DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

April 25, 2025

Dana Flannery
Medicaid Director, Medical Assistance Division
New Mexico Human Services Department
State Capitol
Room 400
Santa Fe, NM 87501

Dear Director Flannery:

The Centers for Medicare & Medicaid Services (CMS) is approving the Health-Related Social Needs (HRSN) services payment methodology document that the state submitted on March 26, 2025, in accordance with special term and condition (STC) 10.14. This document reflects the payment methodologies New Mexico will use for covering the state's HRSN benefits, as authorized by the section 1115 demonstration, "New Mexico Turquoise Care" (Project Number 11-W00285/6).

This approval is conditioned upon compliance with the previously approved STCs, which set forth in detail the nature, character, and extent of anticipated federal involvement in the project.

We look forward to our continued partnership on the New Mexico Turquoise Care section 1115(a) demonstration. If you have any questions, please contact your project officer, Juliana Sharp at Juliana.Sharp@cms.hhs.gov.

Sincerely,

Angela D. Garner -S

Digitally signed by Angela D. Garner -S
Date: 2025.04.25 07:16:03 -04'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Dana Brown, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Turquoise Care Section 1115 Demonstration
Health-Related Social Needs (HRSN) Services Payment Methodology

Instructions
Submission of Rate Determination Methods Information -- States should fill out this template completely as part of the initial submission of new payment methodologies for Medicaid Section 1115 demonstration-authorized services, or when making significant changes to already approved payment methodologies. States must provide the same level of detail as required under the state plan or under 1915(c) waivers in order to receive CMS approval.

Submission of Attestations / Reattestations -- Alternatively, states may also choose to use this template to identify applicable approved waiver or approved state plan pages representing payment methodologies that would apply to the services listed in this template and attest to such. If those rate methods are updated, then the state could re-attest.

State Attestations and Re-Attestations
Attestations **1.** If currently CMS-approved 1915(c) waiver or state plan pages represent the payment methodologies for Medicaid services that the state will also apply to the same or similar 1115-approved services as listed in this template, the state may attest to this here. **NM HCA Response: N/A** All requested elements (a. through d.) must be completed: **a.** Provide SPA transmittal or waiver identification number representing applicable approved payment methodologies: [ ] **b.** Provide State Plan pages or waiver sections for applicable payment methodologies: [ ]. **c.** List 1115 approved services to which the currently CMS approved methodologies will apply: **d.** The state attests that the payment methodologies described in this template do not duplicate payment for other services, consistent with the limitations on improper payments in 42 CFR 431.958 and 42 CFR 431.960(b)(3)(i). The state attests it has processes to ensure duplication of payment does not occur, consistent with requirements for prepayment and postpayment claims review in 42 CFR 447.45(f)(1)(iii). **e.** I, [insert name of SMD or CFO (or equivalent position] [insert title], attest that the above information is complete and accurate in identifying currently CMS approved payment methodologies that the state will use for similar 1115 approved services as listed above in c. **[Signature _____]** **[Name of signatory]**

[Date_____]

2. If the state is contracting with Medicaid managed care plans to deliver demonstration-authorized services using a non-risk arrangement in a Medicaid managed care program, the state must also use the same payment methodology as reflected in this document. The state must comply with 42 CFR 447.362 and attest to this compliance below. If the state does not contract through non-risk arrangements for demonstration-authorized services in a Medicaid managed care program, it should proceed to item 2(b).

If the state provides demonstration-authorized services in more than one program, this section should be completed individually for each program.

a. I, Elisa Walker-Moran, Deputy Finance Director, attest the State of New Mexico contracts with Medicaid managed care plans to deliver demonstration-authorized services through using non-risk arrangements for medical respite services in the Turquoise Care Medicaid Managed Care Program, using the same payment methodologies outlined in this document in its managed care contract, and is in compliance with 42 CFR 447.362.

[Signature_____]

[Name of signatory] ___Elisa Walker-Moran_____]

[Date 3/26/2025]

b. New Mexico contracts with Medicaid managed care plans to deliver demonstration-authorized HRSN nutrition services in Turquoise Care on a risk-basis and these services are accounted for in risk-based capitation rates in accordance with Federal requirements including 42 CFR §§ 438.4, 438.5, 438.7, etc. [ ].

Re-Attestations

If changes are made to payment methodologies referenced in this re-attestation, the state is required to provide updated information and re-attest to this information using this same attestation form, and by also indicating that this is a re-attestation by completing the following information: **NM Response: N/A**

If currently CMS approved 1915(c) waiver or state plan pages represent the payment methodologies for Medicaid services that the state will also apply to the same or similar 1115 approved services as listed in this template, the state may attest here to this.

All requested elements a. through d. must be completed:

a. Provide SPA transmittal or waiver identification number representing applicable approved payment methodologies: [ ]

b. Provide State Plan pages or waiver section for applicable payment methodologies: [ ].

c. List 1115 approved services to which the currently CMS approved methodologies will apply: [ ]

d. I, [insert name of SMD or CFO (or equivalent position] [insert title], attest that the above information is complete and accurate in identifying currently CMS approved payment methodologies that the state will use for similar 1115 approved services as listed above in c.

Rate Determination Methods

Payment Methodology Overview:

Describe the methods that are employed to establish provider payment rates for services and the entity or entities that are responsible for rate determination. This description should include information for all demonstration-authorized services through fee-for-service payment methodologies. If different methods are employed for various types of services, the description may including groups of services for which the same method is employed. Any State laws, regulations, and policies referenced in the description must be available upon request to CMS.

Submission Question	State Input Field	Citation / Other Guidance
Please comprehensively describe the rate setting methods for each service.	Medical Respite: This per diem fee schedule rate methodology was developed using the "Medical Respite Budget Tool" created by the National Health Care for the Homeless Council. See link here: https://nhchc.org/resource/medical-respite-budget-tool/. See Appendix A for description. HRSN Nutrition Services: See Appendix A for description.	§1902(a)(30)(A); 42 CFR §447.201; §430.10
Is it a fee schedule methodology? If so, describe the methodology.	Medical Respite and HRSN Nutrition Services: Yes. Please see Appendix A for the description.	42 CFR §430.10
Is it an actual cost reimbursement methodology? If so, describe the methodology.	Medical Respite and HRSN Nutrition Services: No	2 CFR Part 200; 45 CFR Part 75

If the state is not following a fee schedule or actual cost, can the rate be determined from the language on the submission of the methodology?	N/A	Federal Requirements for Comprehensive State Plan Payment Methodologies
Does the methodology include any bundled rates? If yes, see Bundled Rate guidance, including required plan language and administrative record information and include the same documentation required of SPA submissions here.	Medical Respite and HRSN Nutrition Services: No	Bundled Rate Payment Methodology
Does the methodology include quality incentive payments? If so, please describe the methodology, including quality metrics.	Medical Respite and HRSN Nutrition Services: No	Quality Incentive Payments in the State Plan
Please provide documentation of public notice of the payment methodology.	Medical Respite: https://www.hca.nm.gov/wp-content/uploads/Interested-Parties-Medical-Respite-Rate.pdf HRSN Nutrition Services: Public notice will be posted on the HCA website.	42 CFR §447.205
Are services subject to the Upper Payment Limit (UPL)? (Covered under the following section 1905(a) benefit categories: inpatient hospital services, outpatient hospital services, nursing facility services, institutions for mental diseases, clinic services, intermediate care facility for the individuals with intellectual disabilities (ICF/IID) services, psychiatric residential	Medical Respite and HRSN Nutrition Services: No	Payment Limit Demonstrations 1902(a)(30)(A) 1903(i)(27) 42 CFR §447.272 42 CFR §447.321 42 CFR §447.325

treatment facility services, and qualified practitioner services (for states that pay targeted supplemental payments), durable medical equipment (DME).		
Is the rate setting method uniform across provider types? If no, describe the basis for variation in rate setting for provider types. Does the state employ multiple rate methods (e.g. for different geographies, tiered rates based on beneficiary acuity, value-based/supplemental payments, etc)? If so, please identify them and to what services they apply.	Medical Respite and HRSN Nutrition Services: Yes, the rate setting method will be uniform across provider types.	§1902(a)(30) (A); 42 CFR §447.201
Describe the rate setting methodology for self-directed services. If not applicable (i.e., the state does not offer self-direction), no justification is necessary. Enter N/A.	N/A	§1902(a)(30) (A); 42 CFR §447.201
If the state is proposing a rate increase for HCBS, is the state also making proportionate increases to self-directed service budgets? If yes, the justification should include a description of the state's methodology to apply rate increases to self-directed services and/or budgets.	N/A	§1902(a)(30) (A)

If not applicable (i.e., the demonstration does not offer self-directed services or the state is not proposing a rate increase), no justification necessary. Enter N/A.		
Specify the entity (entities) responsible for rate determination.	Medical Respite and HRSN Nutrition Services: The New Mexico Health Care Authority and/or HCA's actuary.	§1902(a)(30) (A); 42 CFR §447.201
Specify how the state conducts oversight of the rate determination process.	Medical respite: HCA will monitor emerging provider and program experience with medical respite for any potential changes and will update the rates accordingly. HRSN Nutrition Services: HCA and our actuary will monitor emerging provider, MCO, and program experience with HRSN nutrition services and will update rates accordingly.	§1902(a)(30) (A); 42 CFR §447.201
Specify what year rates were last set and/or reviewed for compliance with § 1902(a)(30)(A) of the Act.	Medical Respite and HRSN Nutrition Services: Rates were last set for services in 2025.	§1902(a)(30) (A)
Does the state have a rate review process that is conducted at least every 5 years? Please describe the process.	HCA will review the Medical Respite and HRSN Nutrition Services rates at least once every 5 years.	§1902(a)(30) (A)
Explain how information about payment rates is made available to HCBS participants.	N/A	42 CFR § 447.203 & 205
Does the state offer per-member per-month (PMPM) or other monthly rates? If not applicable no	N/A	Bundled Rate Payment Methodology

justification necessary. Enter N/A.		
Identify source(s) of non-federal share of payments: [X] State general revenue [ ] Health care-related tax [ ] Intergovernmental transfers (IGT) [ ] Certified public expenditures (CPE) [ ] Bona fide provider-related donation If CPE selected, the state must submit its cost recognition methodology for CMS review. If IGT and/or CPE selected, complete the below IGT/CPE attestation. Approval of this submission template and accompanying information does not constitute approval of the indicated source of non-federal share financing.		§1902(a)(2); §1902(a)(30); §1903(a)(1); §1903(w); 42 CFR §433.51(b)

State Attestation for IGT/CPE

If IGT and/or CPE have been selected as a source of the non-federal share of payments, please attest to the following statements: **N/A**

a. The state attests that the sources of non-federal share used to fund payments under the demonstration are consistent with section 1903(w) of the Act and implementing regulations at 42 CFR 433.51. [ ]

b. The state attests that only units of government may provide the non-federal share of demonstration payments using an IGT or a CPE. [ ]

c. The state attests that providers that receive payments under the proposal keep and retain all payment amounts that are paid to them for approved services and activities described within the demonstration. [ ]

d. The state attests that the amounts paid to units of government that participate in the non-federal share through CPEs represent no more than the total amount, consistent with 2 CFR Part 200 and 45 CFR Part 75 for determining allowable costs, expended by the unit of government for providing approved Medicaid services and activities under the demonstration. [ ]

e. I, [insert name of SMD or CFO (or equivalent position] [insert title], attest that the above information is complete and accurate in identifying IGT and/or CPE as a source of state share funding.

[Signature_____]

[Name of signatory] _____]

[Date_____]

*If changes are made to the payment methodologies referenced in this attestation, the state is required to provide updated information about sources of state share and attest or re-attest to the statements above if IGT and/or CPE are selected.

Supplemental or Enhanced Payments		
Supplemental or Enhanced Payments. Section 1902(a)(30)(A) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for federal financial participation to states for expenditures for services under an approved state plan/demonstration. Specify whether supplemental or enhanced payments (i.e. outcome or value-based payments) are made. Indicate one: • No. The state does not make supplemental or enhanced payments for demonstration services. [X] • Yes. The state makes supplemental or enhanced payments for demonstration services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the 1915(c)-like services for which these payments are made; (b) the types of providers to which such payments are made; and (c) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the demonstration. [ ]		
Submission Question	**State Input Field**	**Citation**

Does the state make supplemental or enhanced payments for demonstration services?	Medical Respite and HRSN Nutrition Services: No	N/A
If supplemental or enhanced payments are made, please describe the nature of the payments made.	N/A	§1902(a)(30)(A)
If supplemental or enhanced payments are made, please specify the types of providers that received these payments.	N/A	§1902(a)(30)(A)
If supplemental or enhanced payments are made, specify whether providers retain 100% of the expenditure.	N/A	§1903(a)(1)
If supplemental or enhanced payments are made, describe the basis of such payments and are the payments transparent (i.e., it is clear to the public which providers would receive the additional payments and under what circumstances).	N/A	§1902(a)(30), 42 CFR § 447.201 & 205

GENERAL GUIDANCE ON BUNDLED SERVICES: 42 CFR §441.301(b)(4) also provides that "multiple services that are generally considered to be separate services may not be consolidated under a single definition."

States with bundled payment methodologies should consult the following guidance on Medicaid.gov when filling out this template: https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/bundled-rate-payment-methodology.pdf

Appendix

Please find additional documentation for the proposed payment methodology in Appendix A.

Appendix A

Introduction

According to the Special Terms and Conditions (STCs) section 10.14 HRSN Rate Methodologies requirement, all rate and/or payment methodologies for authorized HRSN services must be submitted to CMS for review and approval at least 60 days prior to implementation.

The state must submit all documentation requested by CMS, including but not limited to the payment rate methodology (or methodologies) as well as other documentation and supporting information (e.g., state responses to Medicaid non-federal share financing questions). The state must also notify CMS if they intend to direct their managed care plans on how to pay for HRSN services.

This document outlines the proposed Medical Respite rate and methodology with an anticipated implementation date of February 1, 2025.

Cost Drivers[1] and Methodology

Cost Category	Assumptions	Per diem (range)
Clinical personnel	2 FTE: RN and Nurse Manager 3 FTE: Medical Assistants 2 FTE: Case Managers 1 FTE: Housing Navigator 2 FTE: Other operations and oversight	$35 - $50
Non-clinical personnel	Non-clinical personnel (e.g., facilities, cleaning, laundry, transportation)	$82 - $117
Meals and short-term housing	3 meals per day and $20 per sq ft facilities cost	$57 - $81
Other programmatic costs	Supplies, travel, communication services, technical assistance, indirect costs, etc.	$57 - $81

Service Rate Range and Midpoint

Rate Range	$232 - $331
Rate Midpoint	$281
Unit of Service	Per Diem
HCPCS Billing Code	T1002, T2033
Delivery System and Payment	FFS and Managed Care non-risk fee schedule payment

[1] All rates are based on actual projected non-Medicaid Medical Respite program costs, calculated in 2024 from the only fully operational Medical Respite facility in New Mexico.

This document outlines the proposed Nutrition Services FFS rate range and methodology with an anticipated implementation date for medically-tailored meals of July 1, 2025. HCA will also require a minimum fee schedule via state directed payment for managed care plans based on the rate information below.

Service Rate Range and Methodology for Medically-Tailored Meals

Service Description	Home delivered, medically-tailored prepared meal or grocery box.
Unit of Service	Per Meal
Rate Range	$9.30–$20.00
HCPCS Billing Code	S5170 and others as determined necessary (e.g. S9977)
Rate Methodology	The rate range is consistent with other State HRSN nutrition supports[2] as well as a recent financial analysis of medically-tailored meals nationwide[3]. This range also accounts for annual increases in the cost of transportation, labor, and ingredients.[4] If the member selects a home-delivered grocery box in place of a prepared meal, the rate range will follow the methodology for nutrition prescriptions described below.
Delivery System and Payment	FFS and directed payment for minimum managed care fee schedule.

Service Rate Range and Methodology for Nutrition Prescriptions

Service Description	Nutrition Prescriptions (e.g., prescriptions for produce, protein boxes, vouchers, or food pharmacies).
Unit of Service	Per Month Cap
Rate Range	$80–$584
HCPCS Billing Code	Varies
Rate Methodology	The rate range aligns with the weekly rate of $20–$30 per produce prescription under New Mexico Farmers' Marketing Association's FreshRx program.[5] The high-end of the range represents 200% of the New Mexico 2025 SNAP allotment for a household of one. Additionally, the rate range aligns with evidence collected from a wide range of nutrition supports programs nationwide[6, 7].
Delivery System and Payment	FFS and directed payment for minimum managed care fee schedule.

[2] Rate range is aligned with per-meal amounts listed on the HRSN fee schedules for Oregon ($12.25 per meal) and Washington ($20.50 per meal).
[3] Study published in 2022 by JAMA Network found a pooled mean cost of $9.30 for Medically Tailored Meals, which represents the range floor.
[4] Annual cost growth was applied to the mean per-meal cost to arrive at $9.30 and up to $20 over the course of the demonstration.
[5] FreshRx Program: https://portal.nifa.usda.gov/web/crisprojectpages/1024422-freshrx-for-health-new-mexico.html
[6] Per an analysis published in 2023: https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.122.009520#:~:text=METHODS:,accounted%20for%20clustering%20by%20program.
[7] This range is also aligned with the Washington State HRSN fee schedule See the WA HRSN Fee schedule here: https://www.hca.wa.gov/assets/program/mtp-nutrition-supports-fee-schedule.pdf Washington's HRSN fee schedule is aligned with 2025 SNAP allotments: https://fns-prod.azureedge.us/sites/default/files/media/file/FY2025-Maximum-Allotments-Deductions.pdf

The State will also provide initial assessments and counseling for nutritional needs as part of nutrition supports for eligible members, using HCPCS codes 97802 and 97803. These services are covered under the New Mexico State Plan. According to the current New Mexico General Fee Schedule, these service rates are $42.20 and $36.75 respectively, per 15 minute unit of service.