HEALTH CARE AUTHORITY

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

**Letter of Direction #56**

**Date:** **May 28, 2025**

**To:** **Turquoise Care Managed Care Organizations**

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

**Subject:** **Medical Respite Services**

**Title:** **Billing and Reimbursement of Medical Respite Services for Individuals Experiencing Homelessness**

The purpose of this letter of direction is to provide Turquoise Care (TC) Managed Care Organizations (MCO) with billing and implementation guidance for medical respite services. New Mexico Medicaid is adding coverage for medical respite services under the 1115 Waiver as a new reimbursable benefit for post-acute recuperative care including room and board for individuals experiencing homelessness with the goal of improving health, reducing readmissions, and reducing costs. This benefit is effective June 1, 2025.

Medical respite services are short-term post-hospitalization housing with room and board for up to six months per year, where integrated, clinically oriented recuperative or rehabilitative services and supports are provided. Post-hospitalization housing services are limited to a clinically appropriate amount of time and no more than 180 days.

Medical respite is for Medicaid members who are homeless and who are too ill to recover from sickness or injury on the street or in a shelter but do not require hospital level care.

1. **Provider Eligibility Requirements:**
   a. Attestation that provider adheres to National Institute for Medical Respite Care (NIMRC) Standards developed by the National Health Care for the Homeless Council.
   b. A Medical Respite provider **must** be enrolled with New Mexico Medicaid as
      i. Provider Type 313 Federally Qualified Heath Centers
      Note: This benefit may experience expansion to include additional provider types and/or provider type specialties.
   c. A medical respite provider must
      i. Adhere to NIMRC Standards developed by the National Health Care for the Homeless Council.

ii. Develop and maintain an individual clinical care plan by an appropriately licensed clinical provider. Each care plan will be developed in conjunction with the member, will include input from the Medical Respite Nurse Manager's assessment of need and will be reassessed periodically as appropriate for the member's condition and length of stay.
iii. Have trained personnel who are equipped to address the needs of people experiencing homelessness.
iv. Adhere to applicable quality environmental services such as but not limited to infection control, inventory management, and staff training
v. For services that would extend beyond the initial 60 days, the medical respite provider must conduct a clinical assessment of the recipient to determine if the recipient meets the inclusion/exclusion criteria outlined in MCO Member Eligibility requirement.

2. **MCO Member Eligibility:**
   a. Medicaid eligible member who is experiencing homelessness and who is too ill to recover from sickness or injury on the street or in a shelter, do not require hospital level care.
   b. An individual must be referred to by a hospital partner and assessed by a nurse manager to meet the inclusion/exclusion criteria for medical respite.
      i. Member eligibility inclusion criteria **includes all** of the following:
         1. Are hospitalized and preparing for discharge,
         2. Have full decision-making capacity,
         3. Can live independently,
         4. Have an acute or chronic clinical issue that is likely to resolve, improve greatly, or stabilize through a Medical Respite stay, and
         5. Have been assessed by a Medical Respite Nurse Manager for medical respite and referred from a hospital partner.
      ii. Member eligibility exclusion criteria **includes any one or more** of the following:
         1. Conditions that require services the medical respite provider site cannot support (e.g., PICC lines, wound vacuums, IV fluids or IV antibiotics), This may vary by provider site and capacity,
         2. Person requires medical help to take medications,
         3. Person is unable to perform activities of daily living (ADLs),
         4. Person is incontinent and cannot self-manage,
         5. Person has high-acuity behavioral health needs requiring inpatient hospitalization.
3. **Prior Authorization:** Prior authorization is not required. Provider must retain clinical assessment for medical respite care exceeding 61 days but not to exceed 180 days.
4. **Billing and Reimbursement:** Medical respite providers will bill and be reimbursed for services as described in this LOD.
   a. **Managed Care claims must:**
      i. **Claim Form:** Submitted on UB-04 Claim Institutional Claim or CMS-1500 Professional Claim form. UB-04 Institutional claims must include the procedure code and modifier.
      ii. **Diagnosis Code**: The Diagnosis Code Z59.00, Z59.01, Z59.02 must be listed

in the first 5 positions.

iii. **Codes:** Must use codes outlined in the Reimbursement section below.

b. In instances where a Medical Respite provider also provides additional services beyond Medical Respite (e.g. FQHC services), and a Medicaid member receives both Medical Respite and these other services within the same day, the provider shall submit claims for the Medical Respite services and non-Medical Respite services separately. In this case providers could submit separate claims or one claim with separate line items.

c. **Reimbursement:** Medical respite service reimbursement are non-risk therefore managed care organizations must reimburse as follows for **HCA approved providers**. This per diem rate includes skilled nursing, medical case management, and housing.

Table 1: Medical Respite Coding and Rates

| Medical Respite Coding and Rates | | | |
|---|---|---|---|
| Revenue Code | Code and Description | Modifier | Rate |
| 0969 | T2033 Residential Care, Not Otherwise Specified (Nos), Waiver; Per Diem | U1- Medical Respite for Individuals Experiencing Homelessness | $331 |

i. Any claims for medical respite services reimbursed at rates that exceed the rate outlined above must be reprocessed by the MCO and paid to reflect the rate above. MCOs must allow providers to resubmit any claims that were initially denied for missing or incorrect information within 90 days of the effective date of this LOD.

d. The MCO's will allow providers who have met the requirements listed above and provided medical respite services to Medicaid eligible members within dates of service June 1, 2025, to the present to submit a claim for the medical respite services and avoid timely filing denials. MCO's will allow providers 90 days from the effective date of this LOD to submit and resubmit a claim and avoid a timely filing denial.

5. **Reporting of Medical Respite Reimbursement:** The Medical Respite reimbursement will be operationalized as a non-risk arrangement. HCA will make separate payments to the MCO based on the applicable utilization for Medical Respite as reported by the MCO.

   a. The MCOs are required to submit utilization and paid amounts by provider group, revenue code, rate cohort, and month as prescribed below. The TC MCO is required to submit utilization and paid amounts as prescribed in table 1. This data will be refreshed quarterly and will be the source for the quarterly payment amounts. Data is due each quarter. MCOs must submit the data via the DMZ no later than ten (10) business days after the last business day of the prior quarter. Note that the first data submission is required ten business days after the close of the quarter in which this LOD is effective, and quarterly thereafter.

   b. Report Format Requirements:

i. File Name Structure: [MCO acronym].[LOD reference].[submission reference].[calendar year reporting cycle].[version]
ii. Acceptable File Formats: Delimited text file (*.txt or *.csv)
iii. Requirements:
    1. Table 1 illustrates the data required and information about how the field should be formatted. Table 2 provides an example of the data output.
    2. The report should include incurred and paid claims with dates of service up to and including the specified period.
    3. Denied or voided claims should be excluded.
    4. Rate cohort assignment must be based on the cohort assignment for the member as of the incurred date of the claim.

**Table 2 - Medical Respite Data File Fields**

| Field Name | Field Information | Format |
|---|---|---|
| Date of Service | The date of service must be formatted as a 4-character year, a 2-character month, and a 2-character day. "YYYYMMDD" | Text |
| Billing Provider NPI | 1234567890 | Text |
| Provider Type | Billing provider type associated with the claim. | Text |
| Procedure Code | CPT or HCPCS Code. Procedure Code should exclusively include T2033 | Text |
| Procedure Code Modifier | Procedure Code Modifier should exclusively include U1. | Text |
| Revenue Code | Revenue Code should exclusively include 0969 | Text |
| Rate Cohort | This should be the rate cohort assigned by HCA to the member for the month the service was incurred. If a member cohort is changed retroactively by HCA, the report should reflect the cohort assigned as of the date of the report.<br><br>Acceptable values align with Financial Reporting Package Rate Cohorts: 001, 002, 003, 004, 005, 006, 007, 008, 009, 010, 011, 012, 013, 300A, 300B, 300C, 301, 302A, 302B, 302C, 303, 304, 310, 312, 320, 322, 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121, 122 (113 does not exist) | Text |
| Units | The claim count associated with per-diem Medical Respite Claims | Number |
| Paid Amount | Amount paid by the MCO | Number |

**Table 3 - Medical Respite Data File Example**

| Date of Service | Billing Prov NPI | Prov Type | Proc Code | Proc Code Mod | Rev Code | Rate Cohort | Units | Paid Amount |
|---|---|---|---|---|---|---|---|---|
| 20250201 | 1234567890 | 313 | T2033 | U1 | 0969 | 300C | 1 | 331.00 |
| 20250201 | 1234567890 | 313 | T2033 | U1 | 0969 | 013 | 3 | 993.00 |
| 20250201 | 1234567890 | 313 | T2033 | U1 | 0969 | 110 | 2 | 662.00 |

c. HCA will make these payments to the MCO on a quarterly basis. The amount of the quarterly payment to the MCO will be based on the distribution of claims. For each quarter HCA will evaluate the claims data to determine the quarterly distribution and update the payment for the MCO. Note that the first payment will cover dates of service from the effective date of this LOD through June 30, 2025. Payments will be made quarterly thereafter.

This LOD will sunset when the contents have been incorporated into the Managed Care Program and other HCA Policies.