HEALTH CARE AUTHORITY

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Dana Flannery, Medicaid Director

Letter of Direction #51-1

Date: **July1, 2025**

To: **Turquoise Care Managed Care Organizations**

From: **Dana Flannery, Director, Medical Assistance Division**

Subject: **Healthcare Delivery and Access Act (HDAA) Directed Payment (previously) Hospital Value Based Program (HVBP) and Hospital Access Program (HAP) Directed Payments**
Repeal and Replace Turquoise Care LOD #51

Title: **CY25 Healthcare Delivery and Access Act (HDAA) Directed Payment**

This Letter of Direction (LOD) is intended to repeal and replace LOD #51 issued by the Health Care Authority/Medical Assistance Division (HCA/MAD) on February 3, 2025. The following updates are included in this revised LOD:

- Updated Calendar Year 2025 HDAA payment dates.
- Removal of Early Elective Delivery Quality Measure for Acute Care Hospital Rural/Urban Performance Measures.
- Addition of Maternal Morbidity Structural Measure for Acute Care Hospital Rural/Urban Performance Measures.
- Addition of Screening, Brief Intervention, and Referral to Treatment (SBIRT) section
- Updated Names in Attachment A for Espanola Hospital, Gerald Champion Regional Medical Center, Presbyterian Hospital, Mimbres Memorial Hospital, and Central Desert Behavioral
- Addition of Presbyterian Kaseman Hospital and Carlsbad Medical Center Rehab to HDAA
- Senate Bill 17 Approval Delay Language Section

HCA/MAD has received approval from the Center for Medicare & Medicaid Services (CMS) for the Calendar Year 2025 (CY25) Healthcare Delivery and Access Act (HDAA), previously referred to as NMSA Senate Bill 17 (SB17) in 2024 Legislative session. HDAA imposes a quarterly access and annual quality assessment on HDAA hospitals. The assessment will be based on inpatient days, and outpatient net revenues, excluding Medicare. The inpatient and outpatient assessments are established by HCA/MAD every year. Out-of-state facilities are not subject to the assessment; therefore, out-of-state facilities are not eligible to receive rate increases or quality payments under the HDAA program. The list of eligible HDAA hospitals is provided under *ATTACHMENT A-HDAA HOSPITALS.*

Healthcare Delivery and Access Act (HDAA) Background
In Calendar Year 2020 (CY20), HCA/MAD established the Hospital Access Program (HAP) Directed Payment with the pool of dollars previously allocated to the Safety Net Care Pool (SNCP) Hospital Uncompensated Care (UC) which CMS required HCA/MAD to sunset December 31, 2019. In CY22, HCA/MAD began working with provider advocacy groups and managed care organizations (MCOs) in the development and transition into the Hospital Value Based Program (HVBP). The HVBP sunset on June 30, 2024. As of July 1, 2024, the HVBP program has transitioned to the HDAA program.

Payment to the MCO
The HDAA Directed Payment is structured as a uniform percentage increase for inpatient (IP) and outpatient (OP) hospital services for HDAA hospitals. All IP/OP services provided by the eligible hospital will receive the same uniform increase. To support the HDAA program, funding will be allocated to the MCOs and subsequently paid by the MCOs to the hospitals based on actual utilization during CY25. HDAA directed payments will be made on a separate payment term basis outside of the monthly capitation rates. HCA/MAD shall provide exhibits for the uniform percentage increase for the access payment to the MCOs on a quarterly basis no later than seventy-five days after the end of the quarter and the quality payment by May 15 of the subsequent calendar year. The MCOs will distribute the separate payment term amount to contracted hospitals as directed by HCA/MAD.

Distribution of Data Intermediary Payment
The HDAA program requires the use of an HCA/MAD selected Data Intermediary to calculate the quality metrics for participating HDAA hospitals. The MCOs entered into an agreement with the Data Intermediary for this program, and the cost has been incorporated into the capitation amount. The Data Intermediary's total fees for its performance of the program are prorated proportionately among the participating MCOs.

Data Sharing and Reporting
As part of the agreement the Data Intermediary will be sharing hospital performance information with the hospitals, MCOs, and HCA/MAD. The MCOs are also required to submit their HDAA payments and supporting documentation to HCA/MAD on the next quarterly HCA/MAD "VBP FIN" report after payments have been submitted to the HDAA hospitals. Payments are reported cumulatively throughout the year on the "HDAA" work tab and finalized on the Annual Supplemental Report.

HealthCare Delivery and Access Act Payments
Access Payment
HCA/MAD will direct the MCOs to make a quarterly access payment to all HDAA contracted hospitals based on HCA/MAD's calculations of access amounts owed to each hospital for CY25 and through the MCO contract consistent with the CMS-approved Directed Payment. MCOs must make electronic deposits for the HDAA Directed Payment program to contracted hospitals based on HCA/MAD's calculations and the payment must be received by the provider as directed by HCA/MAD.

Quality Payment

Forty percent (40%) of each HDAA hospital's estimated CY25 payment will be set aside for the annual quality payment. HDAA hospitals are divided into four hospital groups:

- Acute Care Hospitals (ACH); designated as Frontier or Rural/Urban,
- Long-Term Hospitals (LTCH),
- Inpatient Rehabilitation Facilities (IRF),
- Inpatient Psychiatric Facilities (IPF).

ACHs, designated as Frontier, have different quality metrics and payment calculation methodologies than ACHs designated as Rural/Urban, LTCHs, IRFs, and IPFs. The quality score will utilize CMS reported outcomes and New Mexico Medicaid State Specific Medicaid management information system (MMIS) data for the Data Intermediary to calculate the quality scores. HDAA Hospitals will have access to a quality dashboard to monitor their potential annual quality payout. The quality dashboard will be managed through the Data Intermediary. Access utilization calculations are not provided on the HDAA Quality Dashboard.

Per NMSA SB17 Section 6.F, MCOs are directed to make directed payments to HDAA hospitals no more than fifteen calendar days after receipt of the quality payments from HCA/MAD.

Calendar Year 2025 HDAA Payment Dates:

CY25	**Exhibits to MCO:**	**HDAA Hospital Payment:**
Q1 January 1-March 31, 2025, Access Payment	**August 12, 2025	**August 27, 2025
Q2 April 1-June 30, 2025 Access Payment	September 15, 2025	*September 30, 2025
Q3 July 1-September 30, 2025 Access Payment	December 15, 2025	*December 30, 2025
Q4 October 1-December 31, 2025 Access Payment	March 16, 2026	*March 31, 2026
Annual Quality Payment Date	May 14, 2026	*May 29, 2026

***Based on CMS approval, the CY25 Q1 HDAA Access Payment has been updated to reflect SB17 Approval Delay Language time requirements.*

** The CY25 Q2-Q4 HDAA Payment dates may change based on CMS approval for HDAA CY25 to align with CY25 updated HDAA Assessment dates required by Tax & Revenue Department.*

Senate Bill 17 Approval Delay Language

Per NMSA Senate Bill 17, if the assessment due date has been postponed due to a delay in approval by CMS, the payments to the MCOs shall be due five days after the extended assessment due date. HCA/MAD will direct the MCOs to make the delayed quarterly directed payment to hospitals no more than fifteen days after receipt of payments from HCA/MAD.

HDAA Quality Payment Methodology

The HDAA Hospitals can earn Hospital Quality Performance and Residual Funds payments based on their Medicaid inpatient and outpatient utilization and quality scores. Residual funds reside within each of the four HDAA hospital groups and are distributed amongst that specific group. Successful

administration of the program depends on the hospital's timely and appropriate submission of claims data to the MCOs, attestations to structural measure requirements, data submission to CMS as applicable, and review of hospital-specific information within required timeframes. Quality Payments, based on each hospital's performance, depend on the timely finality of Quality metrics; the payments will be calculated annually. Once the annual quality payment is finalized with the Data Intermediary, the Data Intermediary will provide quality dashboards to the hospitals and the MCOs. These quality dashboards will display for each MCO how much to pay for the HDAA quality program based on each MCOs distribution of membership. The MCO is to make the payment in accordance with the contract that the participating HDAA Hospital signed.

Evaluation Plan Metrics

HCA/MAD will review the pre-and-post comparisons results of the measures indicated for the state directed payment to determine performance outcomes. Note that the hospitals' performance against the performance measures does not impact eligibility for the uniform percentage increase on utilization during the CY25, rating period. The table below features the metrics and baselines for the program for CY25:

Measure Name	Measure Steward/Developer	State Baseline
Acute Care Hospital Rural/Urban Performance Measures		
1. Hospital-Wide All-Cause Unplanned Readmission Measure (HWR) [NQF #1789]	CMS	CY 2023
2. Patient Safety Indicator (PSI) 90: Patient Safety and Adverse Events Composite (serious complications that patients experience during a hospital stay or certain inpatient procedures) [NQF #0531]	CMS	CY 2023
3. Maternal Morbidity Structural Measure: Hospital has obtained "Birthing Friendly" hospital quality designation.	State-Specific New Mexico	CY 2024
4. Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) [NQF #0500]	CMS	CY 2023
5. HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Hospital Inpatient Survey: Communication with Doctors [NQF #0166]	CMS	CY 2023
6. HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Hospital	CMS	CY 2023

Inpatient Survey: Communication with Nurses [NQF #0166]		
7. Screening, Brief Intervention, and Referral to Treatment (SBIRT) - structural measure with attestation	State-Specific Mexico New	CY 2025
8. Care Coordination for Emergency Department Visits for Mental Health– structural measure with attestation	State-Specific Mexico New	CY 2025
Acute Care Hospitals Frontier Performance Measures		
1. Screening, Brief Intervention, and Referral to Treatment (SBIRT) Training – structural measures with attestation	State-Specific Mexico New	CY 2025
2. Care Coordination for Mental Health Emergency Department Visit Follow-Up – structural measure with attestation	State-Specific Mexico New	CY 2025
Long-Term Care Hospitals (LTCH) Performance Measures		
1. 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	CY 2023
2. LTCH QRP Measure #4: Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury [CMIT Measure ID #000121 (not endorsed)]	CMS	CY 2023
3. LTCH QRP Measure #12: National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure [CMIT Measure ID #00460 (CBE-endorsed)]	CMS	CY 2023
4. Care Coordination for Post Discharge Mental Health Follow-Up – structural measure with attestation	State-Specific Mexico New	CY 2025
Inpatient Rehabilitation Facilities (IRF) Performance Measures		

1. 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	CY 2023
2. IRF QRP Measure #10: National Healthcare Safety Network (NHSN) Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure [CMIT Measure ID #00459 (CBE-endorsed)]	CMS	CY 2023
3. IRF QRP Measure #17: Potentially Preventable Within Stay Readmission Measure [CMIT Measure ID #00576 (not endorsed)]	CMS	CY 2023
4. IRF QRP Measure #15: Discharge to Community–PAC IRF QRP [CMIT Measure ID #00210 (CBE-endorsed)]	CMS	CY 2023
5. Care Coordination for Post Discharge Mental Health Follow-Up – structural measure with attestation	State-Specific New Mexico	CY 2025
Inpatient Psychiatric Facilities (IPF) Performance Measures		
1. SUB-2: Alcohol Use Brief Intervention Provided or Offered [IPFQRP Measure]	CMS	CY 2023
2. TOB-3: Tobacco Use Treatment Provided or Offered at Discharge [IPFQRP Measure]	CMS	CY 2023
3. SMD: Screening for Metabolic Disorders [IPFQRP Measure]	CMS	CY 2023
4. Care Coordination for Post Discharge Mental Health Follow-Up – structural measure with attestation	State-Specific New Mexico	CY 2025

Screening, Brief Intervention, and Referral to Treatment (SBIRT)
Definition

HCA/MAD defines the HDAA SBIRT quality structural measure by the following:
SBIRT has two components, screening and brief intervention. Procedure Code H0050, Brief Intervention, is the only component that is evaluated for the SBIRT structural measure. The numerator is the patients who received a brief intervention, a referral to treatment, or both that is documented within 48 hours of the date of a primary or secondary diagnosis of alcohol or drug (AOD) received in an emergency department (ED) (Revenue Codes 0450-0459 on an UB-04 encounter) as defined by procedure code H0050. Procedure code H0050 can be present on the UB-04 claim or documented within a professional claim on the CMS-1500. The denominator is all patients aged 18 years and older with an eligible encounter in an ED (revenue codes 0450-0459 on a UB-04 encounter) with a primary or secondary diagnosis of AOD per the AOD value set during the measurement period. When both numerator and denominator are met, then that claim counts towards the SBIRT structural measure.

SBIRT Claim Types
The SBIRT structural measure can be captured in two claim types:

- Institutional claims
- Professional claims.

To capture the numerator (H0050) and denominator (SUD/AOD diagnosis), the procedure codes and revenue codes need to be correct for SBIRT billing under the claim type.

SBIRT billing codes cannot be added to a closed ED encounter; however, if SBIRT takes place within 48 hours of an ED visit and is billed for in a professional setting with an applicable denominator, then it will be captured in the numerator for SBIRT.

Institutional Claims: Require Procedure & Revenue Codes

Institutional Claims Coding Parameters			
Procedure Code	Procedure Description	Revenue Code	Revenue Code Description
H0049	Screening	914	Behavioral Health Treatment Services- Individual Therapy
H0050	Brief Intervention	914	Behavioral Health Treatment Services- Individual Therapy

Professional Claims: Require Procedure Codes and do not require Revenue Code

Professional Claims Coding Parameters	
Procedure Code	Procedure Code Description
H0049	Screening
H0050	Brief Intervention

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

HDAA Directed Payment Operational and Reporting Requirements

This section provides information about operational, and reporting requirements associated with the directed payment.

- The directed payments are classified as revenue attributed to medical expenses and therefore classified as "premium." The quarterly access and annual quality payments will include gross-up amounts to account for underwriting gain, premium and surtax taxes.
    - HCA/MAD will provide each MCO with the amount of the directed payment and break out the gross-up amounts for each rate cohort.
- The directed payments will be included in the MCOs Medical Loss Ratio and Underwriting Gain calculations outlined in the MEDICAID MANAGED CARE SERVICES AGREEMENT.
    - HCA/MAD directs each MCO 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 HCA/MAD to the MCO by rate cohort.
    - HCA/MAD directs each MCO 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 HCA/MAD to the MCO by rate cohort.
    - HCA/MAD directs the MCOs to support HDAA hospitals by providing support to Medicaid beneficiaries to improve quality of care outcomes.
- 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 does not identify submission errors.
- The HDAA Shared Risk Arrangement, including Separate Payment Term Directed Payments should be reported in the "HDAA Directed Payment" column on the SRA Expense Detail worksheet in FIN Report #23.
- The HDAA separate payment term directed payment revenues can be reported in the Directed Payment Revenue worksheet, HDAA Directed Payment column in FIN Report #23.
- Reconciliations performed as part of the MCO contract (Retroactive Period 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.

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

This LOD will sunset when direction is provided in one or more of the following: Turquoise Care Managed Care Services Agreement, Managed Care Policy Manual, NMAC, Systems Manual, or Behavioral health services division (BHSD) Billing and Systems Manual. The LOD may also sunset upon HCA/MAD notification or completion
of the Turquoise Care Program.

ATTACHMENT A
HDAA HOSPITALS

HOSPITAL NAME	PROVIDER TYPE	NPI
ALBUQUERQUE ER AND MEDICAL HOSPITAL -COORS	201	1558838607
ALBUQUERQUE ER AND MEDICAL HOSPITAL - MONTGOMERY	201	1689370595
ALTA VISTA REGIONAL HOSPITAL	201	1396716643
ARTESIA GENERAL HOSPITAL	201	1437286044
CARLSBAD MEDICAL CENTER	201	1790722346
CIBOLA GENERAL HOSPITAL	201	1780677039
COVENANT HEALTH HOBBS HOSPITAL	201	1215534466
DR. DAN C. TRIGG	201	1962488304
EASTERN NEW MEXICO MEDICAL CENTER	201	1447221742
PRESBYTERIAN HEALTHCARE SERVICES (ESPANOLA HOSPITAL)	201	1154307593
OTERO COUNTY HOSPITAL ASSOCIATION (GERALD CHAMPION REGIONAL MEDICAL CTR)	201	1861450579
GILA REGIONAL MEDICAL CENTER	201	1336220839
GUADALUPE COUNTY HOSPITAL	201	1346249968
HOLY CROSS HOSPITAL	201	1902338049
LINCOLN COUNTY MEDICAL CENTER	201	1558347708
LOS ALAMOS MEDICAL CENTER	201	1285701623
LOVELACE MEDICAL CENTER- DOWNTOWN	201	1306914213
LOVELACE REGIONAL HOSPITAL-ROSWELL	201	1972878361
LOVELACE WESTSIDE HOSPITAL	201	1649373887
LOVELACE WOMENS HOSPITAL	201	1982799375
MEMORIAL MEDICAL CENTER	201	1700821808
DEMING HOSPITAL (MIMBRES MEMORIAL HOSPITAL)	201	1891075446
MINERS COLFAX MEDICAL CENTER	201	1083931109
MOUNTAINVIEW REG MED CTR	201	1205882503
NORLEA HOSPITAL	201	1881630036
PLAINS REGIONAL MEDICAL CTR - CLOVIS	201	1629053509
PRESBYTERIAN HOSPITAL DOWNTOWN	201	1215913470
REHOBOTH MCKINLEY CHRISTIAN HOSPITAL	201	1720084999
ROOSEVELT GENERAL HOSPITAL	201	1073517058
SJRMC INPATIENT REHABILITATION UNIT (SAN JUAN REGIONAL MEDICAL CENTER)	201	1427058510
SANTA FE MEDICAL CENTER	201	1730684853
SIERRA VISTA HOSPITAL	201	1760446009
SOCORRO GENERAL HOSPITAL	201	1790761138
ST. VINCENT HOSPITAL	201	1578587150
THREE CROSSES REGIONAL HOSPITAL	201	1760020044
UNION COUNTY GENERAL HOSPITAL	201	1427051002
CARLSBAD MEDICAL CENTER REHAB	202	1114949781
ADVANCED CARE HOSPITAL OF SOUTHERN NM (LTCH)	203	1083787345
ALBUQUERQUE - AMG SPECIALTY HOSPITAL (LTCH)	203	1518232842
CLEARSKY REHAB HOSPITAL OF RIO RANCHO	203	1093341810

ENCOMPASS HEALTH REHABILITATION HOSPITAL	203	1225001928
KINDRED HOSPITAL ALBUQUERQUE	203	1811075484
LOVELACE UNM REHABILITATION HOSPITAL	203	1700325677
REHABILITATION HOSPITAL OF SOUTHERN NM	203	1679578066
PRESBYTERIAN KASEMAN HOSPITAL	204	1598740482
MESILLA VALLEY HOSPITAL LLC	205	1841205671
BEHAVIORAL HEALTH SERVICES OF NEW MEXICO, LLC (CENTRAL DESERT BEHAVIORAL)	205	1427330679
HAVEN BEHAVIORAL SEN CARE OF ALBUQUERQUE	205	1093079303
THE PEAK HOSPITAL	205	1053652438