NOTICE OF RULEMAKING

The Human Services Department (the Department), Medical Assistance Division (MAD), is amending the following rule that is part of the New Mexico Administrative Code (NMAC): 8.321.2 NMAC - Specialized Behavioral Health Services.

Section 9-8-6 NMSA 1978, authorizes the Department Secretary to promulgate rules and regulations that may be necessary to carry out the duties of the Department and its divisions.

Notice Date: September 10, 2019
Hearing Date: October 16, 2019
Adoption Date: Proposed as January 1, 2020
Technical Citations: 42 CFR 400-1099

MAD is proposing some new services, as well as changes to some existing services. The rule was also reviewed for currency and clarity with changes being made as necessary. Language was also added throughout the rule to direct individuals to the Behavioral Health (BH) Policy and Billing Manual for additional information.

The financial impact for the new services described in this proposed rule, is estimated to be $34,000,000, annually, in combined federal and state funds. The primary fiscal impact is related to new services that are being added as part of the Department's 1115 waiver renewal for the Centennial Care program.

The Department proposes to amend the rule as follows:

Section 8: Mission Statement - Language in this section was removed and will be reserved for promulgation at a later date.

Section 9: General Provider Instruction

Subsection C: The Department proposes to allow licensed alcohol and drug abuse counselors (LADACs) and certified alcohol and drug abuse counselors (CADCs) to provide therapeutic services for alcohol and drug abuse diagnoses only, including treatment of co-occurring mental health conditions when supervised by an independently licensed counselor or therapist. This addition will provide increased access to services for Medicaid recipients with a substance use disorder (SUD).

Subsection D: The Department proposes to add new types of agencies to the list of agencies that may utilize non-independent practitioners under supervision for rendering behavioral health services: 1) a CareLink NM Health Home (CLNM HH); 2) a crisis triage center licensed by the Department of Health (DOH); 3) a Behavioral Health Agency (BHA) with a Behavioral Health Services Division (BHSD) supervisory certificate; 4) an opioid treatment program in a methadone clinic with a BHSD supervisory certificate; 5) a political subdivision of the state of New Mexico as a BHA with a BHSD supervisory certificate; and 6) a crisis services community provider as a BHA with a BHSD supervisory certificate. Each agency type will increase access to behavioral health services through the use of mid-level practitioners.

Subsection E: The Department proposes to add new non-independent practitioners to the list of those that can render services within one of the agencies listed in Subsection D. These are: 1) a registered nurse with existing New Mexico licensure when supervised by a behavioral health certified nurse practitioner, clinical nurse specialist, or physician; 2) a physician assistant; or 3) certain individuals in educational programs including a master's level behavioral health intern, a psychology intern (including psychology practicum students and pre doctoral internship), a pre-licensure psychology post doctorate student, a certified peer support worker, or a certified family peer support worker. All of the practitioners must be enrolled as a MAD provider. The addition of these non-licensed practitioners will extend access to behavioral health services for eligible recipients; provides needed experience for behavioral health interns; add to the workforce within agencies; and support the premise that interns, once assimilated into the New Mexico behavioral health workforce, are more likely to stay in New Mexico once they are licensed. All supervisory requirements must be met. In compliance with 2019 Senate Bill 207 the rule provides for licensed substance abuse associates to be reimbursed for the services provided to medical assistance recipients

within the licensed substance abuse associate's scope of practice.

Subsection I: Added clarity that all pre-authorizations must comply with federal parity laws.

Subsection J: Changes are proposed to requirements for a practitioner to render therapeutic services to an eligible recipient. Detailed requirements for assessments and service or treatment plans have been moved to the BH Policy and Billing Manual. The rule requiring that the diagnostic evaluation and treatment plan must precede the rendering of behavioral health services is proposed to be waived when a recipient only requires up to four behavioral health encounters. Under this condition, a provisional diagnosis based on screening results can be utilized as in the "treat first" clinical model. When a recipient only requires up to four behavioral health encounters, a treatment plan is not required.

Subsection K: The Department proposes to add a requirement for the lead provider to complete a comprehensive assessment and service plan for all recipients with a serious mental illness (SMI) or severe emotional disturbance (SED), as determined through a diagnostic evaluation. Conditions for this requirement include: 1) only the agencies designated in Subsection D of 8.321.2.9 NMAC may bill for a comprehensive assessment. Other agency types and practitioners may bill for an assessment that does not require the accumulation of collateral information from multiple provider types; 2) all practitioner types within such agencies may develop the assessment and plan if they are under the supervision of an independently licensed practitioner and are HIPAA trained; and 3) a comprehensive assessment and service plan cannot be billed if care coordination is being billed through bundled service packages such as case rate, high fidelity wrap around, or CLNM Health Homes.

Subsection L: The Department proposes to add provisions to allow for interdisciplinary teaming to update treatment plans (referred to as "service plans" when developed by an interdisciplinary team). The team consists of a lead agency, which must be one of the agencies listed in Subsection D of 8.321.2.9 NMAC, and at least two other providers or agencies.

Section 10: Accredited Residential Treatment Center (ARTC) for Adults with Substance Use Disorders - The Department proposes to add this benefit for both fee-for-service and managed care eligible recipients subject to approval by the federal Centers for Medicare and Medicaid Services (CMS) as part of the 1115 waiver renewal for Centennial Care and for inclusion in the Medicaid State Plan. This section outlines level-three services as defined by the American Society of Addiction Medicine (ASAM) and requires the ARTC to be accredited by the Joint Commission (JC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA). The effective date will be January 1, 2019, or as otherwise approved by CMS.

Section 11: Accredited Residential Treatment Center (ARTC) for Youth - This section was updated to align with Children, Youth and Families Department (CYFD) regulations. Specifically, the Council on Accreditation (COA) was added as one of the national accrediting agencies. Individuals are directed to the Behavioral Health Policy and Billing Manual for details related to findings and recommendations for an Indian Health Service (IHS) or federally recognized tribal government's ARTC.

Section 12: Applied Behavior Analysis (ABA)

Subsection A: The Department proposes to add a section on coverage criteria, outlining three items that must be in place for ABA services to be covered, unless otherwise allowed under Subsection B: 1) confirmation of the presence or risk of Autism Spectrum Disorder (ASD) by an approved autism evaluation provider (AEP) through a comprehensive diagnostic evaluation (CDE), targeted evaluation, or targeted risk evaluation; 2) an integrated service plan (ISP), which must be developed by the AEP together with a referral to an approved ABA provider agency; or 3) completion of a behavioral or functional analytic assessment to determine if a focused or comprehensive model shall be selected, together with completion of a treatment plan. All services must be rendered in accordance with the treatment plan. In compliance with 2019 House Bill 322 the rule provides that autism spectrum disorder will not be subject to age restrictions or dollar limits.

Subsection B: To comply with new requirements, the Department proposes to update eligible providers based on the three stages of service. Specialty care providers or practitioners who are enrolled as approved behavior analysts (BAs) have been added but must provide additional documentation that demonstrates that the practitioner has the skills, training and clinical experience to oversee and render ABA services to highly complex eligible recipients who require specialized ABA services. The Department also proposes to add additional provider types that may refer a recipient for ABA services, including: psychologists licensed by the New Mexico Regulation and Licensing Division (RLD); psychiatric clinical nurse specialists or certified nurse practitioners with a specialty of pediatrics or psychiatry licensed by the New Mexico Board of Nursing; medical doctor (MD) or doctor of osteopathic medicine (DO) board licensed psychiatrists who are board certified in child and adolescents; or licensed

pediatricians.

Subsection C: The Department proposes to update the identified population. The reader is directed to the BH Policy and Billing Manual for details.

Subsection D: The Department proposes to reorganize covered services in the structure of the rule. The reader is directed to the BH Policy and Billing Manual for details.

Subsection E: Language has been proposed to reflect that prior authorization is no longer required for stage-two ABA services. Stage-three ABA services still require prior authorization.

Section 13: Assertive Community Treatment Services (ACT)

Subsection A: The Department proposes to add three additional provider types as the lead to address the shortage of psychiatrists in New Mexico: 1) a certified psychiatric nurse practitioner; 2) a psychiatric clinical nurse specialist; and 3) a prescribing psychologist under the supervision/consultation of a MD, which may be provided via telehealth. Adds to the two nurse requirement to allow for other allied medical professionals to be used in place of one nurse. Previously, the team leader was required to be a psychiatrist. Added clarity that an ACT agency providing coordinated specialty care for an individual with first episode psychosis must provide services consistent with the coordinated specialty care (CSC) model.

Subsection B: Language is proposed to specify four levels of interaction to assure that services are based on evidence-based practice: 1) face-to-face encounters; 2) collateral encounters with the recipient's family or significant others; 3) assertive outreach with the recipient; and 4) group encounters including basic living skills development, psychosocial skills training, peer groups, and wellness and recovery groups.

Subsection C: Language is proposed to include ACT service eligibility for individuals 15 to 30 years of age who are within the first two years of their first episode of psychosis or meet the criteria of serious mental illness (SMI) with a special emphasis on psychiatric disorders.

Subsection D: Language is proposed to clarify that ACT is a voluntary medical, comprehensive case management and psychosocial intervention program provided on the basis of principles covered in the BH Policy and Billing Manual.

Subsection E: The Department is proposing to allow reimbursement for a six-month period while reimbursing another Medicaid covered service for transitioning levels of care with the condition that the need is identified as a component of the treatment plan. Concurrent therapy modalities may assure a smooth transition with the potential outcome being that there will be no further need for the high level of support provided with ACT services.

Section 14: Behavioral Health Professional Services for Screenings, Evaluations, Assessments and Therapy - The Department is proposing to allow validated screenings and brief interventions for high risk conditions in order to provide prevention or early intervention, based on New Mexico's "treat first" clinical model.

Subsection B: The Department proposes to remove the requirement for an assessment to be conducted at least annually. However, the rule also states that if a non-independent practitioner is conducting the assessment, it must be done under the supervision of an independent practitioner and must be counter-signed by the independent practitioner along with the diagnosis indicating the need for the assessment.

Subsection C: The Department proposes to add language that outpatient therapy services now include consultation with the recipient's family and other professional staff when the service is on behalf of the recipient.

Section 15: Behavioral Health Respite Care (MCO only) - Proposed language has been incorporated to specify that behavioral health respite care is available to MCO members. BH Respite Care was previously outlined in a separate section of NMAC.

Section 16: Behavioral Management Skills (BMS) Development Services - Proposed language has been added to align services with CYFD regulations. BMS is not provided as a stand-alone service but delivered as part of an integrated plan of services to maintain eligible recipients in their communities as an alternative to out-of-home services.

Subsection B: Coverage criteria for BMS has been updated to clarify that a treatment plan must include crisis planning based on an assessment that includes the identification of skills deficits that will benefit from the integrated program of therapeutic services; and 24 hour availability of appropriate staff or implementation of the crisis plan, which may include referral to respond to the recipient's crisis situation. The previous version of the rule did not have the option of referral to an outside source for 24 hour availability of crisis services. Based on the New Mexico Crisis and Access Line (NMCAL) 24 hour crisis service and its referral network, the Department believes

this option should be available based on potentially limited resources in the BMS workforce. The rule expands the primary responsibilities of independently licensed supervisors and directs the reader to the BH Policy and Billing Manual for specifics. The rule also expands the team of professionals to include the recipient and his or her family, which must review the treatment plan every 30 days. If the team assesses a lack of progress over the last 30 days, the treatment plan will be amended and approved by the BMS supervisor.

Section 17: Cognitive Enhancement Therapy (CET) - CET services were previously covered through individual and group therapy reimbursement, but the Department now proposes to classify CET as a "special service." Proposed language is added to require an application to BHSD to assure that required training has occurred, and that the use of the evidence-based practice is in place. A letter of approval from BHSD will be required to add this service to one of these approved agencies: a community mental health center (CMHC); a federally-qualified health center (FQHC); an IHS facility; a PL 93-638 tribal facility; a core service agency (CSA); a CLNM Health Home; or a BHA with a BHSD supervisory certificate. The effective date will be January 1, 2019, or as otherwise approved by CMS.

Section 18: Comprehensive Community Support Services (CCSS)

Subsection A: The Department proposes to add BHAs with a supervisory certificate, CMHCs, and CLNM Health Homes to the list of providers that can deliver CCSS. Training is available through the University of New Mexico (UNM). An attestation that this training has taken place is required for CCSS to be added to the provider's list of specialty services. If providing this service to children and adolescents, CYFD will provide required background checks.

Subsection B: The Department proposes to waive the requirement, up to the first four encounters, for which a diagnostic evaluation must occur prior to treatment; however, a provisional diagnosis must be included for billing. After four encounters, the diagnostic evaluation with a resultant diagnosis is required. This is consistent with the "treat first" clinical model.

Subsection D: The Department proposes to add eligible recipients with substance use disorders to the other two qualifying categories of behavioral health disorders, which are serious mental illness and severe emotional disturbance.

Section 19: Crisis Intervention Services - In this section, the Department proposes to expand the three current crisis intervention services to include a fourth type: crisis stabilization services in a community-based center. Crisis stabilization services are defined as outpatient services for up to 24 hours of stabilization of crisis conditions that may, but do not necessarily, include American Society of Addiction Medicine (ASAM) level-two withdrawal management, and can also serve as an alternative to the emergency department or police department. The eligible population is age 14 years and older.

Subsection B: This section lists the proposed types of provider agencies eligible to deliver crisis stabilization services and specifies proposed staffing requirements. Eligible providers include: CSAs; CMHCs; crisis triage centers; IHS or tribal 638 clinics; hospital outpatient clinics; BHAs with a supervisory certificate; political subdivisions of the state of NM with a supervisory certificate; and opioid treatment programs within a methadone clinic with a supervisory certificate. Staffing must include at least: during all hours of operation, one registered nurse with experience or training in crisis triage and managing intoxication and withdrawal management, if this service is provided; one master's level licensed mental health professional on-site during all hours of operation; a certified peer support worker on-site during all hours of operation; a physician or certified nurse practitioner either on-site or on call during all hours of operation; and at least one staff trained in basic cardiac life support and use of the automated external defibrillator equipment and first aid during all hours of operation.

Subsection C: Proposes to add clarification of covered services, including details of ambulatory withdrawal management, crisis stabilization, and navigational services for individuals transitioning to the community.

Section 20: Crisis Triage Center (CTC) - This new section proposes to add information clarifying that CTC covers both outpatient crisis stabilization and residential services for up to eight days with a limit of 12 beds. The effective date of residential CTC services will be January 1, 2019, or as otherwise approved by the Centers for Medicare and Medicaid Services (CMS).

Section 21: Day Treatment (DT)

Subsection B: The Department proposes to add information clarifying the conditions under which DT

services can be provided and changing covered services to be in alignment with CYFD regulations. Specifically, coverage criteria includes the following provisions: 1) a family who is unable to attend the regularly scheduled sessions at the DT facility due to transportation difficulties or other reasons may receive individual family sessions scheduled in the family's home by the DT agency; 2) the certified DT services provider delivers adequate care and continuous supervision of the client at all times during the course of the client's DT program participation; and 3) 24-hour availability of appropriate staff or implementation of a crisis plan, which may include referral, to respond to the eligible recipient's crisis situation.

Subsection C: To align with CYFD requirements, the Department proposes to add language clarifying covered services. DT services must be identified in the treatment plan, including crisis planning, which is formulated on an ongoing basis by the treatment team. The treatment plan guides and records the following for each client: individualized therapeutic goals and objectives; individualized therapeutic services provided; and individualized discharge and aftercare plans. Treatment plan requirements are detailed in the BH Policy and Billing Manual. Advance schedules are posted for structured and supervised activities that include individual, group and family therapy, and other planned activities appropriate to the age, behavioral and emotional needs of the client subject to the treatment plan.

Section 22: Family Support Services (FSS) (MCO only) - Proposed language has been added to specify that Family Support Services are available to MCO members.

Section 23: Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals or Psychiatric Units of Acute Care Hospitals - The Department proposes language clarifying that there is no age limit for treatment in psychiatric units of acute care hospitals.

Subsection B: The Department proposes to add language that a treatment plan and all supporting documentation must be available for review in the eligible recipient's file.

Section 24: Institutions for Mental Disease (IMDs) - This new proposed section increases IMD coverage from 15 to 30 days for eligible recipients ages 22 through 64 for substance abuse disorders. The effective date of this benefit will be January 1, 2019, or as otherwise approved by CMS.

Section 25: Intensive Outpatient Program (IOP) for Substance Use Disorders

Subsection A: The Department proposes to add three new provider agency types that can deliver IOP services: a CLNM Health Home; a BHA with a BHSD supervisory certificate; or an opioid treatment program in a methadone clinic with a BHSD supervisory certificate. Non-independent practitioners that can provide IOP services under the supervision of the IOP supervisor include a LMSW, LMHC, LADAC, CADC, LSAA, or a master's level psychologist associate. The approval letter author was changed from a MAD IOP approval letter to an IOP Interdepartmental Council approval letter. BHSD, MAD, and CYFD work together in the approval and audit process for IOP services. The concept of a transitional age program for which the provider must specify the age range was added.

Subsection B: The Department proposes to eliminate the list of approved evidence-based programs (EBPs) from the rule and directs individuals instead to the IOP Interdepartmental Council or the BH Policy and Billing Manual. Also contained within those two sources are the directions for having another EBP approved. New wording was added to reemphasize that IOP must address co-occurring mental health disorders, as well as substance use disorders, when indicated.

Subsection C: Proposed language was added to clarify the addition of therapy or counseling services outside of the bundled IOP services. For other mental health therapies, outpatient therapies may be rendered in addition to the IOP therapies of individual and group when the eligible recipient's co-occurring disorder requires treatment services that are outside the scope of the IOP therapeutic services. The eligible recipient's file must document the medical necessity of receiving outpatient therapy services in addition to IOP therapies, and a statement is required from the IOP agency that to postpone such therapy until the completion of the eligible recipient's IOP services is not in the best interest of the eligible recipient. Such documentation includes, but is not limited to: a current assessment, a co-occurring diagnosis, and the inclusion in the service plan for outpatient therapy services. An IOP agency may render these services when it is enrolled as a provider covered under Subsection D of 8.321.2.9 NMAC with practitioners listed in Subsections C and E of 8.321.2.9 NMAC whose scope of practice specifically allows for mental health therapy services; or may refer the eligible recipient to another provider if the IOP agency does not have such practitioners available. The IOP agency may continue the eligible recipient's IOP services in coordination with the new provider.

Subsection D: The Department proposes to lower the age range of adolescents from 13 years to 11 years. This section also includes provision of services that have been mandated by the local judicial system; adds the transitional age group for a separate service; adds the judicial system mandate; and adds the judicial mandate for the adult population program.
Subsection F: Proposes to clarify that medication assisted treatment (MAT) and other mental health therapies are billed and reimbursed separately from the bundled rate and to allow for inclusion of contract employees within the IOP team.

Section 26: Intensive Outpatient Program for Mental Health Conditions (IOP for MH) - This proposed new section of the rule was added to comply with IOP regulations. IOP for mental health conditions currently have no approved evidence-based practices (EBP); therefore, any agency requesting coverage must submit the EBP being proposed to the Interdepartmental IOP Council for approval as indicated in the BH Policy and Billing Manual. The effective date will be January 1, 2019, or as otherwise approved by CMS.

Section 27: Medication Assisted Treatment (MAT): Buprenorphine Treatment for Opioid Use Disorder - The Department proposes to restructure the rule by adding this new section. MAT is already a covered Medicaid benefit.

Section 29: Non-Accredited Residential Treatment Centers (RTCs) and Group Homes (GHs) - Proposed changes were made to align with CYFD regulations.

Subsection A: Proposed language in the rule directs the reader to the BH Policy and Billing Manual for details on CYFD findings and recommendations for RTCs operated by IHS or a federally recognized tribal government.

Subsection B: In this section, the Department proposes the following: 1) to add the statement that RTC services are provided through a treatment team approach and the roles, responsibilities and leadership of the team are clearly defined; 2) to delineate the 24 hour therapeutic group living environment as one that meets the recipient's developmental, psychological, and emotional needs; 3) to update the provision of appropriate on-site staff based on the acuity of recipient needs on a 24 hour basis to ensure adequate supervision of recipients and response in a proactive and timely manner; 4) to direct the reader to the BH Policy and Billing Manual for details on development of the interdisciplinary treatment plan. If the recipient is solely receiving RTC services, a treatment plan is not required; it is only required if the recipient is also receiving other behavioral health services; 5) to assure appropriate discharge timing and planning by requiring regular assessments outlining clinically appropriate after-care services. Discharge planning begins when the recipient is admitted to residential treatment and is updated and documented in the recipient record at every treatment plan review, or more frequently as needed; and 6) to add the requirement that services, care and supervision are provided at all times, including the provision of, or access to, medical services on a 24 hour basis, and the maintenance of a staff-to-recipient ratio appropriate to the level of care and needs of the recipient.

Section 30: Opioid Treatment Program (OTP) - This new proposed section incorporates the previously named Medication Assisted Treatment (MAT) in a methadone clinic with new federal regulations for more comprehensive services when a recipient is receiving methadone treatment. In compliance with 2019 Senate Bill 221 requires prescribers of opioid analgesics shall provide the patient information on the risks of overdose and inform the patient of the availability of an opioid antagonist.

Section 31: Partial Hospitalization (PH) Services in an Acute Care or Freestanding Psychiatric Hospital - The Department proposes to expand the definition of PH and to update requirements.

Subsection A: This section lists the required practitioners for PH: a registered nurse; a clinical supervisor that is an independently licensed behavioral health practitioner or psychiatric nurse practitioner or psychiatric nurse clinician; or a licensed behavioral health practitioner. This section also lists other practitioners that may, but are not required, to be part of the PH team: physician assistants; certified peer support workers; certified family peer support workers; licensed practical nurses; and mental health technicians.

Subsection B: This section lists eight new proposed criteria that must be adhered to for this service: 1) all services must be ordered by a psychiatrist or licensed Ph.D.; 2) PH is a voluntary, intensive, structured and medically staffed psychiatrically supervised treatment program with an interdisciplinary team intended for stabilization of acute psychiatric or substance use symptoms and adjustment to community settings; 3) a history and physical must be conducted within 24 hours of admission; 4) an interdisciplinary biopsychosocial assessment must

be conducted within seven days of admission including alcohol and drug screening; 5) services are furnished under an individualized written treatment plan established within seven days of initiation of service, which must be reviewed and updated every 15 days; 6) documentation must be sufficient to demonstrate that coverage criteria are met; 7) treatment must be reasonably expected to improve the recipient's condition or designed to reduce or control psychiatric symptoms to prevent relapse or hospitalization, and to improve or maintain the recipient's level of function; and 8) for recipients in elementary or secondary school, educational services must be coordinated with the recipient's school system.

Subsection C: The Department proposes language that specifies the conditions for which eligible recipients may receive PH including: the recipient is under the care of a psychiatrist for SMI, SED, or moderate to severe SUD, the recipient must have an adequate support system to sustain/maintain him or herself outside the PH program; recipients 19 and over must have a serious mental illness including substance use and be safely managed in the community with high intensity therapeutic intervention, and would be at risk of requiring inpatient care without this treatment; and recipients age 5 to 18 must have severe emotional disturbances which may include substance use disorders, are able to be safely managed in the community with high intensity therapeutic intervention, and would be at risk of requiring inpatient care without this treatment.

Subsection E: The Department proposes to clarify that a program that only monitors the management of medication for recipients whose psychiatric condition is otherwise stable, is not the combination, structure, and intensity of service that makes up active treatment in a PH program and, therefore, is a non-covered service.

Subsection F: The Department proposes to eliminate prior authorization (PA) unless the length of stay exceeds 45 days, at which time prior authorization is required. The proposed rule stipulates the conditions that must be documented when requesting PA.

Subsection G: The Department lists the services that may be billed separately from PH, which include: performance of necessary evaluations and psychological testing for development of the treatment plan; physical examinations and any resultant medical treatment; any medically necessary occupational or physical therapy; and other professional services not rendered as part of the program.

Section 32: Psychosocial Rehabilitation Services (PSR) - The Department proposes to update the definition of PSR. PSR is to be a transitional level of care based on the recipient's recovery and resiliency goals.

Subsection A: Proposes to add PSR staffing requirements. PSR services must meet a staff ratio guideline of 1:2 minimum and 1:10 maximum. In both the clubhouse and classroom settings, the entire staff works as a team and the team must have a clinical supervisor/team lead that can include: certified peer support workers; certified family support workers; community support workers; and other HIPAA trained individuals working under the direct supervision of the clinical supervisor. Minimum qualifications for the clinical supervisor/team lead include: an independently licensed behavioral health professional; one year of demonstrated supervisory experience; demonstrated knowledge and competence in the field of PSR; and an attestation of training related to providing clinical supervision of non-clinical staff.

Subsection D: The Department proposes to revise the PSR services rendered to include four major components: 1) basic living skills development; 2) psychosocial skills training; 3) therapeutic socialization; and 4) individual empowerment. Components of each of the four major services are also listed.

Subsection F: The Department proposes to clarify that although there is no PA requirement for PSR, the factors for determining medical necessity are: recipient assessment; recipient diagnostic formation; recipient service and treatment plans; and compliance with 8.321.2 NMAC.

Section 33: Recovery Services (MCO only) - This section is currently in rule; however, the Department proposes to move it under this section.

Section 34: Screening, Brief Intervention & Referral to Treatment (SBIRT) - This proposed new section adds the SBIRT service to the Medicaid benefit package. The effective date of this change will be January 1, 2019, or as approved by CMS. Expanded the list of eligible providers to provide this important service to capture the range of psychical health settings where this service can be provided.

Section 36: Supportive Housing Pre-Tenancy and Tenancy Services (PSH-TSS) - This proposed new section adds PSH-TSS to the Medicaid benefit package for recipients enrolled in Centennial Care. The effective date will be July 1, 2019, or as otherwise approved by CMS.

Section 37: Treatment Foster Care I and II (TFC) - The Department proposes to update this section to align with

CYFD regulations. TFC I and II have been combined, rather than listed separately, as requirements are similar. When there is a difference, it is cited in the rule. The definition was modified to reinforce the use of a treatment plan directed to the development of skills and re-integration into family and community.

Subsection A: The Department proposes to update TFC eligibility criteria to include a CYFD certified TFC agency that must be licensed as a child placement agency by CYFD Protective Services.

Subsection B: The Department proposes to add a section clarifying the conditions of coverage for both the agency and TFC families. The conditions are: 1) the TFC agency provides intensive support, technical assistance, and supervision of all treatment foster parents; 2) a TFC I and II parent is either employed or contracted by the TFC agency and receives appropriate training and supervision by the TFC agency; 3) placement does not occur until after a comprehensive assessment of how the prospective treatment foster family can meet the recipient's needs and preferences, and a documented determination by the agency that the prospective placement is a reasonable match for the recipient; 4) an initial treatment plan must be developed within 72 hours of admission and a comprehensive treatment plan must be developed within 14 calendar days of the eligible recipient's admission to a TFC I or II program; 5) the treatment team must review the treatment plan every 30 calendar days; 6) TFC families must have one parent readily accessible at all times, cannot schedule work when the eligible recipient is normally at home, and be able to be physically present to meet the eligible recipient's emotional and behavioral needs; 7) in the event that the treatment foster parents request a treatment foster recipient be removed from their home, a treatment team meeting must be held and an agreement made that a move is in the best interest of the involved recipient. Any treatment foster parent(s) who demands removal of a treatment foster recipient from his or her home without first discussing with and obtaining consensus of the treatment team, may have their license revoked; and 8) a recipient eligible for TFC I or II may change treatment foster homes only under the following circumstances: an effort is being made to reunite siblings; or a change of treatment foster home is clinically indicated, as documented in the client's record by the treatment team.

Subsection C: This section emphasizes the rights of recipients, describes the transition between levels of care, and differentiates between TFC I and TFC II. TFC I services are for an eligible recipient who meets the following criteria: is at risk for placement in a higher level of care or is returning from a higher level of care and is appropriate for a lower level of care; or has complex and difficult psychiatric, psychological, neurobiological, behavioral, psychosocial problems; and requires and would optimally benefit from the behavioral health services and supervision provided in a treatment foster home setting. TFC II services are for an eligible recipient who meets the criteria listed in Section 25 Subsection B of 8.321.2.9 NMAC and also meet one of the following criteria: has successfully completed treatment foster care services level I (TFC I), as indicated by the treatment team; or requires the initiation or continuity of the treatment and support of the treatment foster family to secure or maintain therapeutic gains; or requires this treatment modality as an appropriate entry level service from which the client will optimally benefit. An eligible recipient has the right to receive services from any MAD TFC enrolled agency of his or her choice.

Subsection D: The Department proposes to add new requirements and clarify processes. The TFC parental responsibilities include but are not limited to: 1) meeting the recipient's base needs and providing daily care and supervision; 2) reunification with the recipient's family. The treatment foster parents work in conjunction with the treatment team toward the accomplishment of the reunification objectives outlined in the treatment plan; and 3) ensuring proper and adequate supervision is provided at all times. Treatment teams determine that all out-of-home activities are appropriate for the recipient's level of need, including the need for supervision. The treatment foster care agency provides intensive support, technical assistance, and supervision of all treatment foster parents. The following services must be furnished by both TFC I or II agencies unless specified for either I or II: a) provision of individual, family or group psychotherapy to recipients as described in the treatment plan. The TFC therapist is an active treatment team member and participates fully in the treatment planning process; b) family therapy is required when client reunification with their family is the goal; c) providing crisis intervention on call to treatment foster parents, recipient's and their families on a 24-hour, seven days a week basis including 24-hour availability of appropriate staff to respond to the home in crisis situations; d) assessing the family's strengths, needs and developing a family service plan when an eligible recipient's return to his or her family is planned; e) conducting a private face-to-face visit with the eligible recipient within the first two weeks of TFC I placement and at least twice monthly thereafter by the treatment coordinator; f) conducting a face-to-face interview with the eligible recipient's TFC parents within the first two weeks of TFC I placement and at least twice monthly thereafter by the treatment coordinator; g) conducting at a minimum one phone contact with the TFC I parents weekly; phone contact is not necessary in the same week as the face-to-face contact by the treatment coordinator; h) conducting a private face-to-face interview with the eligible recipient's TFC II parent within the first two weeks of TFC II placement and at least once monthly thereafter by the treatment coordinator; i) conducting a face-to-face interview

with the eligible recipient's TFC II parent within the first two weeks of TFC II placement and at least once monthly thereafter by the treatment coordinator; and j) conducting at a minimum, one phone contact with the TFC II parents weekly by the treatment coordinator; phone contact is not necessary in the same week as the face-to-face contact. **Subsection E:** Proposes to update the dual reimbursement for TFC and CCSS to allow CCSS to be reimbursed while transitional planning from one level to the next, or to family or community is occurring: CCSS as part of the discharge planning from either the eligible recipient's TFC I or II placement.

The register for these proposed amendments to this rule will be available September 10, 2019 on the HSD website at http://www.hsd.state.nm.us/LookingForInformation/registers.aspx or at http://www.hsd.state.nm.us/2017-comment-period-open.aspx. If you do not have Internet access, a copy of the proposed rules may be requested by contacting MAD in Santa Fe at 505-827-1337.

The Department proposes to implement this rule effective January 1, 2020. A public hearing to receive testimony on this rule will be held in the Rio Grande Room, Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, New Mexico, 87505 on Wednesday, October 16, 2019 at 9:00 a.m. Mountain Time (MT).

Interested parties may submit written comments directly to: Human Services Department, Office of the Secretary, ATTN: Medical Assistance Division Public Comments, P.O. Box 2348, Santa Fe, New Mexico 87504-2348.

Recorded comments may be left at *(505) 827-1337*. Interested persons may also address comments via electronic mail to: madrules@state.nm.us. Written mail, electronic mail and recorded comments must be received no later than 5:00 p.m. MT on October 16, 2019. Written and recorded comments will be given the same consideration as oral testimony made at the public hearing. All written comments received will be posted as they are received on the HSD website at http://www.hsd.state.nm.us/2017-comment-period-open.aspx along with the applicable register and rule. The public posting will include the name and any contact information provided by the commenter.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact MAD in Santa Fe at 505-827-1337. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the MAD upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.