HEALTH CARE AUTHORITY

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
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Letter of Direction #36-2

Date: **February 27, 2025**

To: **Turquoise Care Managed Care Organizations**

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

Subject: **Medicaid Provider Payment Rates**

Title: **State Fiscal Year 2025 Payment Rate Increases**

The New Mexico Health Care Authority (HCA) raised Medicaid provider payment rates effective January 1, 2025, as outlined in House Bill 2 (HB2). Raising Medicaid payment rates will ensure access to high-quality care for Medicaid members through appropriate reimbursement of health care services as well as attract and retain healthcare providers to New Mexico. HSD believes that these rate adjustments will help build and protect the New Mexico Medicaid health care delivery network. The proposed rate increases were supported, endorsed and funded by the New Mexico Legislature during the 2024 regular session.

The purpose of this Letter of Direction (LOD) is to direct Managed Care Organizations (MCO) on the implementation of the provider rate increases that are described in the October 9th, 2024 public notice. This increase shall apply to each provider's contracted rates with each MCO. As outlined in HB2 the MCOs shall not negotiate less than the Medicaid fee-for-services (FFS) rate. This includes rates negotiated between MCOs and sub vendors or sub-contractors. Any rate paid to providers for services to Medicaid members within the state of NM must use the MAD FFS rate as the minimum rate. The Agency expects MCOs to maintain current levels of reimbursement for providers who may be contracted above the rate increases outlined in this LOD.

1. For Maternal & Child Health, Physician & Other Practitioners, and Behavioral Health service areas MCOs are directed to increase payment **to a minimum of 150% of the 2024 Medicare fee schedule**, effective January 1st, 2025, as defined in the rate table attached. This increase shall apply to each provider's contracted rates with each MCO.

2. For all codes in other service areas where Medicare FFS rates are available MCOs are directed to increase payment **to a minimum of 100% of the 2024 Medicare fee schedule**, effective January 1, 2025, as defined in the rate table attached. This increase shall apply to each provider's contracted rates with each MCO.

3. For all other identified codes in other service areas without a Medicare rate, MCOs are directed to increase payment to **at least the FFS amount on the table attached,** effective

January 1st, 2025. This increase shall apply to each providers contracted rates with each MCO.

Accredited Residential Treatment Centers for Adults with Substance Use Disorders

Prior to January 2025, reimbursement is made at a facility specific daily rate established by the agency state audit agent after analyzing the costs to provide services.

Beginning January 1, 2025, Tier 1 services are reimbursed at a statewide prospective rate established by the State of New Mexico.

Beginning January 1, 2025, Tier 1 services are reimbursed at the greater of the facility specific daily rate previously established or the statewide prospective rate established by the State of New Mexico.

RHC/FQHC

For rural primary care clinics and Federally Qualified Health Centers (FQHCs), MCOs are directed to increase payment according to the rate letter sent to the provider. FQHC rates are retroactively effective **October 1, 2024**. This increase shall apply to each provider's contracted rates with each MCO.

Community Benefit Rate Increase

a. Agency-Based Community Benefit

Rates for all Agency-Based Community Benefit (ABCB) services shall be increased effective January 1, 2025 as indicated in the table below. *(Do not refer to the attached special rate tables for ABCB services.* If codes are not listed, there is no increase. MCOs must collaborate with ABCB providers to minimize the administrative burden of this rate increase on providers.

Table 1 Agency Based Community Benefit Rate increases effective 1/1/25

ABCB Procedure Code	Service Name	Percent of increase
T1019	Personal Care-Delegated	1.3%
99509	Personal Care-Directed	1.3%
S5110	Personal Care-Training	1.3%
G9006	Personal Care-Admin Fee	1.3%
S5100	Adult Day Health	1.3%
T1002 U1	Respite Provided by RN	1.3%
T1002	Private Duty Nursing Provided by RN	1.3%
S9122	Home Health Aide	17.1%
H2019	Behavior Support Consultation	17.1%
H2019 TT	Behavior Support Consultation (Clinic Based)	17.1%
T1003 U1	Respite Provided by an LPN	1.3%

T1003	Private Duty Nursing Provided by LPN	1.3%
G0151	Physical Therapy	1.3%
G0152	Occupational Therapy	1.3%
G0153	Speech Therapy	1.3%
S9470	Nutritional Counseling	1.3%

a. *Self-Directed Community Benefit*

Self-Directed Community Benefit (SDCB) rates in the Range of Rates Table (Table 2 below) shall be increased effective January 1, 2025 as indicated below. If an SDCB code is not listed, there is no increase. All current rates that fall below the updated minimum amount in the table below shall be increased in collaboration with the Employer of Record (EOR)/Member. All rates currently within the updated range of rates below can be increased as requested by the EOR/Member.

Effective January 1, 2025, the SDCB Range of Rates Table (Table 2 below) should be used to develop new budgets and implement budget revisions. For the impacted SDCB codes below, table 2 should be utilized until updated in the Managed Care Policy Manual.

MCOs have the responsibility to inform their Support Brokers (SB) of the increase in the SDCB range of rates. SBs must work with the SDCB members to determine updated employee and vendor rates. All SDCB members who are updating employee and vendor rates must work with their Care Coordinators and SBs to increase budgets. MCOs must ensure all rates are updated to reflect at least the minimum rate allowed within 60 days of issuance of this Letter of Direction. MCOs must work with Conduent and FOCoS to ensure that the new Range of Rates are reflected correctly in the FOCoS system, and that all Conduent forms are updated as needed within 60 days of the issuance of this LOD.

Table 2: Self-Directed Community Benefit (SDCB) rates in the Range of Rates effective 1/1/25

SDCB Procedure Code	Service Name	1/1/25 Updated SDCB Rate	Unit
S5100	Customized Community Supports	$1.44-9.35	15 min
99509	Self-Directed Personal Care	Minimum wage-$15.48	hour
G0151	Physical Therapy	$14.32-25.67	15 min
G0152	Occupational Therapy	$13.52-25.14	15 min
G0153	Speech/Language Pathology	$17.03-25.68	15 min
H2019	Behavior Support Consultation	$15.00-25.32	15 min
S9122	HH Aide	$20.00	hour
S9470	Nutritional Counseling	$45.41	hour
T1002	Private Duty Nursing- Adults- RN	11.56	15 min

T1003	Private Duty Nursing- Adults- LPN	$7.20	15 min
T1005	Respite-RN	$11.56	15 min
T1005	Respite-LPN	$7.20	15 min

Pay Parity
For non-physician practitioners, MCOs are directed to implement pay parity between physicians and non-physician practitioners. For services that are within the scope of licensure or certification for:

- Certified Nurse Practitioners,
- Physician Assistants,
- Clinical Nurse Specialists,
- Certified Registered Nurse Anesthetists,
- Anesthesiologist Assistants,
- Certified Nurse Midwives
- Licensed Midwives,
- Audiologists,
- Dietician
- Nutritionists,
- Dental Hygienists,
- Licensed Clinical Social Workers
- Licensed Clinical Counselors, and
- Therapists, and other Social Workers.

MCOs will remove reduced reimbursement based on level of licensure.

Implementation
All the rate increases described in this LOD have been calculated and considered as a component of the MCO capitation rates that will be effective January 1, 2025. No reductions have been applied to rates exceeding the assigned threshold and are not considered in the MCO capitation rates and should not be imposed upon providers. HSD pays at the FFS rate plus the gross receipt tax. The MCO administrative costs include gross receipt tax (GRT) in the CAP adjustments.

All rate increases must be completed and all claims with dates of service on or after January 1, 2025 must be adjusted and paid within 60 days of issuing this LOD. HCA has updated the Procedure Pricing Code SPAN file. MCOs must ensure alignment with pricing in this file and all published fee schedules.

All services provided via telehealth, designated with the GT modifier, must be reimbursed equivalent to the pricing for the service without the GT modifier.

HCA identified that service codes for evening, weekend, and holiday differentials (identified with modifiers TV and UH) were incorrectly priced in prior versions of this LOD. Attached please find revised pricing for these services.

> **NOTE:** FQHC rates are effective October 1, 2024. For FQHC claims submitted after October 1, 2024, but not paid based on these parameters, the MCOs are directed to adjust

payments retroactive to October 1, 2024. The deadline to reprocess claims is 60 days from the date of this LOD.

HCA directs MCOs that no rates shall be reduced as a result of this LOD or attached rate table. If an MCO identifies a potential reduction they are directed to contact HCA. This LOD may be amended to address additional rate adjustments for FY2025.

Attachment: AARTC Rate Table
Revisions to Select Behavioral Health Codes

Accredited Adult Residential Treatment Center (AARTC) for SUD Fee Schedule

RENDERING PROVIDER REQUIRED	REVENUE CODE	CPT OR HCPCS CODE	DESCRIPTION WITHIN MEDICAID PROGRAM	FEE SCHEDULE AMOUNT
Residential Treatment Centers for Adults (Substance Use Disorders)				
Report Referring or Ordering Provider in the Attending Provider Field	1003	H0017	Tier 3 - ASAM levels 3.7 and 3.7WM placement criteria for medically monitored short term residential addiction program.	$607.98/day
Report Referring or Ordering Provider in the Attending Provider Field	1003	H0018	Tier 2 - ASAM 3.2WM, 3.2, 3.3, 3.5 placement criteria. Clinically monitored, medium to high intensity level of care for sub-acute, detoxification and/or residential addiction program.	$349.76/day
Report Referring or Ordering Provider in the Attending Provider Field	1003	H0019	Tier 1 - ASAM 3.1 placement criteria. Clinically monitored, low intensity level of care long-term residential (non-medical, non acute care in a residential treatment program).	$249.04/day

Revisions to Select Behavioral Health Codes Effective 1.1.25

CPT OR HCPCS CODE	DESCRIPTION WITHIN MEDICAID PROGRAM	MODIFIERS IF APPLICABLE	Revised Rate
90785	ADD ON CODE see CPT description Unit = 1 service Max Units = 1	TV or UH	$25.49
90791	Psychiatric Diagnostic Evaluation see CPT description Unit = 1 service Max Units = 1	TV or UH	$299.06
90792	Psychiatric Diagnostic Evaluation with Medical Services see CPT description Unit = 1 service Max Units = 1	TV or UH	$336.67
90832	Psychotherapy see CPT description Unit = 30 min Max Units = 2	TV or UH	$136.20
90833	PSYCHOTHERAPY WITH MED EVALUATION AND MANAGEMENT SERVICES see CPT description Unit = 30 min Max Units = 2	TV or UH	$125.20
90834	Psychotherapy see CPT description Unit = 45 min Max Units = 2 One session is billed as 1 unit	TV or UH	$233.09
90836	PSYCHOTHERAPY WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES see CPT description Unit = 45 min Max Units = 2	TV or UH	$158.14
90837	Psychotherapy see CPT description Unit = 60 min Max Units = 1 One session is billed as 1 unit	TV or UH	$264.79
90838	PSYCHOTHERAPY WITH MEDICAL EVALUATION AND MANAGEMENT SERVICES see CPT description Unit = 60 min Max Units = 1	TV or UH	$209.65
90839	PSYCHOTHERAPY CRISIS see CPT description Unit = 1 for first 60 min Max Units= 1	TV or UH	$254.82
90840	PSYCHOTHERAPY CRISIS for additional 30 minutes see CPT description Unit = 1 service Max Units = 1	TV or UH	$126.42
90849	MULTIPLE-FAMILY GROUP PSYCHOTHERAPY see CPT description	TV or UH	$64.15
H0015	Intenstive Outpatient (IOP) Substance Use Disorder (SUD) for Youth (at least 1.5 houres of service	HA	236.91
HS9480	Intenstive Outpatient (IOP) Mental Healht (MH) for Youth (at least 1.5 houres of service	HA	236.91