HUMAN SERVICES DEPARTMENT

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Letter of Direction #36-1

Date: **February 28, 2022**

To: **Centennial Care 2.0 Managed Care Organizations**

From: **Nicole Comeaux, Director, Medical Assistance Division**

Subject: **Hospital Access Program Directed Payment**
(Previously Safety Net Care Pool (SNCP) Hospital Uncompensated Care)
Repeal & Replace LOD #36

Title: **Hospital Access Program (HAP) Directed Payment**

This Letter of Direction (LOD) will repeal and replace LOD #36 *Hospital Access Program Directed Payment.*

The purpose of this LOD is to provide instructions to the Centennial Care Managed Care Organizations (MCOs) for implementing the Hospital Access Program (HAP). The Human Services Department Medical Assistance Division (HSD) has received Centers for Medicare and Medicaid Services (CMS) approval for the annual renewal of the directed payment in accordance with Section 438.6(c) for calendar year 2021 (CY2021). In this LOD, HSD will continue implementing the HAP directed payment. In this LOD, HSD updated the HAP directed payment background, updated the payment distribution, and added quality measures to the evaluation for CY2021.

Hospital Access Program (HAP) Directed Payment Background

In CY2020, HSD established the HAP directed payment with the pool of dollars previously allocated to the Safety Net Care Pool (SNCP) Hospital Uncompensated Care (UC) which the CMS required HSD to sunset December 31, 2019. For CY2021 HSD received CMS approval for annual renewal of the HAP directed payment.

The HAP directed payment is structured as a uniform dollar increase for inpatient and outpatient hospital services for each respective class of SNCP hospitals. The payment increases will be allocated to the MCOs and (subsequently paid by the MCOs to the provider) based on actual utilization of the provider by each MCO. All services provided by the eligible provider within each respective class will receive

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

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

SNCP Classes:

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

HAP Payments for January 1 – December 31, 2021

HSD will inform the MCOs to make payments to all contracted hospitals based on HSD's calculations of amounts owed to each hospital for the period of January 1 through December 31, 2021, consistent with the CMS-approved Directed Payment. ***The MCOs must make electronic deposits for the HAP Directed Payment program to contracted hospitals based on HSD's calculations and the payment must be received by the provider as directed by HSD quarterly. Payments must be received by the hospitals within 10 business days of receipt from HSD.***

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

Evaluation Plan Metrics

While the CY2020 HAP directed payment was approved by CMS without an evaluation plan during the renewal process CMS indicated future approvals would depend on an evaluation for CY2021. The evaluation will be conducted by HSD staff.

HSD will review the pre and post comparisons results of the measure indicated for this preprint to determine performance outcomes. Note that the providers' performance against the performance targets do not impact eligibility for the uniform percent increase on utilization during the CY2021 rating period. The below table features the metrics and baselines for the program for CY2021:

Measure Name	Baseline Year	Baseline Statistic	Performance Target
Follow-up after hospitalization or ED visit for mental illness (FUM) 30-day	2020	NCQA/HEDIS	HSD is currently developing the process to extract data to determine the performance target.
Member Satisfaction – Communication with Doctors	2020	HCAHPS	HSD is currently developing the process to extract data to determine the performance target.
Member Satisfaction – Discharge	2020	HCAHPS	HSD is currently developing the process to extract data to determine the performance target.
Plan All cause Readmissions (PCR)	2020	NCQA/HEDIS	HSD is currently developing the process to extract data to determine the performance target.
Catheter-Associated Urinary Tract Infections (CAUTI)	2020	NM Medicaid specific aggregate 2020 data	HSD is currently developing the process to extract data to determine the performance target.
Central Line-Associated Bloodstream Infection (CLABSI)	2020	NM Medicaid specific aggregate 2020 data	HSD is currently developing the process to extract data to determine the performance target.

HAP Directed Payment Operational and Reporting Requirements

The HAP Directed Payments are classified as revenue attributed to medical expenses and are therefore classified as "premium". The quarterly payments will include gross-up amounts to reflect applicable underwriting gain and premium taxes. The directed payments will be included in the MCO's medical loss ratio and underwriting gain calculations outlined in the CC 2.0 Contract Amendment #2 (Section 7.2).

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

- Each MCO is directed to report the revenue received for the directed payment in the quarterly and annual Financial Reporting package as "other revenue". The amounts recorded in the

financial reporting package **must** match the total payment made by MAD to the MCO by rate cohort.

- Each MCO is directed to report the amount paid by the MCO to hospitals for the directed payment in the quarterly and annual Financial Reporting package as "other services". The amounts recorded in the financial reporting package **must** match the total payment made by MAD to the MCO by rate cohort.
- Amounts paid by the MCO to hospitals for the directed payment should also be reported in FIN-Report #5 for "Other Services" in the Shared Risk/Incentive Arrangements (All programs – Line 42). This will ensure that the FIN-Report Check Totals tab do not trigger submission errors.
- The directed payments are classified as revenue attributed to medical expenses and therefore classified as "premium". The quarterly payments will include gross-up amounts to reflect applicable risk/margin and premium taxes.
    - MAD will provide each MCO the amount of the directed payment and break out the gross-up amounts for each rate cohort.
- Reconciliations performed as part of the CC 2.0 MCO contract (Retroactive Period, Hepatitis C and Patient Liability) will not include the directed payment revenue or expense.
- The directed payment amount paid by the MCO to hospitals should not be included in encounter data submissions.