



State of New Mexico  
Medical Assistance Program Manual  
**Supplement**



**DATE:** January 14, 2019 **NUMBER:** 19-03

**TO:** PROVIDERS PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAMS

**FROM:**  NICOLE COMEAUX, DIRECTOR, MEDICAL ASSISTANCE DIVISION

 WAYNE LINDSTROM, DIRECTOR, BEHAVIORAL HEALTH SERVICES DIVISION

**SUBJECT: BEHAVIORAL HEALTH SUPPLEMENT AND BEHAVIORAL HEALTH POLICY AND BILLING MANUAL - Effective 1/1/2019**

The Medical Assistance Division (MAD) published a proposed Behavioral Health Policy and Billing Manual (BH Manual) and proposed Supplement making updates to Medicaid Behavioral Health. Public notice was provided, and comments were received, which are addressed in this Supplement.

The final BH Manual and Behavioral Health Supplement (BH Supplement) are posted on the HSD website at:

[http://www.hsd.state.nm.us/providers/Registers\\_and\\_Supplements.aspx](http://www.hsd.state.nm.us/providers/Registers_and_Supplements.aspx)

Based on comments, the final version made some technical corrections and some revisions. The BH Supplement offers guidance, policy updates, and explanation of new services that augment current 8.321.2 NMAC. It also addresses 8.308 NMAC, Managed Care; section 9, benefit package; subsection 19 Behavioral Health Services, by identifying and clarifying outdated definitions and referencing the BH Supplement, which is being issued in advance of the rule promulgation of 8.321.2 NMAC so that new behavioral health services are available on January 1, 2019.

**SUMMARY OF COMMENTS:**

The Human Services Department (the Department) requested public comments on the proposed changes. The Department received twenty (20) written comments and no recorded comments.

**Comment #1** - (BH Manual, pg. 59) One commenter stated that the reference to a non-certified behavior analyst should be removed because there is no such thing. According to the commenter, an

individual not appropriately certified should practice as their certification allows until they become a Board-Certified Behavior Analyst (BCBA). The commenter also questioned what would happen if there is malpractice.

**Department Response:** The term "Stage 2 provider without BACB certification" is used in the BH Manual. When the ABA services were introduced in 2015, there was a practitioner type "Interim ABA Provider/Supervisor" that allowed practitioners who met rigorous requirements to work while waiting to sit for the national exam. This Interim ABA Provider/Supervisor was retired in June of 2016 and, as a result, a gap was created in the provider network as many recent graduates from ABA Master's level programs wait up to a year to begin working. The reintroduction of a Stage 2 provider without BACB certification will support the ABA network and has been requested by practitioners in the ABA community. The Department appreciates the commenter's comment. The language stands as proposed.

**Further comment -** (BH Supplement, pg. 24) The same commenter pointed out that one of the eligible populations listed under Cognitive Enhancement Therapy (CET), "autism spectrum disorder, level I" is unclear because DSM 5 identifies levels of support, not levels of ASD. The commenter believes adult ASD diagnosis needs to be added to Medicaid as a covered benefit. The individual is concerned that there are no providers trained in providing CET, specifically for individuals with ASD and states that CET is not considered an evidence-based intervention for ASD. The NM ASD community has urged MAD to take the age caps off ABA services because it is the only evidence-based intervention for adults with ASD and there are already providers in NM. The commenter referenced legislative action passed in 2017, HM51/SM79, that tasked ASD stakeholders with recommending a specific Medicaid behavioral health benefit for adults with ASD. The group recommended ABA; CET was never considered. The commenter suggested that by adding CET without consulting the ASD community, Medicaid would claim to have a behavioral health benefit for adults with ASD; however, CET is limited in scope to individuals with ASD with specific verbal and intellectual skills. The commenter recommended working with those who participated in HM51/SM79 to determine if this service meets the need and if so, develop CET providers. The commenter also suggested that if MAD adds CET as an adult ASD benefit, ABA should be added as well.

**Department Response:** The Department agrees with the commenter's statement referencing autism spectrum disorder, level I. This term has been removed from the Supplement. Regarding CET, a couple of years ago, the Behavioral Health Services Division (BHSD) implemented Cognitive Enhancement Treatment for schizophrenia and a cohort of providers were trained in the CET Cleveland model. The new service definition was based on this model. In the previous iteration of the National Registry of Evidence-based Programs and Practices (NREPP), CET was identified as an EBP for schizophrenia. With the revamping of the NREPP system, it is more likely to be identified as a promising practice. Our pilot program for individuals with schizophrenia was associated with good clinical outcomes, high satisfaction and filled a gap in our treatment system for recovery-oriented services for individuals with psychosis. Therefore, we included CET in the BH rule and we based the service on the CET Cleveland model which conceptualizes schizophrenia as a neurodevelopmental disorder and includes autism spectrum disorder as one of the eligible populations for this modality. An overview of this intervention can be found at: <http://cetcleland.org/> The language stands as proposed.



**Comment #2** - (BH Supplement, pg. 24) One commenter pointed out that the term autism spectrum disorder, level I appears in the Supplement, but not in the BH Policy and Billing Manual.

**Department Response:** The Department appreciates this observation. The term autism spectrum disorder, level I, has been removed from the Supplement.

**Comment #3** - (BH Supplement, pg. 51) One commenter requested two minor changes be made in the Opioid Treatment Program (OTP) section. First, the individual suggests removing the word “dipstick” in the first sentence: “A recipient in comprehensive maintenance treatment receives one random urine dipstick drug detection test per month...” Second, the commenter recommends changing the verbiage in the first sentence of (OTP) reimbursement from “...and urine testing conducted within the agency” to “and urine dipstick testing conducted within the agency.”

**Department Response:** The Department agrees with the commenter and has revised both sentences. The drug screening section has been changed to read “A recipient in comprehensive maintenance treatment receives one random urine drug detection test per month...” and the reimbursement section has been revised to read: “The bundled reimbursement rate for administration and dispensing includes the cost of methadone, administering and dispensing methadone, and urine dipstick testing conducted within the agency.”

**Comment #4** - (BH Supplement, pg. 2) One commenter stated MAD will have to work with Conduent and managed care organizations for providers with out of state licenses to become NM Medicaid providers, which is often a 3-month or longer process which is usually prohibitive for out of state or temporary providers.

**Department Response:** The Department will continue to work with the Managed Care Organizations to credential and license providers as quickly as possible.

**Further comment** - (BH Manual, pg. 33) Two separate commenters suggested that instead of requiring interns to get Medicaid provider numbers and an NPI, which takes a significant amount of time and may consume most of an intern’s period of internship, that a U7 modifier, billed under a supervisor, be used to expedite the process.

**Department Response:** The Department agrees with the commenter and has updated the billing section of the BH Policy and Billing Manual to reflect that a U7 modifier may be used for interns, when billed under a supervisor.

**Further comment** - (BH Supplement, pg. 7) The commenter supported adding 0.5 ASAM level groups to the treat first model.

**Department Response:** The Department appreciates the commenter’s support. The language stands as proposed.

**Further comment** - (BH Supplement, pg. 17) Two separate commenters indicated the 1:10 ratio for Assertive Community Treatment (ACT) may be difficult to achieve due to issues in rural areas including staffing challenges, travel time, availability and other factors. One of the commenters

suggested changing the language to: “Each ACT team shall have an overall staff-to-eligible recipient of 1:10 or lower.”

**Department Response:** The Department agrees with the commenter. The section has been revised to read: “Each ACT team shall have a staff-to-eligible recipient ratio of 1:10 or lower dependent on the nature of the team, based on clinical severity and rural vs. urban environment pending BHSD approval. There is insufficient evidence to establish new ratios for rural areas at this time.”

**Further comment -** (BH Supplement, pg. 18) The commenter stated the definition of assertive outreach is an “odd artifact.” As an evidence-based model, ACT fidelity is often measured by using the Dartmouth ACT Fidelity Scale. The Dartmouth Assertive Community Treatment Scale (DACT) identifies the need for outreach efforts such as street outreach, to ensure ongoing client engagement. The DACT indicates that failure to keep an appointment is not a reason for discharge from ACT; Assertive Outreach is the primary modality to address this. The commenter cited the definition of Assertive Outreach from the Manual for ACT Startups and suggested when a client does not attend a scheduled appointment with an ACT team member, the team member would assertively engage in locating the client. The commenter believes the current definition of assertive outreach is vague and subjective and should be revised. Also, the overall percentage cap of 5% for assertive outreach is unrealistic in a rural setting. The assertive outreach may be clinically ineffective when a team is dealing with high-risk, high-needs individuals who are, for instance, homeless and under the influence. The stated limit may result in precipitous discharge of clients, which is contrary to the evidence-based model.

**Department Response:** The definition of assertive outreach in the Supplement is congruent with the model. The Department accepts the suggestion that an overall percentage of 5% may be clinically ineffective. The language has been revised to clarify the 5% is per individual, and it is stated this way to manage the percent of indirect services.

**Further comment -** (BH Supplement, pg. 24) The commenter pointed out the exclusions for Behavior Management Skills (BMS) do not include Treatment Foster Care (TFC). The individual stated that this is a “thoughtful and useful means” to maintain high-needs behaviorally disordered youth in foster homes.

**Department Response:** The Department appreciates the notice of BMS and TFC co-occurring services.

**Further comment -** (BH Supplement, pg. 26) The commenter questioned the reference to “approved curriculum in behavioral health coaching” in the section on Comprehensive Community Support Services (CCSS); there is no educational program providing this training or education in New Mexico.

**Department Response:** The Department notes this comment; however, this is an approved curriculum in some areas. The language stands as proposed.

**Further comment** - (BH Supplement, pg. 32) The commenter indicated the code allowing same time billing/service by Certified Peer Support Worker (CPSW) should include Community Support Worker (CSW) as the CSW may be working at the same time to identify resources and benefits for the client.

**Department Response:** Community Support Workers are only billable practitioners in CCSS. The language stands as proposed.

**Further comment** - (BH Supplement, pg. 39) The commenter stated the acronym for Family Support Services should be FSS, not FFS.

**Department Response:** The Department thanks the commenter for this observation. The acronym has been corrected to read FSS.

**Further comment** - (BH Supplement, pg. 62) The current language in the Treatment Foster Care (TFC) I & II section treats TFC I and TFC II as separate services, but they are not. All agencies providing TFC provide both levels.

**Department Response:** Although the agency may be the same, there are distinguishing characteristics for the services and reimbursement for the two levels of treatment foster care. The language stands as proposed.

**Further comment** - (BH Supplement, pg. 63) The commenter stated that the sentence: "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, will have their license revoked" may violate appeal rights granted to foster parents. License revocation is a CYFD Foster Care licensee process, not a Medicaid process; therefore, the wording should be revised to read "may have their license revoked."

**Department Response:** The Department accepts this suggestion and has replaced the word "will" with "may"; however, the rest of the section remains as it was written by CYFD.

**Further comment** - (BH Supplement, pg. 65) According to the commenter, the language allowing CCSS billing when a child transitions from a level TFC I to TFC II is inaccurate as the child stays in the same home, with the same coordinator and same therapist; there is no transition, aside from billing a lower rate.

**Department Response:** The Department accepts this comment and will remove the last sentence for transitioning between levels of care, but it will remain for transitioning out of either level.

**Comment #5** - (BH Manual, pgs. 84, 86, 91) One commenter noted a few technical inaccuracies in the BH Manual. The statement that a BA must "submit a 36-month service authorization request" should be stricken as there is no 36 months/3-year request for ABA services. The Current Procedure Terminology (CPT) codes 0368T and 0369T for ABA Stage 3 case supervision or clinical management services should be deleted; these codes will be retired as of January 1, 2019. The new

code, 97155, should be referenced in this section. CPT code 0374T for ABA Specialty Care services should be deleted; this code will be retired as of January 1, 2019 and only code 0373T will be used.

**Department Response:** The Department appreciates the commenter's observations and has made the following corrections: 1) regarding the 36-month service authorization, the language has been revised to state: "the BA must submit an initial 6-month Prior Authorization request and concurrent Prior Authorization requests every 6 months thereafter;" 2) code 97155 is referenced for ABA Stage 3 Adaptive Behavior Treatment by Protocol Modification with one recipient; and 3) the billing as a SCP section has been revised to read: "The SCP bills ABA Stage 2 CPT codes. ABA Specialty Care services are billed utilizing CPT code 0373T with the appropriate U3, U4, or U5 modifier."

**Further comment -** (BH Manual, pgs. 9, 33) The commenter noted that there were two references to appendices in the BH Manual that are not accurate. Appendix L, List of BH Provider types, is not on the website <http://www.hsd.state.nm.us/2017-comment-period-open.aspx> and Appendix T is an outdated version of the Level of Care Guidelines; it does not include ABA services. The commenter provided a copy of the current version.

**Department Response:** The Department appreciates this observation. Appendix L is the BH fee schedule, it is not intended to be a comprehensive list of BH providers. A complete list of Behavioral Health providers can be found at: [https://nmmedicaid.portal.conduent.com/static/ProviderInformation.htm#sandbox\\_title](https://nmmedicaid.portal.conduent.com/static/ProviderInformation.htm#sandbox_title) The outdated version of the Level of Care Guidelines has been removed from the BH Manual.

**Further comment -** (BH Supplement, pg. 24) The same commenter stated that the source that defines "level I" in the term "autism spectrum disorder, level I" under Cognitive Enhancement Therapy (CET), needs to be referenced.

**Department Response:** The Department agrees with the commenter. The term "autism spectrum disorder level I" has been eliminated from the autism spectrum disorder diagnosis.

**Comment #6 -** (BH Supplement, pg. 57) One commenter had three separate remarks related to the Partial Hospital section of the Supplement. First, language allowing for separate billing of electroconvulsive therapy (ECT) services needs to be added.

**Department Response:** The Department agrees with the recommendation and has added ECT to the list of services that are not included in the facility billing code and can be billed separately on a CMS1500.

**Further comment -** (BH Supplement, pg. 57) The commenter indicated the professional billing section appears to be restricted to the codes listed; medication management and E&M codes need to be added as these would be likely services for the provider.

**Department Response:** The E&M codes have been added to the professional billing section; however, the medication management remains unchanged as nurses are required staff in partial hospitalization and would be covered in the facility rate.

**Further comment** - (BH Supplement, pg. 57) The same commenter stated the Department needs to make it clear that other medical services provided by non-behavioral health providers to partial hospital patients may be billed as an additional service to allow for the potential to have a more integrated approach for providing needed medical services for this population.

**Department Response:** The Department agrees that the proposed wording should be revised to clarify that other medical services provided by non-behavioral health providers to partial hospital patients may be billed as an additional service to allow an integrated approach for providing needed medical services. The new verbiage reads: "Other medical services that are not related to the purpose of the partial hospitalization can be reimbursed if they are medically necessary."

**Comment #7** - (BH Manual, pg. 31) One individual stated that "reimbursement for professional services performed at both the originating and distant sites will be paid the same as when the services are furnished without the use of telehealth."

**Department Response:** Behavioral health services furnished via telehealth with an originating and distant site are reimbursed at the same rate as when services are furnished in person.

**Further comment** - (BH Manual, pg. 32) The commenter stated that the telemedicine billing instructions for Indian Health Services does not address Federally Qualified Health Clinics (FQHCs); the originating clinical fee performed by the FQHC should be paid at the encounter rate.

**Department Response:** The Department has revised the language to clarify that the originating clinical fee performed by the FQHC should be paid at the encounter rate.

**Further comment** - (BH Manual, pg. 33) Two commenters recommended referencing MAD Supplement 16-13 under FQHC billing because it provides additional clarification to specialized behavioral health critical to service delivery, which is not specified in the BH Manual.

**Department Response:** The Department has incorporated the FQHC billing instructions into the BH Policy and Billing Manual. Also, community-based services have been added into the BH Policy Manual. Lastly, the modifiers for delineating same day billing for different diagnoses, or different providers, are not new. The modifiers help clarify when multiple encounter rates for BH are billed.

**Further comment** - (BH Manual, pg. 34) Two separate commenters stated the sentence: "The encounter is billed when a practitioner sees a patient at the clinic or in a hospital or nursing facility" limits location to clinic or hospital and does not address BH services that are in-vivo and not in facility (CCSS, MST, ACT, BMS).

**Department Response:** The department added language to the BH Manual to specify that the location may be "in the community."

**Further comment -** (BH Manual, pg. 34) The same commenter asked for clarification as to whether the modifiers XE, XP and XU are new.

**Department Response:** The modifiers for delineating same day billing for different diagnoses, or different providers, are not new. The modifiers clarify when multiple encounter rates for BH are billed.

**Further comment -** (BH Manual, pg. 43) Two commenters questioned why comprehensive assessment 90791 and H0031, completion of 2 assessments, are both needed as this creates a barrier to providing treatment. The commenters contend 90791 is sufficient to identify presenting issues, determine diagnoses, and provide behavioral health treatment. Also, the Comprehensive Assessment in the appendices is the CLNM Comprehensive Needs Assessment, not a diagnostic evaluation.

**Department Response:** The Department agrees with the commenter's suggestion and deleted the need for both to be done, as the diagnostic assessment is comprehensive.

**Further comment -** (BH Manual, pg. 46) The commenter asked if crisis and safety planning are both required or whether clinical discretion can be used to determine when a crisis plan is needed versus a safety plan to avoid delays in treatment.

**Department Response:** The Department accepts the commenter's recommendation. The language has been revised to read: "Crisis and safety are two different things so, there may be a need for an individual to have a crisis plan, a safety plan or both."

**Further comment -** (BH Supplement, pg. 26) The commenter requested clarification as to whether providers that have been certified to provide Comprehensive Community Support Services (CCSS) prior to the UNM training requirement will be grandfathered or provided confirmation of exemption from the UNM training certification.

**Department Response:** Providers that were previously certified to provide Comprehensive Community Support Services (CCSS) prior to the implementation of the UNM training requirement, will be grandfathered. There will be no additional certification required.

**Further comment -** (BH Supplement, pg. 30) The same commenter asked when the initial 20 hours of required training needs to be completed to provide crisis intervention services.

**Department Response:** Section 3.3 of the BH Manual offers clarity regarding the initial 20 hours of required training needed to provide crisis intervention services.

**Further comment -** (BH Manual, pg. 161) Two separate commenters indicated the BH Manual only addresses the Clubhouse model in Psychosocial Rehabilitation Services (PSR); they suggest adding the structured classroom model.

**Department Response:** The Behavioral Health Policy and Billing Manual only addresses the Clubhouse model; however, the BH Supplement provides clarity on the classroom model.



**Further comment** - (BH Supplement, pg. 32) The same commenter stated that the Licensed Associate Marriage Family Therapist (LAMFT) as a non-independently licensed provider needs to be added under Eligible BH Agencies and Practitioners.

**Department Response:** The Department agrees with the commenter; LAMFT has been added to the list of non-independently licensed providers.

**Further comment** - (BH Supplement, pg. 4) The commenter stated that “value-based purchasing agreement” is too broad and should not limit behavioral health services such as evaluation and treatment.

**Department Response:** Value-based purchasing agreements limit the ability to bill for the comprehensive needs assessment but not general evaluation and treatment services.

**Further comment** - (BH Supplement, pg. 17) The commenter stated the team lead for Assertive Community Treatment Services (ACT) should not be restricted to a psychiatrist, CNS, CNP, or prescribing PhD as this is not a current requirement. The commenter recommends including independently licensed provider types such as LPCC, LMFT, LCSW and LISW.

**Department Response:** The Department revised the language to clarify that the ACT team requires a prescriber as well as an independently licensed team lead.

**Further comment** (BH Supplement, pg. 62) - The commenter requested type 313 be included as a practitioner type for Screening, Brief Intervention & Referral to Treatment (SBIRT).

**Department Response:** The BH Supplement specifies that FQHCs, type 313, are eligible agencies to deliver SBIRT.

**Comment #8** - (BH Supplement, pg. 3) One commenter would like clarification as to what the specific requirements are for a Core Service Agency (CSA) and Community Mental Health Center (CMHC) to be a Behavioral Health Medicaid eligible agency.

**Department Response:** Requirements for a CSA or CMHC are under the purview of the Behavioral Health Collaborative and are not part of MAD regulation. The language stands as proposed.

**Further comment** - (BH Supplement, pg. 2) The same individual commented that to be eligible to be reimbursed for providing Medicaid behavioral health professional services, RNs are required to be supervised by a certified nurse practitioner or clinical specialist or physician, but agencies that employ RNs are rarely set up for supervising by those practitioners. They are supervised by other more senior RNs with BC in Psychiatry and/or RNs with MSNs. The commenter requests adding these supervisors to the list of eligible BH practitioners.

**Department Response:** All Medicaid BH services that are reimbursable must be rendered by an independent practitioner or supervised by an independent practitioner. Board certified nurses and nurses with a master’s degree are not independent practitioners and, therefore,

cannot supervise without input from an independent practitioner. The language stands as proposed.

**Further comment** - (BH Supplement, pg. 20) The same commenter requested the option of using a diagnostic evaluation (90791, 90792) as the primary assessment instead of a comprehensive assessment and service plan when the recommended services are limited and/or the consumer refuses multiple services.

**Department Response:** The Department agrees with the commenter. The language has been revised to include the diagnostic evaluation, because it is comprehensive in scope.

**Further comment** - (BH Supplement, pg. 21) The commenter indicated that restricting use of medication administration code T1502 to a “stand-alone” may potentially penalize providers that may be providing multiple services to certain patients who are frequent no-shows.

**Department Response:** The Department thanks the commenter for this observation. The code T1502 has been removed from the BH Supplement.

**Further comment** - (BH Supplement, pg. 21) The same individual asked whether an “in community” premium, similar to the one for CCSS, can be added to H0038 - Peer Support Services.

**Department Response:** In order to add a premium to H0038 - Peer Support Services, cost projections would have to be completed and approved by MAD. The language stands as proposed.

**Further comment** - The commenter recommended that Partial Hospitalization Programs could be granted “deemed status” in terms of regulations if the program itself is accredited by the Joint Commission or other nationally recognized accrediting body. The commenter believes that granting “deemed status” for Accredited RTCs could also reduce the administrative burden for all concerned.

**Department Response:** The Department does not have authority under the Public Health Act to make this change. The language stands as proposed.

**Comment #9** - One commenter stated that CPT code 0359T will be changed to 91751 on the ABA fee schedule.

**Department Response:** The Department thanks the commenter for this observation. CPT code 0359T has been eliminated and replaced with 91755.

**Comment #10** - (BH Supplement, pg. 2) One commenter suggested revising the Eligible Behavioral Health Agencies and Practitioners Section of the BH Supplement because it reads as though independent practitioners can form groups and render care under their licenses. There is confusion as to what the agencies are allowed to do.

**Department Response:** The Department has added language to clarify that “All services must be delivered according to the Medicaid regulation and current version of the Behavioral Health Policy and Billing Manual.”

**Further comment -** (BH Supplement, pg. 2) The same commenter questioned why DOH agencies, such as New Mexico Rehabilitation Center, DOH hospitals, stand-alone psychiatric hospitals (i.e. Haven or Mesilla Valley) are not included in the list of eligible behavioral health providers as these facilities might benefit from being able to render additional care.

**Department Response:** Hospitals are identified as eligible agencies in the BH Supplement, under Eligible Behavioral Health Agencies and Practitioners, Section B, number 6.

**Further comment -** (BH Supplement, pg. 3) The commenter requested clarification as to what “is covered to the same extent as if rendered by a practitioner licensed for independent practice...when the agency has supervisory certification” means. It is unclear whether OTPs can now use a LSAA to do assessments and treatment planning or whether LSAA's can do that in other practices.

**Department Response:** The Department revised the wording to clarify that “All services must be delivered according to the Medicaid regulation and current version of the Behavioral Health Policy and Billing Manual” and thus the scope of practice for each discipline.

**Further comment -** (BH Supplement, pg. 7) Regarding the Treat First section of the BH Supplement, the commenter wants to know if it is true that Treat first can only be rendered for ASAM 0.5.

**Department Response:** Treat First is applicable to all ASAM levels of care, not just to ASAM 0.5.

**Further comment -** (BH Supplement, pg. 9) The same individual asked if (ASAM) level 3.6 should be included as other levels of care are mentioned; 3.6 is also not referenced in the rule.

**Department Response:** There is no ASAM level 3.6.

**Further comment -** (BH Supplement, pg. 17) The commenter questioned whether there can be some leeway with the designated team of 10 to 12 team members requirement related to Assertive Community Treatment (ACT) services. The individual believes that most agencies will need some flexibility on the front end to build patient capacity and staffing and that this could be a huge financial burden with no financial return.

**Department Response:** The Department has added language clarifying that “Lower number of team member compositions may be considered by BHSD for a waiver request dependent on the nature of the clinical severity and rural vs. urban environment pending BHSD approval.”

**Further comment -** (BH Supplement, pg. 17) The commenter would like clarification on whether independent clinical practitioners can be an ACT team lead.

**Department Response:** The Department has revised the wording to clarify that independent behavioral health providers can be ACT team leads.

**Further comment -** (BH Supplement, pg. 18) The commenter pointed out there is a typographical error in the sentence: “The ACT therapy model is based on empirical data and evidence-based interventions that target specific behaviors with an individualized treatment plan of the eligible recipient.” The word “of” should be “for.”

**Department Response:** The Department thanks the commenter for this observation. The sentence has been corrected to read: “The ACT therapy model is based on empirical data and evidence-based interventions that target specific behaviors with an individualized treatment plan for the eligible recipient.”

**Further comment -** (BH Supplement, pg. 43) The commenter indicated “interagency council” needs to be changed to “interdepartmental council” and MAD IOP should read HSD IOP.

**Department Response:** The Department has changed the language from “interagency council” to “interdepartmental council.” The Department rejects the suggestion that MAD IOP should be renamed HSD IOP.

**Further comment -** (BH Supplement, pg. 47) The commenter recommends separating counseling from education and the respective certifications because this is being interpreted as peer support workers can be counselors.

**Department Response:** A fifth category “Practitioners for skills and education” which includes “certified peer support workers or certified family peer support workers to provide skills-building, recovery and resiliency support” has been added to the section for clarity.

**Comment #11 -** One commenter was disappointed that there is no express direction that the Human Services Department (HSD) and the Children Youth and Families Department (CYFD) will collaborate to provide coordinated care and services to effectively serve all children in CYFD custody.

**Department Response:** Although not reflected in the BH Supplement or BH Policy and Billing Manual, the CYFD and BHSD strategic plans address the importance of effective collaboration.

**Further comment -** (BH Manual, pgs. 12-16) The same commenter stated that the BH Manual appears to be “aspirational in nature.” Some sections, including, trauma informed care, recovery and resiliency, and cultural competency defines these concepts/principles without directing how the components are to be integrated into the behavioral health care delivery system. The commenter hoped that revisions to the New Mexico Administrative Code or provisions in the Managed Care organization contracts, or both, will provide specific requirements about coordination and collaboration between HSD and CYFD and incorporate the service delivery components listed in the General Principles.

**Department Response:** Although not reflected in the BH Supplement or BH Policy and Billing Manual, the CYFD and BHSD strategic plans address the importance of effective



collaboration. The core pillars of trauma informed care are currently being defined by CYFD and BHSD in collaboration with stakeholders.

**Further comment** - (BH Manual, Appendix A) The commenter explained that a serious emotional disturbance (SED) classification requires either a DSM diagnosis or a determination that the youth meets criteria for complex trauma, defined as the experience of one of six traumatic events, including abandonment, neglect, sexual abuse or exploitation, physical abuse, emotional abuse, or repeated exposure to domestic violence. A complex trauma classification demands an ex parte court order requiring state custody. The commenter requested the requirement that a child must be subject to an ex parte court order removing the child from the home in order to meet the trauma criteria of SED, be struck from the definition because in some circumstances, the requirement would prevent access to necessary services. A young child who has experienced neuro-developmental disruption due to emotional abuse and neglect, and who struggles with emotional regulation and has engaged in self-harm, for example, may not qualify as SED and, therefore, would not get access to much-needed intensive community-based services if he/she was never subject of a court order removing him/her from the family home. The commenter stressed this exclusionary criterion is an obstacle to early care.

**Department Response:** The Department has incorporated the Treat First Model to allow agencies to commence early treatment of individuals with provisional diagnoses. The language stands as proposed.

**Further comment** - (BH Manual, pg. 11) The commenter believes all behavioral health systems and services should be trauma informed and that the requirement should be expressly stated. The individual suggested the HSD and CYFD consider providing technical assistance and training to those MCOs and providers who are not well-versed in trauma informed care (TIC).

**Department Response:** The CYFD is seeking discretionary external funding to increase statewide capacity to provide training and technical assistance in trauma informed care.

**Further comment** - (BH Manual, pg. 13) The same commenter mentioned that the Recovery and Resiliency section does not state whether, or how, the principle of recovery and resiliency is to be incorporated into the provision of behavioral health care services.

**Department Response:** At this time, the measurement of quality Recovery and Resiliency is an emerging field. The Department will continue to identify best practices in its quantification.

**Further comment** - (BH Manual, pg. 16) The commenter believes the section on Cultural Competency is aspirational instead of being identified as a required component of the Medicaid/behavioral health delivery system.

**Department Response:** At this time, the measurement of quality Cultural Competency is an emerging field. The Department will continue to identify best practices in its quantification.

**Further comment** - (BH Manual, pg. 21) The commenter noted that a "vision" of quality is described however, there is no requirement for development of a data system that includes any of the objectives identified as data points to measure quality.

**Department Response:** The scope of this Supplement does not address the development of a statewide data system. The language stands as proposed.

**Further comment -** (BH Manual, pg. 36) The commenter believes the language on interdisciplinary teaming is confusing because the BH Manual describes what it is and identifies the use of interdisciplinary teams within a few of the listed services, but it does not say when it should be used. Although 8.321.2 NMAC contains provider requirements and a description of discrete types of specialized behavioral health services, it is not a template for delivering integrated care. The commenter stated that these teams could be beneficial for persons labeled as having SMI or SED or for an individual who is in an out of home placement, or at risk of an out of home placement. The interdisciplinary teams can coordinate care and promote a smooth transition to the recipient's home community. Interdisciplinary teaming should be a required component of providing services to all Medicaid eligible children in CYFD custody. The commenter recommended articulating when, and how, an interdisciplinary team is to be used to coordinate care.

**Department Response:** The Department cannot require use of billing codes; it can only encourage best practices. The Department deliberately did not restrict the use of interdisciplinary teaming for youth with SED and in state custody so that it can be used proactively as events change in a child's life.

**Further comment -** (BH Manual, pg. 43) The commenter believes a Comprehensive Needs Assessment (CNA) should be used for all children in CYFD custody, regardless of whether they meet the criteria for SED because it is the screening and assessment tool to establish service needs. Ineligibility may prevent the child from being assessed for more comprehensive community-based services. The commenter also indicated the definition of SED is too narrow as a criterion for administering a CNA because a child could meet the criteria for complex trauma, yet not be considered SED if there is no ex parte court order requiring state custody. Consequently, a child who does not have a more traditional DSM V diagnosis, but has experienced significant trauma and exhibits all of the attendant symptoms and service needs will not qualify for a CNA if the child has never been removed from the family home, which is egregious if the goal of care is to support recipients in their communities in hopes of preventing out of home placements. The commenter recommends adding language that a CNA should be provided to all children in state custody and that there should be collaboration between HSD and CYFD when developing the initial service plan.

**Department Response:** All children in CYFD custody currently meet the SED criteria and, therefore, receive the CNA and care coordination. The issue of HSD and CYFD collaboration with the MCOs falls under the Centennial Care contracting process rather than the Behavioral Health Supplement.

**Further comment -** (BH Manual, pg. 93) The commenter believes the Comprehensive Community Support Services (CCSS) language needs to be amended to specifically address children in state custody. These children need services to promote recovery, rehabilitation and resiliency; and their foster families could benefit from these types of supports.

**Department Response:** Children in state custody are currently eligible for CCSS statewide. The language stands as proposed.

**Further comment** - (BH Manual, pg. 97) The commenter stated that children in foster care and treatment foster care should specifically be included in Crisis Intervention Services because each child and their foster family should have planned access to the services. The commenter pointed out that this is an ideal opportunity for HSD and CYFD to coordinate planning efforts for children in custody.

**Department Response:** Children in foster care are currently eligible for Crisis Intervention Services. The language stands as proposed.

**Further comment** - (BH Manual, pg. 103) The same commenter recommended that the HSD consider providing Family Peer Support Services (FPSS) to foster parents, as a means of supporting the foster parent, thereby facilitating stability for the child in care. Since family peer support workers (FPSW) have lived experience with emotional, behavioral, mental health and/or substance abuse issues as well as knowledge of navigating child serving systems, they may be able to assist foster parents in maintaining a foster child in their home.

**Department Response:** Foster parents are eligible to receive Family Peer Support Services. The language stands as proposed.

**Further comment** - (BH Manual, pg. 122) The commenter suggested CYFD and HSD coordinate efforts to make BMS available to children in foster care as part of a comprehensive community-based service package because the services may reduce the possibility that the child will be removed from the foster home and put into a more restrictive placement.

**Department Response:** Children in foster care are currently eligible for BMS. As part of CYFD strategic planning, the Department will be planning efforts to expand this service.

**Comment #12** - One commenter opposes the proposed provisions in the BH Policy and Billing Manual and BH Supplement and stated that full tribal consultation is required for the proposed changes. The commenter pointed out that New Mexico is one of the top three states with the greatest concentration of Native American members in the U.S.; however, questions regarding equity and common-sense accountability remain unaddressed, especially for behavioral health services in NM. Despite the fact that Indian Health Service/Tribes/Urban (I/T/Us) are a major purchaser of healthcare in NM and gaming tribes contribute millions in game revenue to the State, tax breaks are given to companies like Facebook, Netflix and Intel, which is a significant source of potential income for the State that is lost.

**Department Response:** Tribal consultation was initially requested for the Policy Manual; however, it was rescinded based on changes described below.

**Further comment** - The commenter indicated behavioral health services were “virtually eviscerated under Governor Martinez” and hopes that access grows for both native and non-native New Mexicans. The individual contends the sustained access rests with receiving reasonable reimbursement for services rendered. The commenter stated that the State of New Mexico has made significant gains in increasing access to care through the implementation of the Expanded Medicaid program for adults as well as the CMS directive that allows Native Americans to choose Medicaid fee-for-service or an MCO as their health plan. Thousands more New Mexicans, have been able to access health care

without the threat of a medical bill and thousands more Native American patients have been able to receive specialized medical care outside of IHS, Tribes and Urban Indian facilities. These provisions, which expanded Medicaid and enrollment choices for Native Americans (excepting long term care recipients), increased access and scope of services to its community members. Although Medicaid reimbursement to IHS and tribal organizations are subject to 100% FMAP, the State of New Mexico continues to subject Native American beneficiaries and their health providers in its proposed cuts while tailoring to for-profit organizations.

**Department Response:** The Department recognizes the important health disparities experienced by many Native Americans in New Mexico and is committed to a government-to-government process to address health care.

**Further comment -** The commenter is disappointed that Behavioral Health providers will not be able to bill for Equine Therapy, an evidence-based treatment, and one for which the Substance Abuse and Mental Health Services Administration (SAMHSA) provides grant funding. Additionally, Native American communities deal with significant substance abuse problems, which disproportionately impacts Tribes and strains the limited public health and healthcare resources available to Tribes. Among American Indians and Alaska Natives (AI/ANs), the rate of drug overdose deaths is twice that of the general population; deaths from prescription opioid overdoses increased four-fold from 1999 to 2013 among AI/ANs.

**Department Response:** The Department is not able to add a service that is only available to individuals from a particular race or ethnicity. Equine therapy for behavioral health is not available through New Mexico Medicaid at this time.

**Further comment -** The same commenter stated chronic underfunding, uncompensated care and medical inflation, all lead to delays in care, crowded waiting rooms, long patient cycle times, staff shortages, and worsening health disparities. Underfunding of the Indian Health system forces reliance on third party reimbursements. Specifically, the commenter would like the State to consider paying the OMB rate for multiple visits when a psychiatrist performs Evaluation & Management (E&M) services which involve general psychiatry examination and subsequent psychiatry services. The commenter explained that the University of New Mexico Hospital (UNMH) receives Medicaid payments for both the therapy and E&M services for the same encounter, with an FMAP of 72%. Should I/T/Us be permitted to bill both of the same services using the OMB rate, the FMAP is 100%. The commenter believes the inability to bill psychiatry services under home visits is unethical because the To'Hjiilee community experiences a significant number of crises that require going to the home because of transportation issues for the clients. The individual requests the Department reconsider this decision to help communities that do not have typical urban health care services. Psychiatry services are provided to members that suffer with serious mental illness who do not have the ability to cope; home visits make it possible to address those needs and determine the patient's welfare. Proper and adequate reimbursement for psychological and behavioral health services will improve access and outcomes in tribal communities where mental health and substance use disorders are taking a heavy toll.

**Department Response:** The Department will work with the MCOs to ensure that there are no edits for the denial of multiple services on the same day for services provided by a different



provider or for a different diagnosis or non-overlapping components of the same service. Until January 2021, home visits through IHS or tribal 638 clinics are reimbursable at the OMB rate. IHS and tribal 638 clinics who wish to pursue FQHC status can continue home visits after that time. Any tribal 638 agencies or IHS clinics who wish to pursue FQHC status must approach the Program Policy Bureau of MAD.

**Comment #13** - (BH Supplement, pg. 2) One commenter proposed adding clarifying language to specify that providers should have an active license, and to specify whether provisional or temporary licensures are eligible.

**Department Response:** Language has been added to the description of independent and non-independent licensed providers to clarify that providers should have an active license. Provisional or temporary licensures are not eligible.

**Further comment** - (BH Supplement, pg. 8) The commenter questioned the need for the reference to “Subsection A, B, and C of numeral I” in the sentence: “In addition to the requirements of Subsections A, B, and C of numeral I, to be eligible to be reimbursed for providing ARTC services to an eligible recipient, an ARTC facility...” It is unclear how that applies to Adult Residential Treatment Centers (ARTC).

**Department Response:** The Department agrees that the reference to “Subsection A, B, and C of numeral I” is not necessary. The language has been removed.

**Further comment:** (BH Supplement, pg. 11; BH Manual, pg. 176) Two commenters stated the current language regarding prior authorization supports a “treat first” model, allowing the member to begin treatment while still allowing the MCO to conduct medical necessity review for admission and continued stay treatment; however, the commenter requested language be added to clarify that intent.

**Department Response:** Treat First is not applicable to ARTCs. The first five days within the ARTC is designed to give the facility time to complete a comprehensive assessment.

**Further comment** - The commenter proposed adding language to clearly indicate prior authorization will be required from the MCO beyond 48 weeks for Cognitive Enhancement Therapy (CET) services. Also, guidelines for authorizing greater than 48-week CET should be included in the BH LOC guidelines.

**Department Response:** Parity guidance states that there can be no quantitative limits on behavioral health services. The language stands as proposed.

**Further comment** - (BH Manual, pg. 116; BH Supplement, pg. 57) The same commenter pointed out a technical error regarding HCPCS code S0201. The unit value is per diem, not 8 hours as is stated in the Supplement. Codes 0912, Partial Hospitalization, Less Intensive and 0913 Partial Hospitalization, Intensive, should be included to give providers the flexibility of providing half or full day partial hospitalization with commensurate compensation.

**Department Response:** The HCPS code S0201 is defined based on 8 hours of service delivery which can be billed in fractions. The language stands as proposed.

**Further comment -** (BH Manual, pg. 19) The commenter noted that the Licensed Professional Art Therapist (LPAT) is not included in the definition list for clinical supervisor but should be.

**Department Response:** Since LPAT is an additional degree, the Department rejects this change and encourages LPATs to maintain their initial independent behavioral health provider license.

**Further comment -** (BH Manual, pg. 19) Two separate commenters stated that Licensed Professional Mental Health Counselors (LPCs), Licensed Associate Marriage and Family Therapists (LAMFTs) and Licensed Substance Abuse Associate Counselors (LSAAs) are non-independent active licensures at this time and should be included in the definition of master's level non-independent BH professional.

**Department Response:** The Department agrees with the commenters. Provider types LPC (Licensed Professional Mental Health Counselor), LAMFT (Licensed Associate Marriage and Family Therapist) and LSAA Licensed Substance Abuse Associate Counselor have been added to the definition of master's level non-independent BH professionals.

**Further comment -** (BH Manual, pg. 19) The individual proposed adding new language to address provisional or temporary licensures under the definition for non-master's level, unlicensed BH staff.

**Department Response:** There are liability issues for agencies when seeking reimbursement for individuals with provisional or temporary licenses. The language stands as proposed.

**Further comment -** (BH Manual, pg. 29) The commenter pointed out that the statute cited in the Manual for the definition of telemedicine, NMSA 1978, Section 59A-22-49.3, is a commercial/retail coverage mandate. The individual recommends using the definition in the Medicaid Managed Care Services Agreement with the MCOs for Centennial Care 2.0, which is based on the definition in the New Mexico Telehealth Act, NMSA 1978, Section 24-25-3.C. Store-and-forward information may be excerpted from Section 8.310.2.12(M) NMAC.

**Department Response:** The Department agrees with the commenter. The definition of telehealth has been revised to match the New Mexico Telehealth Act, NMSA 1978, Section 24-25-3.C.

**Further comment -** (BH Manual, pg. 31) The commenter contends that removing the originating site fee for a group that operates both the originating and distant sites disincentivizes furnishing telemedicine. The commenter proposes removing the language that precludes the telemedicine fee when the originating site and the distant site are operated by the same group or entity.

**Department Response:** The telehealth facility fee is intended to cover the additional technical expenses that each agency contributes to cross-agency telehealth partnerships. The language stands as proposed.

**Further comment** - (BH Manual, pg. 33) The commenter proposed adding language to clarify that groups or agencies that are not eligible to use non-independently licensed practitioners may not bill using the U7 modifier for rendering behavioral health services.

**Department Response:** Clarification regarding use of the U7 modifier is provided in Section 1.13 of the BH Manual. When a new employee of an agency is awaiting completion of their enrollment in Medicaid and is providing services, the supervisor's name and NPI may be placed in the rendering field with a U7 modifier, signifying the service was done by someone under their supervision for which they are assuring all licensing and required certifications are in order. To use the U7 modifier, an enrollment application must have already been submitted to MAD. This process can only be used for six months. Once the employee is enrolled in Medicaid, the agency is required to start listing the employee as the rendering provider instead of the supervisor with the U7 modifier.

**Further comment** - (BH Manual, pg. 44) The commenter suggested adding language to clarify the scope and roles of various provider types. Also, LPC practitioners should be added to the list of practitioners eligible to conduct the comprehensive assessment and initial services plan under their relevant supervision.

**Department Response:** The Department has added language to clarify the scope and roles of provider types. "Independently licensed BH practitioners may conduct the comprehensive assessment and initial service plan. LMHCs, LMSWs, LAMFTs, LPCs, psychology interns, post-doctoral students may conduct the comprehensive assessment and initial service plan under the supervision of an independently licensed BH practitioner. Registered nurses may contribute to the assessment and initial service plan to the extent of forming clinical impressions and according to scope of practice. "

**Further comment** - (BH Manual, pg. 48) The commenter pointed out that the current BH fee schedule does not require a rendering provider for Peer Support Services (H0038) and Comprehensive Med Services; therefore, language should be added to clarify that the rendering provider is needed only if indicated on the BH fee schedule.

**Department Response:** The Department thanks the commenter for pointing out this inaccuracy. A rendering provider is required for Peer Support Services. The fee schedule will be corrected.

**Further comment** - (BH Manual, pg. 51) The same commenter believes the language regarding the use of buprenorphine needs to be revised to clarify that the intent is to allow coverage for SUD treatment. Buprenorphine is also available in other formulations to treat pain.

**Department Response:** The Department has added clarifying language to specify that the use of buprenorphine is covered "when used to treat opioid use disorders."

**Comment #14** - (BH Supplement, pg. 4) One commenter asked whether multiple disciplines, (e.g. PSR, CCSS, MST, CLNM Health Home providers), within an agency count as part of teaming.

**Department Response:** It is permissible for multiple disciplines within an agency to bill for interdisciplinary teaming within the same agency.

**Further comment -** (BH Supplement, pg. 4, 6) The same commenter requested clarification regarding billing for a service plan. Page 6 indicates the service plan can be billed twice a per year, but page 4 states it can be billed any time changes are clinically appropriate.

**Department Response:** Service plans can only be billed twice per year for non-SMI/SED recipients. Service plans can be billed when clinically appropriate for individuals with SMI/SED.

**Further comment -** (BH Supplement, pg. 11) The commenter questioned whether Residential Treatment Centers (RTCs) need to be accredited by January 1, 2019 and asked if there is direction for youth RTC's that are in the process of certification/accreditation. Accredited Residential Treatment Centers (ARTCs) for youth is included in the language, but there is no mention of non-accredited.

**Department Response:** There is no change to residential treatment centers for youth. If youth RTCs are seeking accreditation, that can occur at any time. Adult RTCs are not reimbursable until they are accredited; that can occur at any time.

**Further comment -** (BH Supplement, pg. 26) The commenter asked for clarification about Comprehensive Community Support Services (CCSS). The individual questioned whether the State provides CCSS training or whether it is all through UNM and asked what counts for experience with the target population specific to documentation by providers.

**Department Response:** Currently the state provides CCSS training through UNM. Experience is defined as any experience working with individuals with SMI or SED.

**Further comment -** (BH Supplement, pg. 45) One commenter stated that clarification is needed for the specific circumstance when a provider is using the Matrix model and the level of care indicates less than 9 hours of treatment a week is no longer needed. The commenter questioned whether the need for less than 9 hours of treatment indicates the individual no longer meets IOP criteria because the Supplement states IOP is directed by goals in providing the service.

**Department Response:** The Department recommends using the Matrix model of treatment as an outpatient modality, but not keeping the individual in the higher level of IOP treatment if not indicated.

**Comment # 15 -** (BH Manual, pg. 19) One commenter stated that the BH Manual should confirm that FQHCs and CMHCs are currently exempt from supervisory certification.

**Department Response:** The BH Supplement identifies eligible agencies that do not require supervisory certification in Section I.



**Further comment** - (BH Manual, pg. 97) The same commenter requested clarification as to whether the hours need to be in weeks or months in the sentence: "Six hours of training must be received prior to working all crisis services; the balance is received within the first 12 hours."

**Department Response:** The current wording is correct. "Six hours of training must be received prior to working all crisis services; the balance is received within the first 12 hours." The language stands as proposed.

**Comment #16** - (BH Manual) One commenter stated the HSD did not follow the tribal consultation policy. The individual requested the categorization of group therapy as "excluded services" be postponed or rescinded until Tribal Consultation occurs. The inclusion of group therapy codes 90853, 90848 and 90489 as services that are not billed at the OMB All Inclusive Rate (AIR) will be an approximate 94% reduction in revenue from the AIR amount Tribal behavioral health programs are recovering now. The proposed change will have significant and detrimental financial, programmatic, and clinical repercussions. The commenter requests preserving the current payment method and provided information as to how the proposed changes would: 1) negatively impact Tribal health systems; 2) pose a direct threat to Tribal Sovereignty and other Federal Authorities; 3) limit health access to health care for Native Americans utilizing the Taos Pueblo Behavioral Health system, and 4) will not result in significant cost savings to the State for health care to Native Americans.

**Department Response:** The requested changes have been made. The request for tribal consultation has been rescinded.

**Comment #17** - One commenter expressed strong support of the proposed Medicaid behavioral health updates. Specifically, permitting reimbursement of licensed psychologist for services provided by supervised doctoral psychology interns and postdoctoral fellows will have a profound, positive effect on psychological service delivery in New Mexico. The commenter believes there will be three significant benefits: 1) an immediate increase in mental and behavioral health services for underserved citizens in New Mexico; 2) building up the pipeline of professionals in the workforce to supply those services in the future; and 3) increasing capacity to meet the state's long-term mental health needs by creating and sustaining internship sites for doctoral psychology interns in New Mexico.

**Department Response:** The Department appreciates the commenter's support. The language stands as proposed.

**Comment #18** - (BH Supplement, pg.3) One commenter requested a "doctoral-level psychology practicum student" be added as a non-licensed practitioner eligible to provide Medicaid behavioral health professional services to assist the training facility and provide support to the patient community.

**Department Response:** The Department does not have plans to expand reimbursement to doctoral-level psychology practicum students at this time. The language stands as proposed.

**Comment #19 and #20** - (BH Manual, pg. 57) Two commenters strongly recommend having a mandatory requirement for MCOs to employ or contract a qualified provider with specialized knowledge in ABA Treatment (e.g., BCBA, BACB Qualifying Psychologist). These individuals stated that consumers and providers have reported occurrences of treatment authorization delays or

requests from MCOs to modify the treatment plans recommended dosage of ABA treatment from MCOs, which creates delays for families to access treatment.

**Department Response:** The Department appreciates the comment; however, MCO contracts do not require an MCO to employ or contract a qualified provider with specialized knowledge in ABA treatment. The language stands as proposed.

**Further comment -** (BH Manual, pg. 58) The same two commenters stated that current ABA guidelines, which require at least 25% of the supervision be conducted in person and no more than 75% of direct supervision be conducted via Telemedicine, deviates from New Mexico's Telemedicine regulations that impose a requirement for a hybrid model of care in which telemedicine services must be accompanied by on-site care. The commenters recommend removing the cap on Telemedicine delivered services since there is no research or guidelines from the BACB or American Telemedicine Association (ATA) to support this requirement.

**Department Response:** The percentages are not to be considered as the use of telemedicine is considered "in person"; therefore, the language stands as proposed.

**Further comment -** (BH Manual, pg. 59) The same commenters praised the Department for including the Board Certified Assistant Behavior Analyst (BCaBA) as an approved provider; this will increase provider capacity and access to care. The commenters also expressed appreciation for the inclusion of an avenue for non-certified behavior analysts to practice while waiting for the BACB test but recommended adding language in the billing section to specify that non-certified Behavior Analysts receive 5% of supervision for a BCBA and continue to collect supervision documentation that is required during Field Experience Training, as outlined in the BACB Supervision Guidelines. The commenters recommend changing the terminology from a "Non-Certified BCBA" to "Non-certified Behavior Analyst" and adding a requirement for non-certified behavior analysts to report their status to consumers to protect consumers.

**Department Response:** The MCO contracts do not require non-certified behavior analysts to report their status to consumers to protect consumers. The language stands as proposed.

**Further comment -** (BH Manual, pg. 59) Two commenters recommend removing the rostering requirement for Behavior Technicians because it would delay accessing care to ABA treatment and create an administrative burden for both provider organizations and the MCOs. The inability to initiate services while rostering is being completed; a shortage of BT providers and the cost to train and employ a behavior technician makes the proposed changes costly and labor intensive. The commenters suggested that a behavioral health organization be able to bill the non-licensed practitioners (i.e. behavior technicians) either under the group or supervising practitioner (i.e., BCBA).

**Department Response:** The Department appreciates the comment; however, rostering ensures that agencies can be recognized and reimbursed as enrolled providers. The Department will continue to work with the MCOs regarding expediting the rostering process. The language stands as proposed.

**Further comment** - (BH Manual, pg. 86) The commenters recommend the MCOs convert to the new CPT codes by the AMA because providers are concerned about problems with billing Medicaid as secondary insurance; many of the commercial insurers are planning to convert to the new codes in January 2019. The commenters also suggest the continued use of CPT code T1026 because the new codes do not support delivery and billing of Case Management services; which is integral to high-quality treatment of Applied Behavior Analysis.

**Department Response:** The Department appreciates the commenter's suggestion. The new billing codes are now in the new proposed billing schedule.

**Further comment** - (BH Manual, pg. 86) The commenters recommend licensure of Behavior Analysts to protect consumers and ensure behavior analysts can practice under the new CPT codes with other appropriate patient populations.

**Department Response:** New Mexico relies on the national certification board as there is no state licensing board for Behavior Analysts in New Mexico. The language stands as proposed.

**Further comment** - (BH Manual, pg. 36) The same commenters praised the Department for incorporating Integrated Care & Interdisciplinary Teaming and believe it will be critical to enhancing the quality of care for families, particularly in the rural and frontier areas of the state. The commenters recommend modifying the requirements for teaming to include telemedicine modalities because most families in New Mexico living in rural communities will be receiving specialty care services from providers outside of their home communities and it may not be feasible for all interdisciplinary team members to be physically present during meetings. Live video streaming in which the patient and participating providers join via a real-time video conference would resolve this dilemma. The commenters also recommend incorporating consultation with specialty care providers for individuals with severe disabilities under the Integrated Care & Teaming service.

**Department Response:** Teaming can be accomplished through telemedicine. The language stands as proposed.

The Department thanks the individuals for their input.