup shall be composed of representatives from the stakeholder group and the Data Intermediary. The stakeholder workgroup meets on a regular basis to collaborate for ongoing feedback and continuous improvement of the program.

Quality Measurement

Including a balance of quality measure (QM) types, targeting prioritized areas of focus for quality improvement, is crucial in value-based payment programs to ensure a comprehensive, fair, and accurate assessment of healthcare performance. This approach promotes holistic improvements in care, addresses diverse beneficiary needs, helps drive meaningful and sustained quality improvement, and supports acceptance among stakeholders.

The HDAA program's quality payment is based on quality measures selected and agreed upon by HCA and the workgroup.

For details regarding the technical specifications of each quality measure, please refer to the "Technical Specifications" document on the HDAA dashboard.

FOR URBAN AND RURAL ACUTE CARE HOSPITALS

Quality measurement is based on eight (8) quality measures, each worth a certain number of points. Each hospital's QM values are compared to established cut points. Missing/non-calculable values are imputed. Points are assigned for each QM based on a cut point range, then points are summed. The total number of points determines a performance tier, which determines the percentage of maximum hospital-specific payment.

Urban and Rural Quality Measures and Cut Points*

Name	Source	Cut Point Ranges			
Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) [NQF #1789]	CMS; calculated from Medicaid MMIS data	≤ 14.13%	14.14% - 14.27%	14.28% - 14.41%	> 14.41%
	Points	100	75	50	25
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; calculated from Medicaid MMIS data	≤ 0.90	0.91 - 0.92	0.93 - 0.96	> 0.96
	Points	100	75	50	25

Name	Source	Cut Point Ranges			
Screening, Brief Intervention, and Referral to Treatment (SBIRT) Rate [SAMHSA]	Attestation by hospitals; state-specific for New Mexico	Meets requirements		Does not meet requirements	
	Points	100		0	
Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) [NQF #0500]	CMS-reported; All-Payer	≤ 46.00%	47.00% - 62.00%	63.00% - 65.00%	> 65.00%
	Points	25	50	75	100
Early Elective Delivery [Percentage of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery wasn't medically necessary] ***** Measure retired as of 12/31/2024***	CMS-reported; All-Payer	≤ 2%	3% - 5%	6% - 8%	> 8%
	Points	100	75	50	25
Maternal Morbidity Structural Measure: Hospital has obtained "Birthing-Friendly" hospital quality designation ***** Measure replaced Early Elective Delivery as of 1/1/2025***	CMS-reported; All-Payer	Meets requirements		Does not meet requirements	
	Points	100		0	
HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Hospital Inpatient Survey: Communication with Doctors [NQF #0166]	CMS-reported; All-Payer	≤74%	75% - 76%	77% - 82%	> 82%
	Points	25	50	75	100

Name	Source	Cut Point Ranges			
HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Hospital Inpatient Survey: Communication with Nurses [NQF #0166]	CMS-reported; All-Payer	≤ 75%	76% - 79%	80% - 81%	> 81%
	Points	25	50	75	100
Care Coordination for Mental Health Emergency Department Visit Follow-Up	Attestation by hospitals; state-specific for New Mexico	Meets requirements		Does not meet requirements	
	Points	100		0	

**Hospitals that do not offer Labor and Delivery services will undergo evaluation based on seven out of the eight QMs, excluding the Maternal Morbidity Structural Measure. The points earned for their performance on these seven measures will be adjusted to 28.57, 57.15, 85.71, and 114.29 (compared to the standard 25, 50, 75, 100), allowing these hospitals to achieve the maximum possible points.*

Urban and Rural Performance Tier Points

Tier 1	644 to 800 points (maximum possible)
Tier 2	488 to 643 points
Tier 3	332 to 487 points
Tier 4	176 to 331 points
Tier 5	175 or 171.42* points (minimum possible)

** For hospitals that do not offer Labor and Delivery services*

FOR FRONTIER ACUTE CARE HOSPITALS

Quality measurement is based on two (2) structural measures. Each quarter, hospitals are required to attest to whether they have met structural measure requirements.

Frontier Quality Measures and Cut Points

Name	Source	Attestation	
Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training – structural measure with attestation	State-specific New Mexico	Meets requirements	Does not meet requirements
Care Coordination for Mental Health Emergency Department Visit Follow-Up – structural measure with attestation	State-specific New Mexico	Meets requirements	Does not meet requirements

Frontier Performance Payment Tiers

Requirements met	Percentage of hospital-specific maximum payment
Meets requirements for **both** measures	100%
Meets requirements for **one** measure	50%
Does not meet requirements for either measure	0%

FOR INPATIENT REHABILITATION FACILITIES (IRF)

Quality measurement is based on five (5) quality measures, each worth a certain number of points. Each facility's QM values are compared to established cut points. Missing/non-calculable values are imputed. Points are assigned for each QM based on the cut point range; then points are summed. The total number of points determines a performance tier, which determines the percentage of maximum facility-specific payment.

IRF Quality Measures and Cut Points

Name	Source	Cut Point Ranges		
IRF QRP Measure #1: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) [CMIT Measure ID #00520 (CBE-endorsed)]	CMS-reported; All-Payer	< 0.2%	0.2%-0.4%	> 0.4%
	Points	100	66.66	33.33

Name	Source	Cut Point Ranges		
IRF QRP Measure #10: National Healthcare Safety Network (NHSN) Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure [CMIT Measure ID #00459 (CBE-endorsed)]	CMS-reported; All-Payer	< 0.400	0.400-1.000	> 1.000
	Points	100	66.66	33.33
IRF QRP Measure #17: Potentially Preventable Within Stay Readmission Measure [CMIT Measure ID #00576 (not endorsed)]	CMS; calculated from Medicaid MMIS data	< 5.00%	5.00%-6.00%	> 6.00%
	Points	100	66.66	33.33
IRF QRP Measure #15: Discharge to Community–Post Acute Care (PAC) IRF QRP [CMIT Measure ID #00210 (CBE-endorsed)]	CMS; calculated from Medicaid MMIS data	< 67.0%	67.0%-70.0%	> 70.0%
	Points	33.33	66.66	100
Care Coordination for Post-Discharge Mental Health Follow-Up	Attestation by facilities; state-specific for New Mexico	Meets Requirements	Does Not Meet Requirements	
	Points	100	0	

IRF Tier Points

Tier 1	≥ 450 points
Tier 2	≥ 300 - < 450 points
Tier 3	≥ 175 - < 300 points
Tier 4	< 175 points

FOR INPATIENT PSYCHIATRIC FACILITIES (IPF)

Quality measurement is based on four (4) quality measures, each worth a certain number of points. Each facility's QM values are compared to established cut points. Missing/non-calculable values are imputed. Points are assigned for each QM based on cut point range, then points are summed. The total number of points determines a performance tier, which determines the percentage of maximum facility-specific payment.

IPF Quality Measures and Cut Points

Name	Source	Cut Point Ranges		
SUB-2: Alcohol Use Brief Intervention Provided or Offered	CMS-reported; All-Payer	< 70.0%	70.0% - 90.0%	> 90.0%
	Points	33.33	66.66	100
TOB-3: Tobacco Use Treatment Provided or Offered at Discharge	CMS-reported; All-Payer	< 40%	40% - 60%	> 60%
	Points	33.33	66.66	100
SMD: Screening for Metabolic Disorders	CMS-reported; All-Payer	< 40%	40% - 70%	> 70%
	Points	33.33	66.66	100
Care Coordination for Post-Discharge Mental Health Follow-Up	Attestation by facilities; state-specific for New Mexico	Meets Requirements	Does Not Meet Requirements	
	Points	100	0	

IPF Tier Points

Tier 1	≥ 350 points
Tier 2	≥ 250 - < 350 points
Tier 3	≥ 150 - < 250 points
Tier 4	< 150 points

FOR LONG-TERM CARE HOSPITALS (LTCH)

Quality measurement is based on four (4) quality measures, each worth a certain number of points. Each hospital's QM values are compared to established cut points. Missing/non-calculable values are imputed. Points are assigned for each QM based on cut point range, then points are summed. The total number of points determines a performance tier, which determines the percentage of maximum hospital-specific payment.

LTCH Quality Measures and Cut Points

Name	Source	Cut Point Ranges		
LTCH QRP Measure #1: Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) [CMIT Measure ID #00520 (CBE-endorsed)]	CMS-reported; All-Payer	< 0.2%	0.2%-0.4%	> 0.4%
	Points	100	66.66	33.33
LTCH QRP Measure #4: Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury [CMIT Measure ID #000121 (not endorsed)]	CMS-reported; All-Payer	< 2.0%	2.0%-5.0%	> 5.0%
	Points	100	66.66	33.33
LTCH QRP Measure #12: National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure [CMIT Measure ID #00460 (CBE-endorsed)]	CMS-reported; All-Payer	< 0.200	0.200%-1.000%	> 1.000%
	Points	100	66.66	33.33
Care Coordination for Post-Discharge Mental Health Follow-Up	Attestation by hospitals; state-specific for New Mexico	Meets Requirements	Does Not Meet Requirements	
	Points	100	0	

LTCH Tier Points

Tier 1	≥ 350 points
Tier 2	≥ 250 - < 350 points
Tier 3	≥ 150 - < 250 points
Tier 4	< 150 points

Quality Payment Mechanics

The goal of the quality payment mechanism is to provide participating HDAA hospitals with the ability to implement the necessary changes to improve their scores, reward them for incremental improvement and quality achievement, and promote behaviors beneficial for Medicaid beneficiaries, providers, and the MCOs.

Payment will be made based on the schedule below, assuming CMS grants annual approval of the HDAA program within expected timeframes. Updates to the schedule below will be posted to the HDAA dashboard.

Reporting Year	Reporting Quarter	Measurement Period **	Finalize Data and Calculations	Facility Review Period	MCO Review Period	Payment Date
2024 3rd QTR	7/1/2024 – 9/30/2024	1/1/2023 – 12/31/2023	10/1/2024 – 10/31/2024	12/1/2024 – 12/21/2024	*12/22/2024 – 1/7/2025	5/30/2025
4th QTR	10/1/2024 – 12/31/2024	4/1/2023 – 3/31/2024	*1/2/2025 – 1/31/2025	3/1/2025 – 3/21/2025	3/22/2025 – 4/7/2025	
2025 1st QTR	1/1/2025 – 3/31/2025	7/1/2023 – 6/30/2024	4/1/2025 – 4/30/2025	6/1/2025 – 6/21/2025	*6/22/2025 – 7/7/2025	5/29/2026
2nd QTR	4/1/2025 – 6/30/2025	10/1/2023 – 9/30/2024	*7/1/2025 – 7/31/2025	*9/1/2025 – 9/21/2025	9/22/2025 – 10/7/2025	
3rd QTR	7/1/2025 – 9/30/2025	1/1/2024 – 12/31/2024	10/1/2025 – 10/31/2025	12/1/2025 – 12/21/2025	*12/22/2025 – 1/7/2026	
4th QTR	10/1/2025 – 12/31/2025	4/1/2024 - 3/31/2025	1/2/2026 – 1/31/2026	3/1/2026 – 3/21/2026	3/22/2026 – 4/7/2026	
2026 1st QTR	1/1/2026 – 3/31/2026	7/1/2024 – 6/30/2025	4/1/2026 – 4/30/2026	6/1/2026 – 6/21/2026	*6/22/2026 – 7/7/2026	5/28/2027
2nd QTR	4/1/2026 – 6/30/2026	10/1/2024 – 9/30/2025	*7/1/2026 – 7/31/2026	*9/1/2026 – 9/21/2026	9/22/2026 – 10/7/2026	
3rd QTR	7/1/2026 – 9/30/2026	1/1/2025 – 12/31/2025	10/1/2026 – 10/31/2026	12/1/2026 – 12/21/2026	*12/22/2026 – 1/7/2027	

Reporting Year	Reporting Quarter	Measurement Period **	Finalize Data and Calculations	Facility Review Period	MCO Review Period	Payment Date
4th QTR	10/1/2026 – 12/31/2026	4/1/2025 - 3/31/2026	1/2/2027 – 1/31/2027	3/1/2027 – 3/21/2027	3/22/2027 – 4/7/2027	

**** Holiday within timeframe which may alter review period***
***** CMS Care Compare Measurement Period may vary based on the quality measure and facility type. The Data Intermediary will always use the most recent published data by CMS every quarter.***

FOR SPECIALTY HOSPITALS AND ACUTE CARE HOSPITALS DESIGNATED BY HCA AS URBAN AND RURAL

1. Determine the Utilization Multiplier.

Total Funds[1] / Total Utilization[2] = Utilization Multiplier (per claim rate)[3]

[1] Total funds allocated to hospital designation for quality portion of HDAA program
[2] Total utilization = claims (outpatient [OC] + inpatient [IC]) by hospital designation
[3] Utilization multiplier (per claim rate): total funds allocated to the quality portion of the HDAA program divided by sum of measure of utilization by hospital designation

2. Determine the Hospital Quality Performance Payment.

Utilization Multiplier x Tier Percentage x Hospital Utilization = Initial Hospital Quality Performance Payment

- For Acute Care Hospitals designated as Urban and Rural

Year	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
Q3 & Q4 CY 24	100%	100%	100%	100%	100%
2nd year CY 25	100%	100%	100%	100%	100%
3rd year CY 26	100%	85%	75%	50%	0%
4th year CY 27	100%	85%	75%	50%	0%
5th year CY 28	100%	85%	75%	50%	0%

- For Specialty Hospitals (Inpatient Rehabilitation Facilities, Inpatient Psychiatric Facilities, Long-Term Care Hospitals)

Year	Tier 1	Tier 2	Tier 3	Tier 4
Q3 & Q4 CY 24	100%	100%	100%	100%
2nd year CY 25	100%	100%	100%	100%
3rd year CY 26	100%	100%	100%	100%
4th year CY 27	100%	75%	25%	0%
5th year CY 28	100%	75%	25%	0%

3. **Determine Residual Funds Available for each Hospital Designation.**

Total Funds Available - Total Initial Quality Performance Amount for All Hospitals = Residual Funds Available

4. **Determine Residual Percentage:** Residual funds are reallocated based on quality performance. The residual percentage for each quarter is established by dividing the residual funds available for the hospital designation by the total funds available for the designation for the quarter. Residual funds are allocated within each HDAA hospital designation (Acute Care-Urban/Rural, Acute Care-Frontier, LTCH, IRF, and IPF).

Residual Funds Available / Total Funds Available = Residual Percentage

5. **Determine Residual Amount:** A residual amount for each quarter will then be established by multiplying the residual percentage by the hospital's total funds available.

Residual Percentage x Total Funds Available = Residual Amount

6. **Determine Total Quality Payment.**

Initial Hospital Quality Performance Payment + Residual Amount = Total Quality Payment

7. **Determine Hospital Total Quality Payment for Each MCO:** The Hospital Total Quality Payment is attributed to each MCO as follows:

Hospital Total Quality Payment x MCO Payment Percentage from HCA = Hospital Total Quality Payment for Each MCO

8. **Calculate Hospital Annual Quality Payment:** The Hospital Annual Quality Payment is determined by summing the quarterly amounts.

FOR HOSPITALS DESIGNATED BY HCA AS FRONTIER

1. **Determine the Utilization Multiplier.**

Total Funds[1] / Total Utilization[2] = Utilization Multiplier (per claim rate)[3]

[1] Total funds allocated to hospital designation for quality portion of HDAA program
[2] Total utilization = claims (outpatient [OC] + inpatient [IC]) by hospital designation
[3] Utilization multiplier (per claim rate): total funds allocated to the quality portion of the HDAA program divided by sum of measure of utilization by hospital designation

2. **Determine the Hospital Quality Performance Payment.**

Utilization Multiplier x Percentage of Hospital-Specific Maximum Payment x Hospital Utilization = Hospital Quality Performance Payment

The hospital receives a percentage of their hospital-specific maximum payment as follows:

Requirements Met	Percentage of Hospital-Specific Maximum Payment
Meets requirements for **both** measures	100%
Meets requirements for **one** measure	50%
Does not meet requirements for either measure	0%

3. **Determine Residual Funds Available for Hospital Designation.**

Total Funds Available - Total Initial Quality Performance Amount for All Hospitals = Residual Funds Available

4. **Determine Residual Percentage:** Residual funds are reallocated based on quality performance. The residual percentage for each quarter is established by dividing the residual funds available for the hospital designation by the total funds available for the designation for the quarter. Residual funds are allocated within each HDAA hospital designation (Acute Care-Urban/Rural, Acute Care-Frontier, LTCH, IRF, and IPF).

Residual Funds Available / Total Funds Available = Residual Percentage

5. **Determine Residual Amount:** A residual amount for each quarter will then be established by multiplying the residual percentage by the hospital's total funds available.

Residual Percentage x Total Funds Available = Residual Amount

6. **Determine Total Quality Payment.**

Initial Hospital Quality Performance Payment + Residual Amount = Total Quality Payment

7. **Determine Hospital Total Quality Payment for Each MCO:** The Hospital Total Quality Payment is attributed to each MCO as follows:

Hospital Total Quality Payment x MCO Payment Percentage from HCA = Hospital Total Quality Payment for Each MCO

8. **Calculate Hospital Annual Quality Payment:** The Hospital Annual Quality Payment is determined by summing the quarterly amounts.

CALCULATION REVIEW

The Data Intermediary developed the New Mexico HDAA Dashboard ("HDAA Dashboard"). The dashboard communicates all quality program data reported by the hospital in connection with the quality measures and, for the final version of the HDAA Dashboard, the annual amounts earned by the hospital based on quarterly performance.

Quality payments based on each hospital's performance are dependent on the timely finalization of quality payments based on the other hospitals' respective performance. To achieve this, hospitals are expected to:

- Promptly and appropriately submit claims data to MCOs;
- Complete attestation activities in the HDAA Dashboard;
- Ensure data submission to CMS as applicable; and
- Review and challenge resultant calculations.

For the specified review period following the conclusion of each quarter, hospitals will have the opportunity to review and communicate any final questions, concerns, or challenges about the HDAA Dashboard calculations applicable to their respective hospital to the Data Intermediary. Challenges shall be limited to claims-based quality measure numerators and denominators, and CMS reported quality measure values.[1]

Hospitals shall ensure that, during and throughout the course of each quarter, they will promptly review and communicate any questions, concerns, or challenges to the Data Intermediary regarding interim, in-progress, or equivalent HDAA Dashboard calculations furnished or made accessible by the Data Intermediary to the hospitals during each quarter.

A hospital's failure to adhere to the processes outlined in this section will reduce or potentially eliminate their opportunities to review and challenge the HDAA Dashboard calculations reported by the Data Intermediary. At the conclusion of the specified review period, hospitals will have no further rights to submit new data nor to review or challenge

[1] Please note: The Data Intermediary reports rates for CMS Hospital Compare measures as reported on the CMS Hospital Compare website: https://www.medicare.gov/care-compare/?providerType=Hospital

the accuracy of their hospital's previously submitted data or the HDAA Dashboard calculations and results, whether with the Data Intermediary, MCOs, or HCA.

After the review period, the Data Intermediary will make available the HDAA Dashboard results to the MCOs for their review. The HDAA Dashboard and related quality payment amounts produced by the Data Intermediary following the MCOs' review shall be final and binding, with no further reconciliation for the applicable quarter.

MCOs will issue payment to the hospitals based on the payment schedule above.

Timeline

Period	Milestones
CY 2024 Q1	• Senate Bill 17 passed New Mexico Senate and House of Representatives in February and signed by the Governor on March 1 • Project kickoff meeting completed with workgroup • Initial discussions regarding quality measures
CY 2024 Q2	• Statement of Work signed with HCA and Data Intermediary • Initial discussion of payment methodology and funds allocation
CY 2024 Q3	• Quality measures finalized in August • MCOs contracted with Data Intermediary in August • Overview of HDAA at all-hospital meeting in August
CY 2024 Q3 (continued)	• HDAA monthly stakeholder meetings for hospitals began in September • HDAA tax waiver model and pre-print submitted to CMS for review and approval
CY 2024 Q4	• Targets/cut points finalized in October for performance measurements starting July 2024 • MMIS data transfer, validation, and measure calculation • Finalized payment methodology and funds allocation • HDAA pre-print for CY2024 and tax waiver model approved by CMS • HDAA pre-print for CY2025 submitted to CMS
CY 2025 Q1	• MCOs completing contract amendments for hospitals • Data Intermediary receives CY 2024 facility and MCO quality payment information from HCA Medicaid Actuary
CY 2025 Q2	• Quality payment for CY2024 made to hospitals based on IP/OP Medicaid Utilization, Quality Measures, and the successful

Period	Milestones
	submission of 7/1/24 – 12/31/24 data. Anticipated payment date 5/30/2025
CY 2026 Q2	• Quality payment for CY2025 made to hospitals based on IP/OP Medicaid Utilization, Quality Measures, and the successful submission of 1/1/25 – 12/31/25 data. Anticipated payment date 5/29/2026.
CY 2027 Q2	• Quality payment for CY2025 made to hospitals based on IP/OP Medicaid Utilization, Quality Measures, and the successful submission of 1/1/26 – 12/31/26 data. Anticipated payment date 5/28/2027.

Program Definitions

- **ACUTE CARE HOSPITAL:** A New Mexico facility providing emergency services, inpatient medical, and nursing care for acute illness, injury, surgery, or obstetrics, including facilities licensed by HCA as general hospitals, critical access hospitals, and rural emergency hospitals.
- **DATA INTERMEDIARY:** This refers to Net Health, the company selected by HCA and engaged by the MCOs to calculate the amount of the quality payment to each of the eligible hospitals.
- **FRONTIER HOSPITALS:** Acute care hospitals located in the following counties: Catron, Cibola, Colfax, De Baca, Guadalupe, Harding, Hidalgo, Lincoln, Mora, Quay, San Miguel, Sierra, Socorro, Torrance, and Union.
- **HEALTH CARE DELIVERY AND ACCESS ACT (HDAA):** Senate Bill 17, approved by the New Mexico legislature in January 2024, imposing an assessment on certain hospitals, creating the Health Care Delivery and Access fund, creating the Health Care Delivery and Access Act Medicaid-Directed Payment program, and providing that revenue from that fund be used as additional reimbursement to certain hospitals.
- **HOSPITAL:** A hospital or specialty hospital participating in the program.
- **INPATIENT PSYCHIATRIC FACILITY (IPF):** A facility that primarily provides, by or under the supervision of a physician, psychological or psychiatric services for the diagnosis and treatment of mentally ill persons.
- **INPATIENT REHABILITATION FACILITY (IRF):** A facility that primarily provides rehabilitative care to inpatients.

- **LONG-TERM CARE HOSPITAL (LTCH):** A facility that provides long-term inpatient medical care for medically complex patients whose length of stay averages greater than 25 days.
- **MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS):** An integrated group of procedures and computer processing that is used for verifying provider enrollment and client eligibility, managing healthcare provider claims and MCO encounters, benefit package maintenance, and addressing a variety of Medicaid business needs.
- **PARTICIPATING PROVIDER:** A hospital or specialty hospital determined to be eligible to participate in the program and who has met requirements to participate.
- **PERFORMANCE TIER:** The level of quality performance based on the summation of quality measure points and utilized to determine quality payment.
- **PROGRAM:** The HDAA value-based payment program that is based on quality performance.
- **QUALITY MEASURE:** Metrics selected to analyze facility improvement in quality.
- **QUALITY PAYMENT:** Quarterly payments made to participating providers based on quality measure performance.
- **QUARTER:** A calendar year quarter; January 1 through March 31 is the first Quarter (Q1) of a calendar year; April 1 through June 30 is the second Quarter (Q2); July 1 through September 30 is the third Quarter (Q3); and October 1 through December 31 is the fourth Quarter (Q4).
- **RESIDUAL FUNDS:** Funds remaining at the end of a quarter that were not allocated based on the tier percentage methodology.
- **RURAL HOSPITAL:** Acute care hospital located in a county with a population of 125,000 or less, according to the most recent federal census.
- **SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT):** An evidence-based, public health approach used to identify, reduce, and prevent problematic substance use and substance use disorders (SUDs). SBIRT can help identify substance use issues before they become severe. It can be integrated into the primary care, emergency department, and community health settings, and it reduces healthcare costs by preventing more severe substance-related conditions.
- **SMALL URBAN HOSPITAL:** Acute care hospital located in a county with a population greater than 125,000 and that has fewer than 15 licensed inpatient beds as of January 1, 2024.
- **SPECIALTY HOSPITAL:** Inpatient Rehabilitation Facilities (IRF), Inpatient Psychiatric Facilities (IPF), and Long-Term Care Hospitals (LTCH).
- **TIER PERCENTAGE:** Allocation percentage of the Utilization Multiplier (per claim rate) based on a hospital's Performance Tier.

- **URBAN HOSPITAL:** Acute care hospital located in a county with a population of more than 125,000, according to the most recent federal census.
- **YEAR:** The HDAA program will be evaluated based on calendar year January 1 through December 31.
- **WORKGROUP:** The program workgroup shall be composed of representatives from HCA, representatives from the Data Intermediary, representatives from each MCO, representatives from the New Mexico Hospital Association, and representatives from participating hospitals.

Version history

Version	Date	Description	Author	Approved By
1.0	Jan. 16, 2025	Initial version	Laura Ignarski	Rayna Fagus
1.1	April 2, 2025	Added SBIRT to “Program Definitions” section; added instruction regarding technical specifications to “Quality Measurement” section; added “Version History;” updated Executive Summary and Funding Mechanism sections	Laura Ignarski	Rayna Fagus