HEALTH CARE QUALITY SURCHARGE (HCQS) VALUE-BASED PAYMENT (VBP) PROGRAM

FINAL EFFECTIVE 7/1/2025

EXECUTIVE SUMMARY

The Health Care Quality Surcharge (HCQS) was created by Senate Bill 246 (SB246) in the 2019 Regular Legislative Session. The program imposes a daily surcharge on certain types of Facilities, including Nursing Facilities (NF) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), for non-Medicare bed days. The purpose of the surcharge is to increase each Facility's Medicaid reimbursement rates by at least the rate of nursing home inflation and to provide bonus payments to Medicaid Certified Nursing Facilities based on performance data.

FUNDING MECHANISM AND PAYMENT ARRANGEMENT

The **Health Care Quality Surcharge (HCQS) Value-Based Payment (VBP) Program** ("the program") is funded through a provider surcharge, a general fund allocation, and a Medicaid Managed Care State Directed Payment (SDP) payment arrangement of the Value-Based Payment (VBP) type to promote increased access to care and improved quality outcomes for Medicaid beneficiaries. Through this payment arrangement, the Managed Care Organizations (MCOs) make specific payments to healthcare providers, as directed by the Health Care Authority (HCA).

PAYMENT MECHANICS

There are three payment mechanisms:

1. **Surcharge Add-On:** Paid on a per diem basis to Facilities (NF and ICF/IID). The Surcharge Add-On is calculated by HCA and provided to the MCOs and Nursing Facilities. This amount will change each July 1st in accordance with the statute.
2. **MBI Increase:** Added to the rate paid on a per diem basis to Facilities (NF only). HCA will increase the current rate by stated MBI Increase percentage on July 1st in accordance with the statute.
3. **Quality Payment:** Only applicable to Nursing Facilities (NF). The quality payment calculation shall follow the methodology contained in this document.

*NOTE: The remainder of this document refers to the **QUALITY PAYMENT** mechanism.*

GOALS

- Incentivize Nursing Facility providers to improve or maintain high quality outcomes for Medicaid beneficiaries.
- Increase access to services for Medicaid beneficiaries.
- Better value for Medicaid funds spent on care.

STAKEHOLDERS

- New Mexico Health Care Authority
- New Mexico Nursing Facilities

- New Mexico Health Care Association (NMHCA)
- Turquoise Care MCOs: Blue Cross Blue Shield of New Mexico, Molina Healthcare of New Mexico, Presbyterian Health Plan, and United Healthcare Community Plan of New Mexico

DATA INTERMEDIARY

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

WORKGROUP

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

MINIMUM REQUIREMENTS FOR PROVIDER PARTICIPATION

- Medicaid Certified Nursing Facility
- Required contracts/agreements executed with the Data Intermediary and MCOs
- Must submit required data to Data Intermediary and meet data completeness standards*
- Must have Medicaid utilization during the measurement quarter to receive payment

*Net Health will develop data completeness standards for MDS data submission based on historical volumes of Facility data submissions. Failure to meet the minimum data completeness standards will result in suspension of payment calculations pending results of a Facility audit. If the Facility can provide appropriate documentation to support the decrease in MDS volume, payment calculations will resume. Specific audit requirements and timelines will be developed.

GUIDING PRINCIPLES FOR PROGRAM DESIGN

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

COMPONENTS OF THE PROGRAM

1. **Funding Mechanism**: how the rate improvement and quality incentive payments in the program are funded.

2. **Quality Measurement**: specific metrics used to evaluate the performance of healthcare providers in the program.
3. **Assessing Performance**: methodology used to evaluate provider performance on quality metrics, which may include comparisons to baselines and performance targets.
4. **Linking Performance to Payment**: methodology used to relate provider outcomes to an incentive payment, intended to align financial incentives with the quality strategy.
5. **Ongoing Evaluation and Changes**: systematic approaches to measure impact, maintain regulatory compliance, and ensure the effectiveness, sustainability, and relevance of the program.

QUALITY PAYMENT COMPONENTS

There are two components of the Quality Payment.

1. **Tiered Percentage Quality Payment:**
    - Performance is based on quality measures
    - Total funds available each quarter is determined by HCA/actuarial vendor
    - Facility maximum payment = per diem rate (total funds available / total Medicaid bed days for participating Facilities) * Facility bed days
    - Facility maximum payment is adjusted by a tiered percentage based on quality performance
    - Unearned funds go to the high-acuity pool
2. **High-Acuity Add-On:**
    - Additional per-diem payment based on Facility's High-Acuity Medicaid Bed Days (residents with certain behavioral and complex neurological diagnoses)
        - ALS (MDS I8000 = G12.21)
        - Lewy-Body Dementia (MDS I8000 = G31.83)
        - Dementia with behavioral disturbance (MDS I8000 = F02.81 or F03.91)
        - Cerebral palsy (MDS I4400 is checked)
        - Multiple sclerosis (MDS I5200 is checked)
        - Huntington's disease (MDS I5250 is checked)
        - Parkinson's disease (MDS I5300 is checked)
        - Tourette's syndrome (MDS I5350 is checked)
        - Traumatic brain injury (MDS I5500 is checked)
        - Bipolar disorder (MDS I5900 is checked)
        - Schizophrenia (MDS I6000 is checked)
        - Psychotic disorder other than schizophrenia (MDS I5950 is checked)
        - Post-traumatic stress disorder (MDS I6100 is checked)

- Total funds available is determined by the residual funds from tiered percentage quality payments

DISQUALIFICATION EVENTS

To ensure fair and equitable performance measurement across Facilities, certain disqualification events will result in no payment for the performance quarter.

- No MDS data submission for the quarter
- MDS submission below data completeness standard
- No Medicaid utilization (bed days) for the quarter

PENALTIES

RESERVED

At this stage, the program focuses on incentivizing quality improvement and outcomes through positive rewards. While penalties for underperformance are not included in the current program design, we anticipate incorporating such mechanisms in future iterations to further align with value-based care principles. This phased approach allows providers time to adapt and achieve success under the program before penalties are introduced.

QUALITY MEASURES (QM)

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

QUALITY MEASURES USED FOR PERFORMANCE ASSESSMENT:

MEASURE NAME	MEASURE TYPE	AREA(S) OF QUALITY FOCUS
Long Stay Prevalence of Pressure Ulcers (CMS N045.01)	Outcome Measure	Clinical Outcomes
Long Stay Falls with Major Injury (CMS N013.02)	Outcome Measure	Clinical Outcomes
Long Stay Weight Loss (CMS N029.02)	Outcome Measure	Clinical Outcomes
Long Stay Worsened ADL (CMS N028.03)	Outcome Measure	Functional Status
Long Stay Hospitalization (Net Health NQF #2827)	Utilization Measure	Utilization of Healthcare Services
Infection Control Program Structural Measure*	Structural Measure	Infection Control

MEASURE NAME	MEASURE TYPE	AREA(S) OF QUALITY FOCUS
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.		
Patient Experience Structural Measure* 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.	Structural Measure	Patient Experience and Quality of Life
Behavioral Health Care Coordination Structural Measure* Facility completes the operational readiness, training, implementation, and operationalization activities necessary to effectively coordinate care for residents with behavioral health needs.	Structural Measure	Behavioral Health and Access to Care
CMS Nursing Home Five-Star Quality Rating System – Health Inspection Score	Outcome Measure	Regulatory Compliance

*For structural measures, Facilities will attest each quarter to whether specific, auditable performance requirements have been met or not met. Specific requirements for each quarter will be determined with input from the stakeholder workgroup.

MONITORED-ONLY MEASURES:

"Monitored only measures" are quality metrics that are tracked and reported but not directly tied to financial incentives or penalties. In VBP programs, a balanced approach with a mix of incentivized and monitored-only measures helps sustain comprehensive quality improvement. Changing quality measures to "monitored only" after performance targets have been achieved keeps the program dynamic and responsive and is a strategic approach to enhancing quality and outcomes, as it helps ensure that performance does not decline on these measures when providers shift their focus and resource allocation to new measures in the program. Ongoing monitoring of measures on which performance targets have been met can prevent complacency and encourage providers to maintain high levels of performance. A robust monitoring framework promotes transparency and alignment and ensures any declines in performance can be detected promptly.

Measures that are monitored-only include the following.

- Long Stay Antipsychotic (CMS N031.04)
- Long Stay Influenza Vaccine (CMS N016.03)

- Long Stay Pneumococcal Vaccine (CMS N020.02)
- Long Stay Depression (CMS N030.03)

ASSESSING PERFORMANCE ON QUALITY MEASURES & LINKING PERFORMANCE TO PAYMENT

After the close of each performance quarter, Facility performance is assessed, performance is linked to payment, and Facility payments are calculated using the following methodologies.

1. **Determination of Quality Funds Available:** A "per diem rate" for all Facilities is established by dividing the total number of dollars available for Total Quality Funds by the total number of Medicaid Bed Days across all Facilities and MCOs.
   Total Funds / Total Medicaid Bed Days Across All Facilities and MCOs = Per Diem Rate

   If prior period adjustments are required due to a Facility amending their prior period tax reporting, all adjustments will be reflected in the current period. The necessary adjustment will be made to the Medicaid Bed Days.
   (Total Funds – Prior Period Adjustments) / Facility Medicaid Bed Days = Adjusted Medicaid Bed Days

2. **Determination of Quality Measure (QM) Outcomes:** The Data Intermediary calculates each Facility's QM performance outcomes. For calculated measures, outcomes are determined using calculated QM rate values. For structural measures, outcomes are determined using Facility attestation data.

   If a specific QM cannot be calculated for a Facility, e.g., not enough instances in the denominator, the Facility's value will be imputed, i.e., the Facility will be assumed to perform at the state median, as calculated by the Data Intermediary.

3. **Scoring (Calculation of Points):** Each QM is worth a certain number of points. Each Facility's QM performance outcomes are compared to established cut points. Points are assigned for each QM based on the point ranges below, then the points are summed.

(SEE TABLE ON NEXT PAGE)

NAME	IDENTIFIER	DATA SOURCE	BASELINE TIMEFRAME	POINTS				
				20	40	60	80	100
Long Stay Prevalence of Pressure Ulcers	CMS N045.01	Calculated from MDS data	CY 2024	≥16.28%	11.11-16.27%	7.63-11.10%	4.28-7.62%	< 4.28
Long Stay Falls with Major Injury	CMS N013.02	Calculated from MDS data	CY 2024	≥7.48%	4.97-7.47%	3.20-4.96%	1.67-3.19%	< 1.67%
Long Stay Weight Loss	CMS N029.02	Calculated from MDS data	CY 2024	≥12.13%	8.66-12.12%	5.84-8.65%	2.97-5.83%	< 2.97%
Long Stay Worsened ADL	CMS N028.03	Calculated from MDS data	CY 2024	≥29.30%	21.51-29.29%	15.64-21.50%	10.39 - 15.63%	< 10.39%
Long Stay Hospitalization	Net Health NQF #2827	Calculated from MDS data	CY 2024	≥19.45%	13.80-19.44%	9.03-13.79%	4.30-9.02%	< 4.30%

NAME	IDENTIFIER	DATA SOURCE	BASELINE TIMEFRAME	POINTS	
				0	100
Infection Control Program Structural Measure	State-Derived	Facility attestation	CY 2025	Requirements not met	Requirements met
Patient Experience Structural Measure	State-Derived	Facility attestation	CY 2025	Requirements not met	Requirements met
Behavioral Health Care Coordination Structural Measure	State-Derived	Facility attestation	CY 2025	Requirements not met	Requirements met

NAME	IDENTIFIER	DATA SOURCE	BASELINE TIMEFRAME	POINTS				
				0	50	100	150	200
CMS Health Inspection Score	CMS	Reported by CMS	CY 2024	TBD*	TBD*	TBD*	TBD*	TBD*

*Cut points TBD secondary to CMS changes to the Health Inspection Score effective 7/30/2025.

4. **Determination of Performance Tier:** The total number of points determines the Facility's performance tier as shown in the table below. The performance tier determines the percentage of maximum Facility-specific payment the Facility receives.

TIER	POINTS REQUIRED
Tier 1	820-1000
Tier 2	640-810
Tier 3	460-630
Tier 4	290-450
Tier 5	100-280

5. **Calculation of Tiered Percentage Quality Payment:** The applicable tier percentage from the table below is applied to the per diem rate, and the resulting rate is multiplied by the number of Medicaid Bed Days attributable to the Facility to determine the Tiered Percentage Quality Payment for that Facility.

Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
100%	75%	50%	25%	0%

(Per Diem Rate * Tier Percentage) * Facility Medicaid Bed Days = Initial Tiered Percentage Quality Payment

6. **Calculate High-Acuity Add-On:** A High-Acuity Add-On payment is calculated based on the Facility's High-Acuity Medicaid Bed Days, by taking the residual funds for the period (across all Facilities) from the Tiered Percentage Quality Payment Calculation and dividing that by the sum of High-Acuity Medicaid Bed Days for the Facilities that have High-Acuity Medicaid Bed Days. This High-Acuity Per Diem is then multiplied by the Facility's High-Acuity Medicaid Bed Days to arrive at the High-Acuity Add-On payment.

   (Residual Funds) / (Sum of High-Acuity Medicaid Bed Days) = High-Acuity Per Diem

   High-Acuity Per Diem * High-Acuity Medicaid Bed Days for Facility = High-Acuity Add-On Payment

7. **Calculate Total Quality Payment:** The Total Quality Payment is calculated by summing the Facility's Tiered Percentage Quality Payment and High-Acuity Add-On Payment (if applicable).

   Adjusted Tiered Percentage Quality Payment + High-Acuity Add-On Payment = Total Quality Payment

SCHEDULE OF PAYMENTS

Facility Quality Payments shall be made based on the schedule below.

Performance Period	SFY	Payment By*
July 1, 2025 – September 30, 2025	Q1 SFY26	January 30, 2026
October 1, 2025 – December 31, 2025	Q2 SFY26	April 30, 2026
January 1, 2026 – March 31, 2026	Q3 SFY26	July 30, 2026
April 1, 2026 – June 30, 2026	Q4 SFY26	October 30, 2026
etc.	etc.	etc.

**Dates are subject to change based on CMS Preprint approval.*

MDS DATA AND CALCULATION REVIEW PROCESS

Successful administration of the program depends on the Facility's timely and appropriate submission of MDS data to the Data Intermediary, related engagement with the Data Intermediary, agreement to correct MDS data as needed, to review resultant calculation, and to challenge resultant calculations if indicated. Quality Payments based on each Facility's performance are dependent on timely finalization of the Quality Payment calculation process and are dependent on Facilities' respective performance.

A Pay for Performance Scorecard ("P4P Scorecard") is provided by the Data Intermediary to each Facility with MDS data reported by the Facility, Quality Measures outcomes, and payment calculations showing the amounts earned by the Facility for the Quarter.

1. Facilities shall ensure that, during and throughout the course of each Quarter, they will:
    a. Report MDS data to the Data Intermediary no less frequently than monthly (more frequent reporting is strongly encouraged); and
    b. Promptly review and communicate any questions, concerns, or challenges to the Data Intermediary regarding estimated and final P4P Scorecard calculations furnished or made accessible by the Data Intermediary to the Facilities during each Quarter.

2. For 30 days following the conclusion of each Quarter, Facilities have a further opportunity to submit new or corrected MDS data and communicate questions or concerns to the Data Intermediary. During this 30-day review period, Facilities may:
    a. Submit to the Data Intermediary any new (i.e., previously unsubmitted) MDS data for the just-concluded Quarter;
    b. Submit to the Data Intermediary any corrections to previously submitted MDS data for the just-concluded Quarter; and
    c. Communicate to the Data Intermediary any final questions, concerns, or challenges about the P4P Scorecard calculations applicable to their respective Facility.

3. A Facility's failure to adhere to the processes outlined in this section will reduce or potentially eliminate their opportunities to review and challenge the P4P Scorecard calculations reported by the Data Intermediary. At the conclusion of the 30-day review period, Facilities will have no further rights to submit new MDS data nor to review or challenge the correctness of their Facility's previously submitted MDS data or the P4P Scorecard calculations and results, whether with the Data Intermediary, MCOs, or HCA.

4. After the 30-day review period, the Data Intermediary will make available the P4P Scorecard results to the MCOs for their review. The P4P Scorecards and related VBP payment amounts produced by the Data Intermediary following the MCOs' review shall be final and binding, with no further reconciliation for the applicable Quarter.

5. MCOs will issue payment to the Facilities based on the payment schedule in the chart above.

6. If a Facility inaccurately reports its taxable base, the Facility has the responsibility to inform Myers & Stauffer to correct the reporting. If the reporting is for prior period(s), the increase/decrease to the available funds will be made in the current period. This amount will be communicated from HCA to the Data Intermediary.

FACILITY CHANGES OF OWNERSHIP (CHOW)

The following requirements must be met for quality assessment, payment calculation, and Facility access to the P4P Dashboard and other Net Health solutions.

The HCQS VBP Eligibility Date begins the quarter the new owner receives an "Approved Medicaid Application" from HCA, if the following conditions are met by the last day of that quarter (no exceptions may be made):

- Net Health receives the required signed contracts/agreements back from the New Owner.
- Net Health has the historical MDS data loaded into the New Owner's entity.
- Net Health has made required system updates to accommodate the CHOW.

Until the New Owner has an "Approved Medicaid Application" from the Health Care Authority and has met the HCQS VBP Eligibility requirements, the following will occur:

- Prior Owner's MDS data will be used for quality assessment calculation.
- Prior Owner's Medicaid Bed Days will be used for quality payment calculation.
- Prior Owner will receive quality payment.

If the New Owner has an "Approved Medicaid Application" and has met all HCQS VBP Eligibility Date conditions stated above, then:

- New Owner's MDS data will be used for quality assessment calculation.
- New Owner's Medicaid Bed Days will be used for quality payment calculation.
- New Owner will receive quality payment, if the new owner meets requirements below
    - Net Health may not calculate payments for an MCO for the New Owner until:
        - An "Enrolled Medicaid ID" is approved by HCA for the New Owner and is showing as active in the NM Medicaid system, and Net Health is notified by HCA.
        - The MCO contracting process is complete with the New Owner, and Net Health is notified by the MCO.

DEFINITIONS

ADJUSTED MEDICAID BED DAYS: Adjustments in FACILITY bed days required based on prior period adjustments to reporting.

DATA INTERMEDIARY: This refers to Net Health, the company selected by HCA and engaged by the MCOs to calculate the amount of the QUALITY PAYMENT to each of the eligible Facilities.

FACILITY: Participating Nursing Facility.

FACILITY MEDICAID BED DAYS: The sum of the number of days that each bed was occupied by a patient who was covered by Title XVIII of the Social Security Act for an individual FACILITY as reported on quarterly HCQS tax reports which include Medicaid Fee for Service, Medicaid Managed Care, and Medicaid Hospice days.

HIGH-ACUITY: High-acuity residents will be identified through the MDS data set, Section I as per federal MDS guidelines, with certain behavioral health and complex neurological conditions, including cerebral palsy, multiple sclerosis, ALS (G12.21), Lewy-Body dementia, dementia with behavioral disturbance (MDS I8000 = F03.918, FO3.911, F02.818, or F02.811), Parkinsons, psychotic disorder, manic depression (bipolar disease), Schizophrenia, PTSD, Huntington's Disease, Tourette's Syndrome, or TBI.

HIGH-ACUITY ADD-ON: Additional payment made to a FACILITY based on their High-Acuity Medicaid Bed Days.

HIGH-ACUITY MEDICAID BED DAYS: The sum of the number of days that each bed was occupied by a patient who fits the definition of High-Acuity.

MEDICAID BED DAYS: The sum of the number of days that each bed was occupied by a patient who was covered by Title XVIII of the Social Security Act.

PER DIEM RATE: Calculated Rate based on the total amount of monies allocated to the HCQS VBP program divided by sum of the total number of Medicaid Bed Days across all Facilities and MCOs.

PERFORMANCE TIER: Based on the summation of points earned by the FACILITY'S Quality Measures.

QUARTER: Refers to a fiscal calendar year QUARTER commencing July 1, e.g. July 1 through September 30 is the 1st Quarter whereas January 1 through March 31 is the 3rd QUARTER.

QUALITY MEASURE: Metrics selected to assess FACILITY performance and analyze FACILITY improvement in quality.

QUALITY PAYMENT: Quarterly payments made to Nursing Facilities based on QUALITY MEASURE performance. Payments will be based on data collected in the QUARTER four months prior. Refer to the schedule at the end of the document for payment timing for respective periods.

RESIDUAL FUNDS: Funds remaining at the end of a QUARTER that were not allocated based on the TIER PERCENTAGE methodology and penalties applied.

TIER PERCENTAGE: Allocation percentage of the Per Diem Rate based on a FACILITY'S Performance Tier.

TIERED PERCENTAGE QUALITY PAYMENT: Payment based on the FACILITY'S performance on QUALITY MEASURES.

TOTAL FUNDS: Total amount of monies available for the HCQS VBP QUALITY PAYMENT for the given QUARTER.

TOTAL QUALITY PAYMENT: The sum of the FACILITY'S TIERED PERCENTAGE QUALITY PAYMENT and HIGH-ACUITY ADD-ON PAYMENT.

YEAR: The HCQS VBP program is based on the State Fiscal Year, July 1st through June 30th.