Mondragon, Tabitha, HCA

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Sent: Friday, July 26, 2024 3:33 PM
To: HCA-madrules
Subject: [EXTERNAL] HSR vol. 47, #15 - Specialized BH Provider Enrollment & Reimbursement
Attachments: Comments-TheDisabilityCoalition-2024.07.26.pdf

The comments of The Disability Coalition in HSR vol. 57, #15 - Specialized Behavioral Health Provider Enrollment and Reimbursement, are attached.

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July 26, 2024

Human Services Department (Health Care Authority)
Office of the Secretary
Attn: Medical Assistance Division Public Comments
Submitted by email to HSD-madrules@hsd.nm.gov

Re: HSR vol. 47, #15 – Proposed amendments to NMAC 8.321.2, Specialized Behavioral Health Provider Enrollment and Reimbursement

These comments on proposed amendments to NMAC 8.321.2 are submitted on behalf of The Disability Coalition, which represents the interests of persons with disabilities of all types. Member organizations of the Coalition include The Arc of New Mexico, New Mexico Developmental Disabilities Council, Disability Rights New Mexico, and two independent living centers, the Independent Living Resource Center that serves central and part of southern New Mexico and New Vistas, which serves the north-central and northeast portions of the state. The Governor's Commission on Disability is an advisory member of the Coalition.

1) Throughout the rule, the Health Care Authority (HCA, or the Authority) proposes to drop the reference to "services" and change the term "service(s) and treatment plan" to "treatment plan". The rationale for the change is not explained in the Register or the Notice of Opportunity to Comment, so it is unclear whether HCA believes the reference to "services" is duplicative and therefore unnecessary or if the intent is to make a substantive change in the concept of the plan.

Chapter 8.321 outlines "services" available to Medicaid enrollees, as indicated by the chapter title ("Behavioral Health Services"), and the word is used throughout the rule – hundreds of times, in fact. To the extent HCA intends to narrow the content of these plans, we believe that is inappropriate and any such implication should be emphatically denied. If the intent is to remove language seen as redundant with no substantive change, that should be stated clearly.

2) **321.2.9, General provider instruction** – In 321.2.9.C.9, HCA proposes to add occupational therapists to the list of licensed independent practitioners authorized to provide services. In 321.2.9.E.3 .f-I, the proposal is to add youth peer support workers, community support workers, community health workers and tribal community health representatives to the list of authorized non-licensed practitioners. We support these changes, which appropriately bolster the workforce serving individuals with behavioral health needs.

3) A **new 321.2.12, Accredited Adult Residential Treatment Centers (AARTCs) for Adults with Serious Mental Health Conditions**, is added to the rule. Although no explanation is given, we assume this is intended to cover facilities that qualify as institutions for mental diseases (IMDs), for which expanded use has been authorized in the Centennial Care/Turquoise Care waiver. We opposed that change and again express our disappointment that HCA is pursuing expanded use of inpatient facilities rather than strengthening community-based options for mental health treatment. We also note the following concerns:

a) There is no size limitation in the proposed regulatory language. This could lead to warehousing of individuals in large institutions, an outcome that we oppose and that flies in the face of decades of emphasis on serving people with mental health conditions in the community rather than in institutions, as well as the Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999).

b) It is not clear whether all admissions to such facilities will be voluntary or if patients may be admitted and retained involuntarily.

c) It is not clear what oversight there will be for AARTCs or who will be responsible for that oversight to ensure that these facilities comply with legal requirements. Merely requiring accreditation by a national accrediting body does not qualify as adequate oversight by the state. We have been unable to locate any HCA regulations on licensure for these facilities[1] , and the only provisions relating to AARTCs in the Authority's Behavioral Health Policy and Billing Manual apply to AARTCs for substance use disorders, not those for adults with serious mental health conditions, the subject of this regulatory section.

4) **Renumbered 321.2.13, Applied Behavioral Analysis** – We support the proposal to eliminate the list of provider types whose diagnoses of autism spectrum disorder (ASD) will be accepted and replace it with authorization to accept diagnoses from licensed practitioners whose scope of practice allows them to render such a diagnosis.

5) **Renumbered 321.2.17, Behavioral Management Skills (BMS) Development Service**s – Existing language in 2.17.D.4 says that "BMS is not a reimbursable service through the

[1] NMAC Chapter 8.321 Parts 3 and 4 on accredited and non-accredited RTCs, respectively, are shown as repealed.

medicaid school-based service program." It is not clear whether this is intended to mean that BMS are part of the service package covered by the Centennial Care/Turquoise Care managed care organizations (MCOs) rather than through the school-based service program or that they are not covered by Medicaid at all when provided in schools. If the former, we suggest that the rule be amended to explicitly state that coverage is provided through the MCOs for Medicaid recipients who are enrolled with those organizations. For children who are not enrolled with an MCO – as may be the case with Native American children, for whom MCO enrollment is optional and who may remain in Medicaid fee-for-service – the rule should be amended to remove the payment exclusion in school-based services.

If the regulatory provision is instead a holdover from the days when the Human Services Department refused to cover school-based services such as BMS on the grounds that schools were responsible for these services, it should be updated to remove that outdated position. BMS development services are part of the Medicaid benefit package furnished as part of EPSDT (Early and Periodic Screening, Diagnosis and Treatment). 8.308.9.19.B NMAC. Medicaid pays for services that are part of an individualized education program (IEP), individualized family service plan (IFSP), section 504 plan, individual health care plan (IHCP), or are otherwise medically necessary. 8.320.6.9.

The Centers for Medicare and Medicaid Services (CMS), in State Medicaid Director Letter #14-006, made clear that schools are not considered legally liable third parties under Medicaid law and that Medicaid-covered services must be covered by Medicaid even if they are provided in the schools, as directed by Medicaid statute in section 1903(c) of the Social Security Act. Federal regulations make clear that the state Medicaid agency is obligated to pay for services necessary to ensure that children with disabilities receive the free and appropriate public education (FAPE) to which they are entitled under federal law and that coverage of those services cannot be denied because they are provided in a school context. 34 CFR 300.154(b)(i and ii). The regulations are also explicit in stating that the obligation of the Medicaid agency "must *precede*" the financial responsibility of the school district or state education agency. 34 CFR 300.154(a)(1).

6) **Renumbered 321.2.20, Crisis Intervention Services (CIS), and 321.2.21, Crisis Triage Centers (CTCs)**– We start by addressing these sections jointly to note the interrelationships and conflicts – or simply confusion – in them.

Renumbered 321.2.20, Crisis Intervention Services, covers a variety of crisis intervention and stabilization services, including crisis triage. This is appropriate, as triage <u>is</u> a crisis stabilization service. See 321.2.20.5.b.i: "[C]risis stabilization includes… i) crisis triage that involves making crucial determinations within several minutes about an individual's course of treatment". That

triage is part of crisis stabilization is incorporated into New Mexico statute in numerous places: the Public Health Act, Health Care Code and Mental Health/Developmental Disabilities Code all define a crisis triage center as a licensed facility that "provides stabilization of behavioral health crises and may include residential and nonresidential stabilization". NMSA 24-1-2(B), 24A-1-2(B), 43-1-3(G), emphasis added.

We note also that the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* issued by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) make no reference to "crisis triage centers" and address triage as a screening function, in accordance with the usual meaning of the word. It appears that the term "crisis triage center" is an artifact of early discussions in New Mexico about such facilities, which were spearheaded by then-Sen. Mary Kay Papen in connection with efforts to establish a CTC in Las Cruces, where the facility follows an under-24-hour model that explicitly excludes longer-term stays.

Carving out CTCs from crisis intervention services seems to be a relic of an earlier time that has not kept pace with best practices in behavioral health services, as reflected in the SAMHSA Guidelines. Because separating CTCs from other crisis intervention services covered by Medicaid appears to be somewhat illogical and out of step with best practice, we recommend that HCA consider revising the regulations to reflect best practices and to incorporate CTCs into 321.2.20 along with other crisis intervention services. However, we recognize that CIS and CTC provisions are currently set out in separate portions of the rule and offer the following comments on each of them.

I. *Crisis triage centers, 321.2.21*: HCA proposes to add the words "or involuntary" to 321.2.21, in accordance with a statutory change made by the Legislature in 2023 (SB 310). However, HCA then proposes to go well beyond that statutory change by adding the following sentence: "Involuntary admissions are for individuals who have been determined to be a danger themselves or others and are governed by the requirements of the New Mexico Mental Health and Developmental Disabilities Code, NMSA 1978 43-1-1 through 43-1-21." This inexplicably both narrows and broadens the revised statutory provision.

SB 310's purpose, as detailed in hearings on the bill as it went through the legislative process, was to allow law enforcement officers to take individuals experiencing behavioral health crises to a CTC rather than to a hospital emergency room or to jail, both of which are recognized as inappropriate places for a person in a mental health crisis. Allowing such law enforcement drop-offs even without explicit consent from the individual also permits officers to return more quickly to their duties rather than remaining at an ER with the person or going through a jail booking process. Thus, SB 310 aimed to permit such drop-offs (which are considered best

practice; see the SAMHSA Guidelines) even if the individual does not affirmatively consent to go to the CTC. By limiting involuntary drop-offs to persons determined to be dangerous under the MH/DD Code, HCA would foreclose this option for many of the very people it was intended to cover.[2]

At the same time, the proposed rule would change the role of a CTC from its intended crisis stabilization function and make it part of the longer-term involuntary commitment procedures under the MH/DD Code. The proposed language says CTCs are for people "determined" to be dangerous under that Code, and "determinations" on that point are made by a judge as part of the process of ordering an involuntary inpatient commitment. See 43-1-11(E). A law enforcement officer may detain someone based on "reasonable grounds to believe" they present a likelihood of harm to self or others, and a health care practitioners may "certify" to that effect, but they do not make a "determination" under the Code. See 43-1-10(A).

If HCA intends to allow involuntary admission to a CTC based on the criteria in sec. 43-1-10(A), the rule should make that clear and should cite to the relevant statutory section. On the other hand, if the intent is to allow longer-term involuntary commitments to CTCs, that is not authorized by the MH/DD Code, which includes CTCs in the definition of "evaluation facility" but does not authorize commitment to them beyond that – a function for which they are not intended and for which they probably are not well suited.

We note that HCA appears to have altered its understanding of the proper role of CTCs along with its own name. The Fiscal Impact Report on SB 310, available at https://nmlegis.gov/Legislation/Legislation?Chamber=S&LegType=B&LegNo=310&year=23, states that then-HSD advised that "crisis triage centers are intended to provide a safe option to individuals experiencing a behavioral health crisis whose presentation and concerns do not rise to the level of requiring a hospitalization." (Emphasis added). Bringing CTCs into the involuntary commitment procedures authorized under the MH/DD Code is inconsistent with that role as described by HSD/HCA itself.

We caution HCA about changing the role of CTCs to engage them further in the involuntary commitment process. CTCs should provide the "safe option" identified by HSD for an individual in crisis to go and get help in a welcoming environment. Making these centers a cog in the commitment process is likely to change the perception of CTCs and deter their voluntary use. Any such change should be approached with considerable caution, lest the role of CTCs in helping people in crisis be undermined.

[2] We note that the language used by HCA in the proposed rule does not track that used in the MH/DD Code, which does not refer to "dangerousness" but to "likelihood of serious harm [to self or others]".

II. *Crisis intervention services, 321.2.20*:

a) In 321.2.20.A.2, for face-to-face clinic crisis services, HCA proposes to add to the tasks required within the first two hours of the crisis event by directing the clinic to "develop or update the crisis and safety plan". This plan does not appear to be defined or explained in the rule, where the only other reference we found to crisis and safety plans is for the Intensive Outpatient Program for MH Conditions (renumbered 321.2.27). It would be helpful to add clarification of what this plan is, what role it plays in the person's care, and what it is expected to cover.

b) 321.2.20.A.3, mobile crisis response, currently consists of a single sentence and is proposed to be extensively rewritten and expanded.

i) In 321.2.20.A.3.a.iii, awkward drafting appears to preclude services in the least restrictive environment. We assume this is not the intent and suggest revising this to be clearer.

ii) In 321.2.20.A.3.b.iv, HCA proposes to add a provision requiring language access for persons with limited English proficiency and those who are deaf or hard-of-hearing as well as requiring compliance with the Americans with Disabilities Act, the Rehabilitation Act and the Civil Rights Act. Although these clear legal obligations should go without saying, we appreciate having them explicitly set forth in the rule.

7) **Renumbered 321.2.27, Intensive Outpatient Program (IOP) for Mental Health Conditions** – We note an apparent conflict within the proposed language: 321.2.27.C.4 on "covered services" says the recipient must meet criteria for severe emotional disturbance (SED) or serious mental illness (SMI) "and have a diagnosis" to be eligible for IOP services. But 321.2.27.D.1 and .3 on "identified population" say that IOP is for those with the relevant diagnosis or those mandated by a court. Not only do these latter provisions conflict with the earlier one, they appear to provide for IOP services to those who do not have a diagnosis that would make such services appropriate. We suggest clarifying these provisions.

Thank you for your consideration of these comments.

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