8. Multi-Systemic Therapy (MST). MST provides an intensive family preservation model of treatment for youth and their families who are at risk of out-of-home placement. MST is for the benefit of the child. The MST model is based on evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services include an initial assessment to identify the focus of the MST intervention and face-to-face therapeutic interventions with the youth and family in the following functional domains: adaptive, communication, psychosocial, problem solving, and behavior management. Specialized therapeutic and rehabilitative interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence.

   Any agency that seeks and is certified by MST, Inc. can provide MST services. Services are available in-home, at school and in other community settings including a federally qualified health center (FQHC), an Indian Health Service (IHS) facility, a PL 93-638 tribally-operated facility, an agency licensed by the Children, Youth, and Families' Department as a Children's Core Service Agency, and private agencies and schools certified by the New Mexico Department of Health or the Children, Youth, and Families' Department.

   All agencies must be able to provide twenty-four (24) hour coverage, seven (7) days per week, by licensed Masters and/or Bachelors level staff. Bachelor's level staff must have a degree in social work, counseling, psychology or a related human services field and must have at least three (3) years of experience working with the target population that is, children/adolescents and their families. Staffing for MST services shall be comprised of no more than one-third Bachelors level staff and, at minimum, two-thirds licensed Masters level staff.

9. Substance Use Disorder Continuum of Services

   The comprehensive continuum of services for the screening, assessment, and treatment of substance use disorders includes several new services based upon the American Society of Addiction Medicine's levels of care (ASAM LOC) including placement criteria, staffing, and standards. These services are designed for an individual's restoration to a functional level within his or her life and community.

   1. Screening, Brief Intervention, and Referral to Treatment (SBIRT)
      A. Definition: SBIRT is a community-based practice designed to identify, reduce and prevent problematic substance use or misuse and co-occurring mental health disorders as an early intervention. SBIRT is a universal screening specific to age, face-to-face brief intervention for positive screening results, and a referral to behavioral health services if indicated.

      B. Practitioners delivering the service must be trained in a state-approved educational curriculum and include:
         1. Registered nurses;
         2. Certified nurse practitioners;
         3. Clinical nurse specialists;
         4. Behavioral health practitioners at all educational levels;
         5. Behavioral health interns under the supervision of an independently licensed behavioral health practitioner;
         6. Certified peer support workers;
         7. Certified family peer support workers;
         8. Licensed physician assistants;

9. Physicians;
10. Medical assistants; and
11. Community health workers.

2. Peer Support Services
   A. Definition: Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. Recovery is a rehabilitative process characterized by continual growth and improvement in one's health and wellness, social and spiritual connection, and renewed purpose.

      Family Peer Support Services (FPSS) enable parents and other primary caregivers to gain the knowledge, skills and confidence to effectively manage their own needs and the needs of the family member with the condition, ultimately moving to more family independence.

   B. Practitioners:
      1. Certified Peer Support Workers
         a. Must complete the educational program offered at the Behavioral Health Services Division of the Human Services Department or the Family Peer Support training by the Children, Youth and Families Department
         b. Must complete the test and be certified by the Counseling and Therapy Practice Board
         c. Must be supervised by an independent practitioner or someone trained and certified to supervise peers.
      2. Certified Family Peer Support Workers
         a. Must complete the educational program offered at the Children, Youth and Families Department
         b. Must complete the test and be certified by the Counseling and Therapy Practice Board
         c. Must be supervised by an independent practitioner or someone trained and certified to supervise peers.

3. Dyadic and triadic therapy for a baby or child diagnosed with a behavioral health condition or at risk because of the caregiver's behavioral health condition includes the mother, father, or primary caregiver together with the child. Dyadic and triadic therapies are types of family therapies for the direct benefit of the child. Independently licensed practitioners represent the dyadic and triadic providers.

4. Outpatient withdrawal management (WM):
   A. Definition: Withdrawal signs and symptoms are sufficiently resolved so that the patient can be safely managed outside of the clinic; at night has supportive living situation.

      1. Ambulatory WM without extended on-site management
         a. Services: a comprehensive medical history and physical examination; medication or non-medication methods of WM; patient education; non-pharmacological clinical support; involvement of family members or significant others in the WM process; and discharge or transfer planning including referral for counseling and involvement in community recovery support groups.

b. Staff:
   i. on call physician, nurse, psychologist
   ii. on-site nurse, counselors, social workers, peer support workers

2. Ambulatory WM with extended on-site monitoring
   a. services include the above services plus an addiction-focused history; sufficient biopsychosocial screening to determine the level of care; an individualized treatment plan; and monitoring and assessment of progress throughout the day
   b. Staff:
      i. on call physician, nurse, psychologist
      ii. on-site nurse, counselors, social workers, peer support workers

5. Crisis Stabilization

A. Definition: Crisis Stabilization is an outpatient service providing up to 24-hour stabilization of crisis conditions. Crisis Stabilization includes services that are designed to ameliorate or minimize an acute crisis episode or to prevent incarceration, emergency department, inpatient psychiatric hospitalization, or medical detoxification. Services are provided to eligible recipients who have suffered a breakdown of their normal strategies or resources and who exhibit acute problems or disturbed thoughts, behaviors, or moods which could threaten the safety of self or others. Ambulatory withdrawal management may be included. Some Centers may also offer navigational services for individuals transitioning to the community from correctional facilities upon official release from custody/detention.

B. Staffing: Crisis stabilization community centers must be minimally staffed during all hours of operation with:
   1. one registered nurse with experience or training in crisis triage and managing intoxication and withdrawal management if offered;
   2. one licensed master's level mental health practitioner;
   3. one certified peer support worker; and
   4. either on-site or on call one board certified physician or licensed clinical nurse specialist, or licensed certified nurse practitioner.

6. Intensive Outpatient for SUD:

A. Definition: Time limited IOP services utilizing a multi-faceted approach to treatment for an eligible recipient who requires structure and support to achieve and sustain recovery. IOP must utilize a research and evidence-based model approved by the IOP Interagency Council and target specific behaviors with individualized behavioral interventions. IOP core services include: individual substance use disorder related therapy; group therapy and psycho-education.

B. Staff: IOP services are provided through an integrated interdisciplinary approach including staff expertise in both addiction and mental health treatment
   1. Each IOP program must have an independently licensed clinical supervisor
   2. The team may have services rendered by non-independent practitioners under the direction of the IOP supervisor including LMSW, LMHC, LADAC, CADC, LSAA, and master's level psych associates.

7. Intensive Outpatient for Mental Health Conditions: All conditions as IOP for SUD apply.

8. Partial hospitalization: 20 or more hours of service/week for multi-dimensional instability, not requiring 24-hour care.
   A. Partial hospitalization updated coverage criteria:
      1. Extend coverage to youth as part of EPSDT in a psychiatric hospital;
      2. Include SUD in addition to mental health;
      3. Qualified agency types include acute care hospitals with psychiatric services and psychiatric hospitals as specialty hospitals.

9. Adult Accredited Residential Treatment Centers (AARTC) for SUD with three sub-levels:
   A. Definition: Adult Accredited Residential Treatment Centers for Substance Use Disorder are facilities for adult recipients, who have been diagnosed as having a substance use disorder (SUD).

   B. Sub-levels of care
      1. Level 3.1: Clinically managed low-intensity residential service: 24-hour structure with trained personnel; at least 5 hours of clinical service/week. This level is often a step down from a higher level of care and prepares the recipient for outpatient treatment and community life.
      2. Level 3.3, 3.5, and 3.2 withdrawal management are clustered together in a second level of service with specific programming for each sub type:
         a. Level 3.3, clinically managed population specific high intensity residential services: 24-hour structure with trained counselors to stabilize multi-dimensional imminent danger; less intense programming and group treatment for those with cognitive or other impairments unable to use full therapeutic community; and preparation for outpatient treatment.
         b. Level 3.5, clinically managed high intensity residential services: 24-hour care with trained counselors to stabilize multi-dimensional imminent danger; and preparation for outpatient treatment.
         c. Level 3.2 withdrawal management, clinically managed residential withdrawal management: Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.

            The recipient remains in a Level 3.2 withdrawal management program until:
               i. withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
               ii. the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management services is indicated.
      3. Level 3.7 and 3.7 withdrawal management are clustered together in a third level of service with specific programming for each sub type.

         Services are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, peer support workers or other health and technical personnel under the direction of a licensed physician.

a. Level 3.7: medically monitored intensive inpatient services: 24-hour nursing care with physician availability for significant problems; 16 hour/day counselor availability.
b. Level 3.7 withdrawal management: medically monitored inpatient withdrawal management: Severe withdrawal, 24-hour nursing care and physician visits; unlikely to complete withdrawal management without medical monitoring.

The recipient remains in a level 3.7 withdrawal management program until:

i. withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
ii. the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management services is indicated.

10. Crisis Triage Centers (CTCs)

A. Definition: Crisis Triage Centers are community-based alternatives to hospitalization or incarceration authorized by 2014 NM HB212 Crisis Triage Center legislation. The facilities are either outpatient only (providing crisis stabilization as indicated above), or mixed outpatient and residential, with no more than 16 beds. They serve youth and adults to provide voluntary stabilization of behavioral health crises including emergency mental health evaluation, withdrawal management, and care.

Services include physical and mental health assessment, de-escalation and stabilization; brief intervention and psychological counseling; clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems; psychological and psychiatric consultation; other services determined through the assessment process; and may include ambulatory withdrawal management; and, if residential, all level 3 withdrawal management services.

B. The following individuals and practitioners must be contracted or employed by the provider agency as part of its crisis triage center service delivery:

1. an administrator which can be the same person as the clinical director;
2. a full-time clinical director;
3. a charge nurse on duty 24 hours/day, seven days/week;
4. an on-call physician 24 hours/day, seven days/week;
5. a master's level licensed mental health practitioner;
6. two certified peer support workers;
7. a part time psychiatric consultant, hours dependent on the size of the facility; and
8. at least one staff trained in basic cardiac life support (BCLS), the use of the automated external defibrillator (AED) equipment, and first aid.

The ratio of direct care staff to individuals shall increase on the basis of the clinical care needs of the individuals in residence as well as the number of operational beds.

11. Medication Assisted Treatment (MAT)

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

The state assures that Methadone for MAT is provided by Opioid Treatment Programs (OTP) that meet the requirements in 42 C.F.R. Part 8.

A. Medication Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. There are FDA approved medications to treat alcohol use disorder, smoking and opioid use disorder. MAT treatments for opioid use disorder include, but are not limited to, methadone, buprenorphine and naltrexone, which are regulated under the Controlled Substances Act.

B. For non-OTP-based MAT for Opioid Use Disorder (OUD) (does not include methadone):

<u>Eligible providers and practitioners:</u>

1. Any clinic, office, or hospital staffed by required practitioners.
2. Practitioners for diagnosing, assessment, and prescribing include:
    a. a physician or DO licensed in the state of New Mexico that has board certification in addiction medicine or addiction psychiatry or has completed special training and has the federal waiver to prescribe buprenorphine;
    b. a certified nurse practitioner that has completed 24 hours of required training and has a DATA 2000 waiver; or
    c. a physician assistant licensed in the state of New Mexico and has the federal DATA 2000 waiver to prescribe buprenorphine.
3. Practitioners for administration and education:
    a. a registered nurse licensed in the state of New Mexico; or
    b. a physician assistant licensed in the state of New Mexico.
4. Practitioners for counseling and education may include behavioral health practitioners licensed for counseling or therapy.
5. Practitioners for skills and education include certified peer support workers or certified family peer support workers to provide skill-building, recovery and resiliency support.

C. MAT services provided through an Opioid Treatment Program include the provision, administration, and/or dispensing of methadone or other narcotic replacement or narcotic agonist drug items as part of a detoxification treatment or maintenance treatments as defined in 42 CFR part 8, *Medication Assisted Treatment for Opioid Use Disorders.* The Opioid Treatment Program must comply with the requirements and meet all accreditation and certification standards as specified in 42 CFR part 8, subparts B and C. MAD pays for coverage for MAT for opioid addiction to an eligible recipient through an opioid treatment center as defined in (42 CFR Part 8), certification of opioid treatment programs (OTP). Services include, but are not limited to, the administration of methadone (opioid replacement medication) to an individual for detoxification from opioids and maintenance treatment. The administration/supervision must be delivered in conjunction with the overall treatment based upon a treatment plan, which must include counseling/therapy, case review, drug testing, and medication monitoring.

Eligible providers and practitioners:

1. Provider requirements:
    a. Accreditation with a substance abuse and mental health services administration (SAMHSA)/CSAT approved nationally recognized accreditation body, (e.g., commission on accreditation of rehabilitation facilities (CARF), joint commission (JC) or council on accreditation of services for families and children (COA).
    b. Behavioral health services division (BHSD) approval. As a condition of approval to operate an OTP, the OTP must maintain above accreditation. In the event that such accreditation lapses, or approval of an application for accreditation becomes doubtful, or continued accreditation is subject to any formal or alleged finding of need for improvement, the OTP program will notify the BHSD within two business days of such event. The OTP program will furnish the BHSD with all information related to its accreditation status, or the status of its application for accreditation, upon request.
    c. The BHSD shall grant approval or provisional approval to operate pending accreditation, provided that all other requirements of these regulations are met.
2. Staffing requirements:
    a. Both clinical services and supervision by licensed practitioners must be in accord with their respective licensing board regulations. Provider staff members must be culturally competent.
    b. Programs must be staffed by:
        i. medical director (MD licensed to practice in the state of New Mexico or a DO licensed to practice in the State of New Mexico);
        ii. clinical supervisor (must be one of the following: licensed psychologist, or licensed independent social worker; or certified nurse practitioner in psychiatric nursing; or licensed professional clinical mental health counselor; or licensed marriage and family therapist;
        iii. licensed behavioral health practitioner; registered nurse; or licensed practical nurse; and (iv) full time or part time pharmacist.

D. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)

__X__ Generic first policy
_____ Preferred drug lists
_____ Clinical criteria
_____ Quantity limits

_____ The state does not have drug utilization controls in place.

E. Limitations

In New Mexico, the DUR board tracks MAT utilization and access, but has placed as few utilization requirements into place as possible because our focus is on extending rather than limiting access.

Managed Care Organizations (MCOs) are directed to adopt a generic first policy for buprenorphine/naloxone products. A MCO can require a recipient to use a generic version of a drug prescribed as a brand name unless the prescriber specifically states on the prescription "brand medically necessary." When the "brand medically necessary" is written by hand on the prescription (not a rubber stamp), a pharmacy bills using a "dispense as written" indicator on the National Council for Prescription Drug Programs (NCPDP) transaction.

MCOs are also directed to require a prior authorization for buprenorphine-only oral products, due to higher abuse potential. No prior authorization is required for buprenorphine in any other formulation when used to treat opioid use disorders. Any formulation of buprenorphine used for the treatment of opioid use disorders is exempt from the generic-first coverage provisions 8.324.4.12 NMAC. Prescribers should specifically state on the prescription in writing "brand medically necessary". The pharmacy then bills using the "dispense as written" indicator on the NCPDP. Best clinical practices when prescribing buprenorphine for the treatment of opioid use disorders (e.g. systematic checking of the prescription monitoring programs and periodic urine drug screening) should be addressed through a provider alert rather than a prior authorization process.

There are no limitations on counseling and behavioral therapies related to MAT, other than continuing medical necessity.

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4. **Adult Accredited Residential Treatment Centers (AARTC) for Substance Use Disorders** – Reimbursement is made at a provider-specific daily rate established by the state agency contracted audit agent after analyzing the costs to provide services. Room and board costs are not included in the Medicaid rate and are not reimbursable; however, AARTCs are eligible for an additional flat fee paid by the state. Cost that are considered in the rate are: direct service costs, direct supervision costs, therapy costs including all salaries, wages, and benefits associated with health care personnel, admission discharge planning, clinical support costs, non-personnel operating costs including expenses incurred for program related supplies and general administration costs.

5. **Crisis Triage Centers (CTC)** – Reimbursement is made at service rates that are uniquely determined for each provider based on provider costs as determined by the state agency contracted audit agency. Costs are determined by considering: type of service (residential or mixed residential/non-residential), direct service costs, direct supervision costs, therapy costs including all salaries, wages and benefits associated with health care personnel, clinical support costs, non-personnel operating costs and general administration costs.

6. **Medication Assisted Treatment (MAT)** – Reimbursement is made for all drugs and biologicals approved or licensed by the FDA used for MAT to treat Opioid Use Disorder (OUD) including methadone, buprenorphine, and naltrexone. Reimbursement is also made for MAT drugs for other forms of substance use disorder (SUD), including medications for alcohol use disorder such as acamprosate and disulfiram. MAT related counseling services and behavioral therapy services are reimbursed on a fee schedule basis, or as a part of the bundled rates received by AARTCs, CTCs, health homes and other providers.

   Except as otherwise noted in the state plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of April 1, 2021 and are effective for services provided on or after that date. All rates are published at http://www.hsd.state.nm.us/providers/fee-schedules.aspx.