State of New Mexico
Medical Assistance Program Manual

Supplement

HEALTH CARE AUTHORITY

DATE: **May 28, 2025** **NUMBER: 25-08**

TO: **All PRACTITIONERS**

FROM: **DANA FLANNERY, MEDICAL ASSISTANCE DIVISION**

THROUGH: **ALANNA DANCIS, DNP, CHIEF MEDICAL OFFICER**

SUBJECT: **BILLING AND REIMBURSMENT FOR MEDICAL RESPITE SERVICES FOR INDIVIDUALS EXPERIENCING HOMELESSNESS**

The purpose of this supplement is to provide Turquoise Care (TC) providers 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 recipients 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 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, 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 New Mexico Medicaid Recipient Eligibility requirement.

2. **New Mexico Medicaid Recipient 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 but 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 exceed180 days.
4. **Billing and Reimbursement:** Medical respite providers will bill and be reimbursed for services as described in this supplement.
   a. **Billing Requirements:**
      i. **Claim Form:** Submitted on UB-04 Institutional Claim or CMS-1500 Professional Claim. UB-04 Institutional claims must include the procedure code and modifier.
      ii. **Diagnosis Code**: The Diagnosis Code Z59.00, Z59.01 or Z59.02 must be listed in the first 5 positions.
      iii. **Codes:** Must use codes outlined in the Reimbursement section below.
   b. **Reimbursement:** Medical respite services are reimbursed for **HCA approved providers** at a per diem rate includes skilled nursing, medical case management, and housing.

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	$331

		Experiencing Homelessness	

c. In instances where a Medical Respite provider 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.
d. The HCA 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. HCA will allow providers 90 days from the date on Supplement to submit a claim and avoid a timely filing denial.

For questions regarding this guidance, please contact the Medical Assistance Division, Benefits and Reimbursement Bureau at madinfo.hca@hca.nm.gov.