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

July 17, 2026

Alanna Dancis, Interim Medicaid Director
New Mexico Health Care Authority
PO Box 2348
Santa Fe, NM 87504-2348

Dear Alanna Dancis:

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 a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on December 4, 2025, and a final revised preprint was received on June 29, 2026. The proposal has a control name of NM_VBP.Fee_NF2_Renewal_20260101-20261231**.**

CMS has completed our review of the following Medicaid managed care SDP(s):

- Value-based purchasing and uniform increase arrangement established by the state to increase nursing facility per diem rates by the market basket index (MBI) factor and to provide quality incentive payments for nursing facilities that meet performance requirements on specified quality metrics for the rating period covering January 1, 2026 through December 31, 2026, incorporated into the capitation rates through a separate payment term and risk-based rate adjustment up to $82.87 million.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, 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 will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

CMS approval of this SDP preprint is conditioned on the state's continued compliance with Medicaid program integrity requirements, including 42 CFR 438 and 42 CFR 455. The state must ensure that the state and its managed care plans appropriately support program integrity activities, including the prevention, detection, investigation, referral, and resolution of fraud, waste, and abuse through appropriate staffing, oversight, controls, data, analytics, reporting, audits, and other actions. The state is responsible for monitoring all aspects of the managed care program, including the performance of every managed care plan related to program integrity as required in 42 CFR 438.66(b)(9). Any material changes to managed care plans' program integrity responsibilities must be clearly effectuated through the state's managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

CMS is approving this SDP based on the state's analysis and attestation that the total payment rates under this SDP do not exceed 100 percent of the total published Medicare payment rate as required for expansion states or 110 percent of the total published Medicare payment rate as required for non-expansion states in accordance with section 71116 of the Working Families Tax Cut (WFTC) legislation, which is effective for rating periods beginning on or after July 4, 2025. In the absence of a total published Medicare payment rate, the payment limit is the payment rate under the Medicaid state plan (or under an approved waiver of such plan). CMS's assessment that this SDP results in total payment rates that do not exceed the applicable payment rate limit under section 71116 of the WFTC legislation is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements and CMS's initial assessment of compliance with the applicable payment limit under section 71116 of the WFTC legislation may be modified subject to regulatory changes.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

JOHN F. GILES JR -S

Digitally signed by JOHN F. GILES JR -S
Date: 2026.07.17 12:02:30 -04'00'

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 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 (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) 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 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   January 1, 2026 - December 31, 2026
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* July 1, 2026
3. Identify the managed care program(s) to which this payment arrangement will apply:
   Turquoise Care 1115 Medicaid managed care program (PH and LTSS services)
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $ 82.87 million
   a. Identify the estimated federal share of this state directed payment: $ 60.49million
   b. Identify the estimated non-federal share of this state directed payment: $22.38 million

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
CY20, CY21, CY22, CY23, CY24, CY25, CY26 Jan-June (pending approval)

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☒ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(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 should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

The State of New Mexico plans to use §438.6(c)(1)(iii)(B) to implement the Healthcare Quality Surcharge (HCQS) Act to provide a uniform dollar increase to Nursing facility per diem rates for the market basket index (MBI) factor and per diem add-on for each respective class of Nursing Facility as defined by the statute and to provide quality incentive payments to Nursing Facilities that meet performance requirements on specified quality metrics. The uniform dollar increase to Nursing Facilities for bed days for Medicaid beneficiaries for this payment arrangement will apply from July 1, 2026 through December 31, 2026 and is based on the annual per Medicaid bed day unit rate based on quarterly nursing facility assessment revenue in accordance with 42 CFR 433.68 and approved by CMS. This directed payment, applicable from July 1, 2026 through December 31, 2026, is made only to MCO contracted providers and only on behalf of Medicaid beneficiaries covered under the Medicaid managed care contract for the applicable rating period only. Payments will not be made on behalf of individuals who are uninsured, covered for such services by another insurer, nor Medicaid services provided through the state fee-for-service program.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

See Attachment 3.1-A, Page 2 of New Mexico's State plan, available at: https://www.hsd.state.nm.us/medical-assistance-division-state-plan/

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☒ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 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.

If checked, please answer all questions in Subsection IIA.

b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), 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. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

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

11. 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. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

HCQS VBP includes nine long term stay quality components that are provided in response to Table 1. The quality metrics will be equally weighted for payment each quarter. The nursing facilities' improvement in quality will be evaluated by comparing each nursing facility's outcome to established performance cut points. Points are assigned for each measure based on established point ranges, then the points are summed. Based on the total number of points a facility earns, a quality payment will be paid to the facility, where better performance results in higher payments. The quality payment will not affect a facility's per diem rate. The HCQS VBP is required of all Nursing Facilities per statute. The HCQS VBP program also incentivizes High-Acuity.

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable. If the state needs more space, please use Addendum Table 1.A and check this box: ☐

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a. See preprint addendum (Excel) Table 1.A						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

The process of setting performance targets for specific measures is critical. Our methodology to establish performance targets focuses on data-driven analytics and clinical expertise.
*Data-Driven Approach: Our methodology begins with a rigorous analysis of historical data. We utilize all available data to assess past performance. This data-driven approach provides a baseline understanding of how the facilities and the state have performed in the past, offering valuable insights into areas that require improvement.
*Benchmarking: We go beyond internal data analysis by benchmarking against national performance and best practices. This external comparison helps us identify areas where we can set ambitious yet achievable performance targets. Benchmarks also serve as reference points for assessing the competitiveness of our goals.
*Clinical Expertise: Clinical expertise is a fundamental component of our methodology. Our team of healthcare professionals, including physicians, nurses, and specialists, plays a crucial role in target setting. They contribute valuable insights regarding clinical relevance, patient outcomes, and the feasibility of targets within the context of patient care.
*Continuous Improvement: Our methodology is not static. We embrace a culture of continuous improvement, regularly reassessing and refining performance targets based on ongoing data analysis, clinical feedback, and evolving industry standards. This adaptive approach ensures that our targets remain relevant and attainable as healthcare practices evolve.
*Stakeholder Engagement: Engaging all program stakeholders is integral to our methodology. We gather input from these groups on a quarterly basis to ensure that performance targets align with their priorities and expectations, fostering a sense of ownership and collaboration.
*Transparency and Accountability: Transparency is a core principle in our methodology. We communicate performance targets clearly to all stakeholders, fostering a sense of shared responsibility. Additionally, we establish mechanisms for accountability, tracking progress and addressing deviations from targets through a data-driven, clinically-informed approach.
For structural measures, quarterly performance requirements for each measure are developed through a collaborative process with stakeholders (HCA, participating providers, and MCOs).
Our methodology for setting performance targets combines robust data analysis, clinical expertise, and a commitment to continuous improvement. It is a holistic approach that acknowledges the dynamic nature of healthcare and strives for excellence in patient care while ensuring fairness and accountability. By following this methodology, we are confident in our ability to drive positive outcomes and provide the highest quality of care to Medicaid beneficiaries.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

Multiple provider performance measures are involved, and payment will be based on performance targets. For a provider to receive payment, they will not be required to meet performance targets on all measures. We believe it is not always realistic or practical to expect providers to meet the performance target on each measure to receive full payment. A more flexible and reasonable approach is to adopt a tiered payment structure where providers can receive partial payment based on their performance on individual measures.
Payment to participating providers in the program is based on a tiered payment structure as follows:
1. Each measure is worth a certain number of points.
2. Each facility's measure values are compared to established cut point performance benchmarks for each measure.
3. Points are assigned for each measure based on where the facility's values fall within the cut point ranges.
4. Points from all measures are summed. The total number of points determines the facility's performance tier.
5. The performance tier achieved determines the percentage of maximum facility-specific payment the facility receives.
6. Residual funds are distributed through a High-Acuity Add-On adjustment, based on the facility's High-Acuity Medicaid Bed Days (i.e. residents with certain behavioral and complex neurological diagnoses), intended to incentivize increased access to care for residents with high-acuity care needs.
We believe that a tiered payment approach has the following advantages:
* Promotes Continuous Improvement: Implementing a tiered payment approach recognizes that healthcare providers may excel in certain areas while facing challenges in others. By rewarding partial payment for meeting performance targets on specific measures, providers are encouraged to focus on areas where they can achieve meaningful improvements and work towards enhancing overall performance gradually.
* Ensures Fairness: Healthcare is a complex field with diverse patient populations and unique challenges. A one-size-fits-all approach may not account for these variations, leading to potential disparities in payment distribution. A tiered approach acknowledges the nuances in care delivery and ensures fair compensation based on individual measure achievements.
* Mitigates Burden: Expecting providers to meet performance targets on all measures can be burdensome, especially when some measures may be outside their direct control or have limited resources allocated. A tiered payment system eases this burden by recognizing achievements on specific measures, motivating providers to continue striving for excellence without feeling overwhelmed.
* Encourages Participation: A tiered payment approach can encourage broader participation in performance-based payment arrangements. Providers who may not initially meet all performance targets may still be willing to participate, knowing that they can earn partial payment for their efforts.
* Focus on High-Impact Measures: A tiered payment system allows for prioritization of high-impact measures that significantly influence patient outcomes and healthcare quality. Providers can channel their resources and efforts into areas where improvements will have the most substantial positive impact on patient care.
In conclusion, adopting a tiered payment approach provides a flexible and pragmatic method of incentivizing providers to enhance their performance in a multi-measure payment arrangement. It acknowledges the challenges and variations within the healthcare system, while fostering a culture of continuous improvement and fairness. Ultimately, this approach can lead to improved patient outcomes and better overall healthcare delivery.

c. For state-developed measures, please briefly describe how the measure was developed?

State-developed structural measures address participating providers' capacity, systems, and processes to provide high-quality care and to improve their quality outcomes in the State's areas of interest.
* Each category of quality measurement (structural, process, and outcome) is a piece of the complete picture, not a sole measure of quality.
* When there is an absence of existing, validated measures in a particular area of interest, a structural measure can provide a way to begin the process of quality measurement as an initial step.
* Sometimes there is high variability in providers' current processes that could have a significant impact on their outcomes in a particular area of interest. A structural measure can be instrumental in helping to align provider processes. This also helps ensure more that future data collected is more consistent, with less variability and outliers.
* Implementation of a structural measure can allow providers to actively participate in determining how outcomes will later be measured, and it gives them time to implement the processes needed for data collection. In addition, we process improvement generally leads to better outcomes.
Performance requirements:
* Specific performance requirements each quarter, focusing on the quality area of interest, incentivize desired activities across all participating providers.
* Performance requirements are framed as progressive steps focusing on the planning, operational readiness, implementation, training, and operationalization activities necessary to achieve the desired outcome.
* Performance requirements are developed through a collaborative process with stakeholders (HCA, participating providers, and MCOs).
Provider activities and attestations:
* During each quarterly measurement period, providers complete the activities required to comply with performance requirements for that period.
* During the corresponding reporting period, providers attest to meeting the requirements in the online Dashboard (secure website).
Provider performance is assessed by determining if they have met all performance requirements associated with each measure and have attested to doing so.
Structural measures are implemented for a limited period of time with a plan to transition to a calculated outcomes measure in the area of interest within six to eighteen months.

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☒ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

N/A

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

N/A

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

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed 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 below) providing services under the contract related to the reform or improvement initiative.

b. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

N/A

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 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.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

N/A

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

N/A

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

The MBI increase is 3.9%; the Class 2 per diem add-on is $29.14 per Medicaid bed day; the Class 3 per diem add-on is $10.20 per Medicaid bed day.

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

The MBI and per diem add on will generally be paid upon processing of the initial claim. If the MCO needs to reprocess any claims retroactively to comply with the directed payment, the MCO has the flexibility to do so.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The uniform dollar increase to Nursing Facilities is based the annual per Medicaid bed day unit rate based on quarterly nursing facility assessment revenue in accordance with 42 CFR 433.68 and approved by CMS. The values provided in Q19b apply to Medicaid bed days in January-December 2026.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☐ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☒ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

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

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

The uniform dollar per diem add-on varies by Nursing Facility class, the uniform MBI factor increase is the same across Nursing Facility classes, and both apply to all New Mexico Medicaid Nursing Facilities (excluding for Out-of-State Nursing Facilities). The quality payment is available to all New Mexico Nursing Facilities that meet the quality metrics.
Nursing Facility Classes:
• Class 1 - A health care facility with less than sixty beds;
• Class 2 - A health care facility with greater than sixty beds and less than ninety thousand annual Medicaid bed days;
• Class 3 - A health care facility with more than ninety thousand annual Medicaid bed days

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(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 program only has three class of facilities. The payment arrangement is incorporated into the capitation rates and the contract in Turquoise Care Attachment 10.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box: ☐

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Nursing Facilities	49.3%	22.1%	0.0%	N/A	71.4%
b.					
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☒ Other; Please define: Nursing facility benchmarking analysis is based on Medicare comparison

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

The State of New Mexico utilized nursing facility Medicare data for New Mexico based on cost reports with data from 2020 to 2022, provided by Myers and Stauffer, to source the Medicare rate benchmark for this analysis. Data elements used include nursing facility Medicaid number, nursing facility name, number of days, and payment amount. Data from this database was used to calculate an average cost per day for nursing facility services.

The State of New Mexico used the projected average statewide Medicaid cost per day for nursing facility services for comparison to the Medicare rate. This ratio of the Medicaid rate to the Medicare rate results in the Average Base Payment Level from Plans to Providers (absent the state directed payment). The HCQS-NF VBP directed payment amount, as well as all applicable directed payments for the corresponding service, were converted to an average cost per day using Medicaid nursing facility days. The resulting rates were compared to the Medicare rate to calculate the "Effect on Total Payment Level of State Directed Payment" and "Effect on Total Payment Level of Other SDPs" percentages in the Provider Payment Analysis.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

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

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

MCR-NM-0010-TC

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Attachment 10

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☒ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

12/31/2026

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

12/31/26

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

a. ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.

b. ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.

c. ☒ Other, please describe: An adjustment applied in the development of the monthly base capitation rates and a separate payment term for the program quality component of this state directed payment

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The per diem add-on and MBI increase are built into monthly capitation rates. Consistent with past years, the quality payment is incorporated in the rates as a separate payment term. Question 31a does not allow for more than one selection. As the quality payments are contingent upon nursing facilities achieving the specified metrics for the performance period, it is preferable to account for this component of the directed payment as a separate payment term so that MCOs do not receive excess funds in the monthly capitation rates if performance is not achieved by the provider classes.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

a. ☐ State general revenue

b. ☐ Intergovernmental transfers (IGTs) from a State or local government entity

c. ☒ Health Care-Related Provider tax(es) / assessment(s)

d. ☐ Provider donation(s)

e. ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

a. Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box: ☐

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

N/A

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Healthcare Quality Surcharge	Nursing Facilities	No	No	Yes		No
ii. Healthcare Quality Surcharge	ICF-IID	Yes	Yes	Yes		No
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. SB246 Health Care Quality Surcharge Act	August 30, 2019	Approved	11/19/2019
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.hca.nm.gov/wp-content/uploads/NM-Quality-Strategy-2024.pdf
- **b.** The effective date of quality strategy. July 1, 2024

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year): Jul-27
- **b.** Note any potential changes that might be made to the goals and objectives.

  None at this time.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Build a New Mexico health care delivery system where every Medicaid member has a dedicated health care team that is accessible for both preventive and emergency care that supports the whole person - their physical, behavioral, and social drivers of health.	Decrease hospital readmissions for mental illness	9
b. Identify groups that have been historically and intentionally disenfranchised and address health disparities through strategic program changes to enable an equitable chance at living healthy lives.	Glycemic Status Assessment for Patients with Diabetes (GSD)	10
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

NM Medicaid is focused on ensuring that expenditures for care and services being provided are measured in terms of quality and not solely by quantity. The quality scores were identified as areas where New Mexico's quality is less than the national average. With input from the New Mexico Health Care Association, NM Nursing facilities, NM Division of Health Improvement, and NM HCA an agreement was made on nine quality metrics.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. 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 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. 7-Day Follow up After Hospitalization for Mental Illness (FUH)	CY2020	36.19%	Increase the 7-day follow-up after hospitalization for mental illness rate by 1 percentage point per year from the baseline	
ii. Glycemic Status Assessment for Patients with Diabetes with Poor Control(GSD)	CY2020	52.55%	Decrease the Glycemic Status Assessment for patients with diabetes by 1 percentage point per year from baseline	
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

HCQS VBP evaluation data for all CY26 will not be available for CMS reporting until May 2027 to allow run out time and analyze time of data.

PREPRINT SUBSECTION IIA: VALUE-BASED PAYMENT/DELIVERY SYSTEM REFORM

ADDENDUM TABLE 1.A. PAYMENT ARRANGEMENT PROVIDER PERFORMANCE MEASURES

Directions

1. In Table 1.A below, use the rows to add more measure(s) to Table 1 that the State will tie to provider performance under this value-based payment or delivery system reform arrangement (provider performance measures). States may also use Table 1.A in lieu of completing Table 1 in the preprint. Input data only in beige cells in columns B - H.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the State only needs extra rows to complete Table 1 in the preprint, please delete Tabs 2.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 1.A: Payment Arrangement Provider Performance Measures

Column I	Measure Name and NQF # (if applicable)	Measure Steward/Developer	Baseline Year	Baseline Statistic	Performance Measurement Period	Performance Target	Notes
Data Format	Free text	Set values (select one)	Year (CY or FY YYYY)	Percent (0.49%)	Free text	Percent (0.49%)	Free text
			Baseline year must be added after the first year of the payment arrangement	Baseline percentage must be added after the first year of the payment arrangement	If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment		If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here
Example	*Percent of High-Risk Residents with Pressure Ulcers - Long Stay*	*Centers for Medicare & Medicaid Services*	CY 2018	9.23%	Year 2	8.03%	
a.	Percent of Residents With Pressure Ulcers (LS) (CMS ID: N654.02) (CMIT Measure ID: 513)	Centers for Medicare & Medicaid Services	CY 2024	8.39% (average across all facilities)		Pending data analysis	
b.	Percent of Residents Experiencing One or More Falls with Major Injury (LS) (CMS ID: N813.02) (CMIT Measure ID: 520)	Centers for Medicare & Medicaid Services	CY 2024	3.29% (average across all facilities)		Pending data analysis	
c.	Percent of Residents Who Lose Too Much Weight (LS) (CMS ID: N629.03) (CMIT Measure ID: 524)	Centers for Medicare & Medicaid Services	CY 2024	6.31% (average across all facilities)		Pending data analysis	
d.	Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased (LS) (CMS ID: N629.04) (CMIT Measure ID: 531)	Centers for Medicare & Medicaid Services	CY 2024	16.80% (average across all facilities)		Pending data analysis	
e.	Long Stay Hospitalization (Net Health NQF #2627)	Other (specify in "Notes" column)	CY 2024	11.00% (average across all facilities)		Pending data analysis	AHCA/Net Health/NQF
f.	Infection Control Program Structural Measure	State-defined	CY 2025	Positive attestation (for each facility)		100% positive attestation (across all facilities)	Structural measure with Facility attestation to performance requirements. Facility has an effective infection control program that includes pursuing improved outcomes in resident and employee vaccination rates, prevention of healthcare-acquired infections, and antibiotic stewardship.
g.	Patient Experience Structural Measure	State-defined	CY 2025	Positive attestation (for each facility)		100% positive attestation (across all facilities)	Structural measure with Facility attestation to performance requirements. Facility completes the operational readiness, training, implementation, and operationalization activities necessary to measure patient experience, which is directly related to the quality and safety of healthcare services delivered and impacts health outcomes.
h.	Behavioral Health Care Coordination Structural Measure	State-defined	CY 2025	Positive attestation (for each facility)		100% positive attestation (across all facilities)	Structural measure with Facility attestation to performance requirements. Facility completes the operational readiness, training, implementation, and operationalization activities necessary to effectively coordinate care for residents with behavioral health needs.
i.	CMS Nursing Home Five-Star Quality Rating System – Health Inspection Score	Centers for Medicare & Medicaid Services	CY 2024	160.00 (average across all facilities)		Pending data analysis	
j.							
k.							
l.							
m.							
n.							
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PIMPREP SECTION VII: QUALITY CRITERIA AND RISK MITIGATION FOR ALL PAYMENT ARRANGEMENTS

ADDENDUM TABLE B.4: EVALUATION MEASURES, BASELINE AND PERFORMANCE TARGETS

Directions

B. Use Table B.4 below to add each measure the State intends to use in the evaluation of this payment arrangement, including (1) the baseline year, (2) the baseline statistics, and (3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. States may also use Table B.4 in lieu of completing Table B in the preprint. Input data only in beige cells in columns B - F.

States should only submit the tables they populate in CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A.- B.4. For example, if the State only needs extra rows to complete Table B in the preprint, please delete Table 1.A. - 7.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE B.4: Evaluation Measures, Baseline and Performance Targets

Column#	Measure Name and NQF# (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes
Data Format	Free text	Free text	Percentage (88.8%)	Percentage (88.8%)	Free text. If the State will deviate from the measure specification, please describe here. If the State is using a state-specific measure, please define the numerator and denominator here. In addition, describe any planned data or measure stratifications (for example, age, race, or ethnicity) the State will use to evaluate the payment arrangement.
Example	Pts' dissatisfaction for Adults Ages 18 - 64 (PUA-AD); NQF # 0038	CY 2020	34.6%	34.0%	
i.	Percent of Residents: With Pressure Ulcers (LS) (CMS ID: N640.02) (CMIT Measure ID: 312)	CY 2020	8.39% (average across all facilities)	Pending data analysis	
ii.	Percent of Residents: Experiencing One or More Falls with Major Injury (LS) (CMS ID: N613.02) (CMIT Measure ID: 322)	CY 2020	3.24% (average across all facilities)	Pending data analysis	
iii.	Percent of Residents: Who Lose Too Much Weight (LS) (CMS ID: N629.03) (CMIT Measure ID: 324)	CY 2020	6.31% (average across all facilities)	Pending data analysis	
iv.	Percent of Residents: Whose Need for Help with Activities of Daily Living Has Increased (LS) (CMS ID: N639.04) (CMIT Measure ID: 531)	CY 2020	19.80% (average across all facilities)	Pending data analysis	
v.	Long Stay Hospitalization (Net Health NQF #0527)	CY 2020	11.00% (average across all facilities)	Pending data analysis	
vi.	Infection Control Program Structural Measure	CY 2020	Pre-bar attestation (for each facility)	≥80% positive attestation (across all facilities)	Structural measure with Facility attestation to performance requirements. Facility has an effective infection control program that includes pursuing improved outcomes in resident and employee vaccination rates, prevention of healthcare-acquired infections, and antibiotic stewardship.
vii.	Patient Experience Structural Measure	CY 2020	Pre-bar attestation (for each facility)	≥80% positive attestation (across all facilities)	Structural measure with Facility attestation to performance requirements. Facility completes the operational readiness, training, implementation, and operationalization activities necessary to measure patient experience, which is directly related to the quality and safety of healthcare services delivered and impacts health outcomes.
viii.	Behavioral Health Care Coordination Structural Measure	CY 2020	Pre-bar attestation (for each facility)	≥80% positive attestation (across all facilities)	Structural measure with Facility attestation to performance requirements. Facility completes the operational readiness, training, implementation, and operationalization activities necessary to effectively coordinate care for residents with behavioral health needs.
ix.	CMS Nursing Home Five-Star Quality Rating System – Health Inspection Score	CY 2020	1.63.00 (average across all facilities)	Pending data analysis	