



HEALTH CARE
AUTHORITY

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

February 11, 2025

James G. Scott, Director
Division of Program Operations
Medicaid & CHIP Operations Group
Centers for Medicare and Medicaid Services
601 E. 12th St., Room 355
Kansas City, MO 64106

Dear Mr. Scott:

Enclosed please find documents related to New Mexico State Plan Amendment (SPA) 24-0013, Ambulatory Surgical Centers Services, Federally Qualified Health Centers (FQHCs), Renal Dialysis Facilities And Rural Health Centers (RHCs) Annual Rate Increase.

New Mexico is requesting to increase the annual rate, per 2024 House Bill 2, for Ambulatory Surgical Centers Services, Federally Qualified Health Centers (FQHCs), Renal Dialysis Facilities And Rural Health Centers (RHCs).

The HCA followed a process that included public notification, tribal notification, and web posting. Documentation of these activities is attached.

Please refer to the attachments for the transmittal form and notices.

We appreciate your consideration of this state plan amendment. Should you have any questions on this amendment, please contact Valerie Tapia at: Valerie.Tapia@hca.nm.gov or (505) 257-8420.

Sincerely,

Dana Flannery
Medicaid Director

cc: Dana Brown, CMS

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2. STATE

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL
SECURITY ACT XIX XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

5. FEDERAL STATUTE/REGULATION CITATION

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY _____ \$ _____
b. FFY _____ \$ _____

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT

10. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

Authority Delegated to the Medicaid Director

11. SIGNATURE OF STATE AGENCY OFFICIAL



15. RETURN TO

12. TYPED NAME

13. TITLE

14. DATE SUBMITTED

FOR CMS USE ONLY

16. DATE RECEIVED

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

INSTRUCTIONS FOR COMPLETING FORM CMS-179

Use Form CMS-179 to transmit State plan material to the Center for Medicaid & CHIP Services for approval. Submit a separate typed transmittal form with each plan/amendment.

Block 1 - Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a **calendar year** basis with the first two digits being the two-digit year (e.g., 21-0001, 21-0002, etc.). Because states have different state fiscal years, a calendar year is required for consistency.

Block 2 - State - Enter the two-letter abbreviation code of the State/District/Territory submitting the plan material.

Block 3 - Program Identification - Enter the applicable Title of the Social Security Act (Title XIX Medicaid or Title XXI CHIP).

Block 4 - Proposed Effective Date - Enter the proposed effective date of material. The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted. With respect to expenditures for assistance under such plan, the effective date may not be earlier than the first day on which the plan is in operation on a statewide basis or earlier than the day following publication of notice of changes.

Block 5 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 6 - Federal Budget Impact - 6(a) - IN WHOLE DOLLARS, NOT IN THOUSANDS, Enter 1st **Federal Fiscal Year** (FFY) impacted by the SPA & estimated Federal share of the cost of the SPA for 1st FFY. The first FFY should be the FFY inclusive of the earliest effective date of any amended payment language; **6 (b)** - Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. In general, the estimates should include any amount not currently approved in the state's plan for assistance.

Block 7 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material amended and transmitted. If additional space is needed, use bond paper. **New pages** should be included in Block 7, but not in Block 8.

Block 8 - Page No.(s) of the Superseded Plan Section or Attachment (if Applicable) - Enter the page number(s) (including the transmittal number) that is being superseded. If additional space is needed, use bond paper. **Deleted pages** should be included in Block 8, but not in Block 7.

Block 9 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 10 - Governor's Review - Check the appropriate box. See SMM section 13026 A.

Block 11 - Signature of State Agency Official - Authorized State official signs this block.

Block 12 - Typed Name - Type name of State official who signed block 11.

Block 13 - Title - Type title of State official who signed block 11.

Block 14 - Date Submitted - Enter the date that the state transmits plan material to CMCS. Unless the state officially withdraws this SPA and then resubmits it, this date should not be revised. Documentation of version revisions will be maintained in the CMCS administrative record.

Block 15 - Return To - Type the name and address of State official to whom this form should be returned.

Block 16–22 (FOR CMS USE ONLY).

Block 16 - Date Received - Enter the date plan material is received by CMCS. This is the date that the submission is received by CMCS via the subscribed submission process.

Block 17 - Date Approved - Enter the date CMCS approved the plan material.

Block 18 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 22 or attach a sheet.

Block 19 - Signature of Approving Official - Approving official signs this block.

Block 20 - Typed Name of Approving Official - Type approving official's name.

Block 21 - Title of Approving Official - Type approving official's title.

Block 22 - Remarks - Use this block to reference and explain agreed to changes and strike-throughs to the original CMS-179 as submitted, a partial approval, more than one effective date, etc. If additional space is needed, use bond paper.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT STATE OF NEW
MEXICO
AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Attachment 4.19-B

Page 3a

4. **Licensed Midwives (Lay Midwives):** Payments to licensed midwives are reimbursed at 100% of the physician fee schedule as described in Item I. A of Attachment 4.19 B for global delivery codes.

The fee schedule, set as of January 1, 2025, is effective for services provided on or after those dates. All rates and any updates or periodic adjustments to the fee schedule are published on the New Mexico Medicaid website. Notice of changes to rates will be made as required by 42 CFR 447.205. Reimbursement for governmental and non-governmental providers are paid the same, uniform rate unless otherwise noted on the payment pages.

C. Other Services

1. **Ambulatory Surgical Centers Services** – Free standing ambulatory surgical centers are paid at the Medicare fee schedule. For procedures not covered by Medicare, the Department establishes a fee schedule amount equivalent to the amount allowed for procedure of similar complexity.

The fee schedule, set as of January 1, 2025, is effective for services provided on or after that date. All rates and any updates or periodic adjustments to the fee schedule are published on the New Mexico Medicaid website.

2. **Renal Dialysis Facilities** – Renal dialysis facilities are paid at the Medicare fee schedule. For procedures not covered by Medicare, the Department establishes a fee schedule amount equivalent to the amount allowed for procedure of similar complexity.

The fee schedule, set as of January 1, 2025, is effective for services provided on or after that date. All rates and any updates or periodic adjustments to the fee schedule are published on the New Mexico Medicaid website. Notice of changes to rates will be made as required by 42 CFR 447.205.

3. **Licensed Birth Centers** – Licensed birth centers are paid at the Medicaid fee schedule. The agency's fee schedule, set as of January 1, 2025, is effective for services provided on or after that date. All rates and any updates or periodic adjustments to the fee schedule are published on the New Mexico Medicaid website. Notice of changes to rates will be made as required by 42 CFR 447.205.

TN No: 24-0013

Approval Date: mm/dd/yyyy

Supersedes TN. NO. 24-0009 (Pending)

Effective Date: 01/01/2025

Once the base period rate for each FQHC and RHC has been calculated, any claims paid for dates of service on or after January 1, 2001, that were paid an interim rate, will be reprocessed. This processing will adjust the payment on each claim to the PPS base rate amount.

d. Updates to PPS base rates:

Beginning in Federal Fiscal Year (FFY) 2002, and each year thereafter, each FQHC and RHC payment amount (on a per visit basis) will be increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services. This adjustment to the PPS rate will be effective each October 1.

FQHC and RHC payment amount (on a per visit basis) will receive uniform rate increases effective January 1, 2025, based on legislative appropriation.

e. Alternative Payment Methodology (APM)

An alternative payment methodology will be implemented effective April 1, 2003. This alternative methodology will re-index the PPS rates effective March 31, 2003 by the cumulative percentage difference between the increase in the Medical Care Component of the Consumer Price Index-Urban (CPI-U) for the 12 months in the calendar year 2001 and the increase in the Medicare Economic Index (MEI) effective for calendar year beginning January 1, 2002, and the increase in the Medical Care Component of the CPI-U for the 12 months in calendar year 2002 and the increase in the MEI effective for the calendar year beginning January 1, 2003. The new rates will be effective April 1, 2003. Beginning in Federal Fiscal Year 2021, the Department will calculate the APM by trending the PPS rate by the greater of either the MEI or the CPI-U. Providers must be notified of the APM rate and must agree to receive the APM. This APM will be at least equal to PPS.

Dental APM

Effective October 1, 2019, an alternative payment methodology will be paid for FQHC dental encounters. The alternative payment methodology is based on the national average cost of a dental encounter as established by the Health Resources and Services Administration (HRSA) Uniform Data system for 2017. Beginning in Federal Fiscal Year 2021, the Department will calculate the dental APM by trending the dental APM effective October 1, 2019 by the greater of either the MEI or the CPI-U. Providers must be notified of the dental APM rate and must agree to receiving the dental APM. The dental APM will be at least equal to PPS.

f. Change in Scope of Services

Once the PPS rates are determined as outlined in this section, adjustments to those rates will reflect changes in the scope of services will be made upon the written request of the provider and approval by the Medical Assistance Division (MAD). A provider's request for a PPS rate adjustment due to a change in scope of service must be received no later than 90 days after the provider's fiscal year end during which the change in scope of service occurred. The provider should notify MAD in advance of any impending changes. The provider will be required to submit data supporting that a change in the scope of service transpired. This documentation will include FQHC and RHC information report and any other supporting documentation considered necessary by MAD or its designee.

A minimum of six months should have elapsed since the change in the scope occurred to ensure the change was not temporary and that there is sufficient information upon which to base a rate adjustment. If the change in scope of service occurred in the last six months of a FQHC's and RHC's fiscal period, MAD may require the FQHC and RHC to submit an additional information report, covering at least six months since the change in scope of service transpired, to obtain the information necessary to evaluate the request.

MAD and/or its designee will review the request and determine if an adjustment to the established PPS rate is merited. The following criteria will be used to evaluate each FQHC request for a rate adjustment due to a

change in scope of service. MAD's final determination will be communicated to the FQHC and RHC in writing.