From:	David Ley
To:	HSD-madrules
Date:	Friday, April 2, 2021 10:46:30 AM
Attachments:	CONSOLIDATED NMBHPA COMMENTS RE PROPOSED CHANGES TO 8.docx

Please see attached collected comments from the members of the NM BH Provider Association

Thanks,

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CONSOLIDATED NMBHPA COMMENTS RE PROPOSED CHANGES TO 8.321.2

APRIL 2021

Dear MAD – HSD. The NM Behavioral Health Provider's Association collected comments from our members on the proposed changes to NMAC. We've appended those comments below for your review and response.

8.321.2.9.E – *"by one of the provider's agencies listed in numbers one through nine of Subsection D of 8.321.2.9 NMAC, when the agency has a behavioral health services division (BHSD) supervisory certificate, and numbers 10 through [13] 15 of Subsection D of 8.321.2.9 NMAC*" – this language is somewhat unclear - does this mean that an agency listed in 10-15 (ctc, bha, etc) does NOT need a BHSD supervisory certificate?

8.321.2.9. N – Least restrictive setting: How does the state expect providers to document or identify that a setting IS the least restrictive? Numerous of our members raised concern about how the state will monitor or enforce this requirement.

8.321.2.11 - *Least restrictive setting*: How does the state expect providers to document or identify that a setting IS the least restrictive?

***8.321.2.19 – Face to face clinic crisis services*:** does the state mean that any Medicaid provider may now bill these clinic crisis face to face services?

8.321.2.22 – Family Support Services - does the state mean that any Medicaid provider may now bill these services?

8.321.2.32 PSR – MCO's have historically required agencies to provide a CMHC license in order to bill for PSR. Is the state intent that now any Medicaid agency can provide PSR?

1. *8.321.2.9 GENERAL PROVIDER INSTRUCTION:*
   E. A behavioral health service rendered by a licensed practitioner listed in Paragraph (2) of Subsection E of 8.321.2.9 NMAC whose scope of licensure does not allow him or her to practice independently or a non-licensed practitioner listed in Paragraph (3) of Subsection E of 8.321.2.9 NMAC is covered to the same extent as if rendered by a practitioner licensed for independent practice, when the supervisory requirements are met consistent with the practitioner's licensing board within his or her scope of practice and the service is provided through and billed by one of the provider's agencies listed in numbers one through nine of Subsection D of 8.321.2.9 NMAC, when the agency has a behavioral health services division (BHSD) supervisory certificate, and numbers 10 through [13] 15 of Subsection D of 8.321.2.9 NMAC.

   Should this read: "...the service is provided through and billed by one of the provider's agencies listed in numbers one through nine of Subsection D of 8.321.2.9 NMAC, OR WHEN A

PROVIDER'S AGENCIES LISTED IN numbers 10 through 15 of Subsection D of 8.321.2.9 NMAC has a behavioral health services division (BHSD) supervisory certificate."

Otherwise, it is STILL ambiguous about who needs the supervisory certificate.

2. *8.321.2.9 GENERAL PROVIDER INSTRUCTION:*
Section L, (2), (d) "the recipient, who is the subject of this service plan update, must be a participating member of every teaming meeting."

Language should be included that takes young or fragile children into account. A client who is 6 years old for example, may be adversely affected by participation in all teaming sessions depending on the nature of their trauma. Requiring any client to be present in every teaming meeting potentially negates the entire trauma informed approach.

3. *8.321.2.9 GENERAL PROVIDER INSTRUCTION:*
N. All specialized behavioral health services should be delivered in the least restrictive setting. Least restrictive settings will differ between services and facilities, and are generally defined as a physical setting which places the least restraint on the client's freedom of movement and opportunity for independence and enables an individual to function with as much choice and self-direction as safely appropriate. In addition, access to or receipt of one service may not be contingent on requiring an individual to obtain or utilize any other service; for example, a housing service may not require a treatment component, nor may an outpatient treatment service require participation in housing. Multiple services may be encouraged, under appropriate circumstances, but may not be required.

Will "Least restrictive settings will differ between services and facilities" be clarified somewhere? This sentence is exceptionally vague. Are agencies supposed to use their best judgement? Additionally, language regarding staying HIPAA compliancy might be useful here.

4. *8.321.2.19 CRISIS INTERVENTION SERVICES:*
Section B Eligible Practitioners, (2) Face-to-face clinic crisis services:

This section has been removed, however, face-to-face services are still listed under section A and section C. Does this mean there are no restrictions on what provider or agency types may provide face-to-face in clinic crisis services?

Section D also refers to the BH policy and billing manual for specifics. One specific the manual does not include is which crisis codes should be utilized (H2011 vs 90839/90840).

5. *8.321.2.22 FAMILY SUPPORT SERVICES (FSS) (MCO reimbursed only):*
E. Reimbursement: To help an eligible MCO member receive medically necessary services, the centennial care MCOs pay for family support services.

Language around whether family support may overlap in time with other BH services would be useful. For example, may an underage client receive therapy services at the same time as a parent/care giver is receiving family support services (centered around the underage client's care), when both services are billed to the underage client's Centennial plan?

6. *8.321.2.9 GENERAL PROVIDER INSTRUCTION:*

Section K, (3) A comprehensive assessment and service plan cannot be billed if care coordination is being billed through bundled service packages such as case rates, value based purchasing agreements, high fidelity wraparound or CareLink NM (CLNM) health homes.

We must do a comprehensive assessment to determine whether a client will benefit from High Fidelity Wrap services. We do not know ahead of time whether a client will agree to participate and if they will be enrolled during the same month that the assessment took place. This means that we bill all assessments to the MCO. Then the burden is on the MCO to reverse the claim. Or on us to notice if the MCO has not reversed the claim. The administrative burden created by this could easily be alleviated by adding language to allow the first assessment to be covered, prior to enrollment, even if it is done during the first month of enrollment.

7. 8.321.2.9 GENERAL PROVIDER INSTRUCTION:

Certain procedures, such as the Comprehensive Assessment (H0031) or the Diagnostic Evaluation (90791) are limited to once per year in the BH fee schedule or in the BH policy and billing manual. Language around when exceptions may be made would be useful, either in the NMAC or policy and billing manual. As an example, Medicare has changed their coverage limitation for the Diagnostic Evaluation to 3 times per year. Per LCD L35101 "An additional diagnostic evaluation service may be considered medically reasonable and necessary for the same patient if a new episode of illness occurs, an admission or a readmission to inpatient status due to complications of the underlying condition occurs, or when re-evaluation is required to address a new referral question. Certain patients, especially children and geriatric patients may require more than one visit for the completion of the initial diagnostic evaluation." AND "Medicare will not cover more than three psychiatric diagnostic evaluations, psychiatric diagnostic evaluation with medical services (or a combination of both) per year, per beneficiary, by the same provider." Since NM Medicaid generally follows Medicare rules, clarification on frequency/reasoning would be nice. Currently each MCO has different rules regarding the Diagnostic Evaluation and will make exceptions based on different criteria.

8.321.2.9 C-8 – Independent Providers

A licensed professional art therapist (LPAT) licensed by RLD's counseling and therapy practice board and certified for independent practice by the art therapy credentials Board (ATCB). **Will, this new provision Grandfather in existing LPAT providers therapist without testing by required. Will this hold the same weight as an LPCC, LISW, and LMFT?**

8.321.2.18 A. (2) (a) - COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS):

Minimum staff qualifications for the community support worker (CSW): a bachelor's degree, an associate's degree, a high school diploma or equivalent, and a certified peer support worker (CPSW) or as a certified peer family specialist. **Does this now limit having a CSW at the Masters Level? Can we still bill the H2015 with the HO modifier for a Master's Degree?**

8.321.2.9 (D) (1) (8) and (9) *The following agencies are eligible to be reimbursed for providing behavioral health professional services when all conditions for providing services are met:*

Mental Health Resources, Inc. meets the following
(1) *a community mental health center (CMHC);*
(8) *a core service agency (CSA); and*
(9) *a CareLink NM health home (CLNM HH).*

YET IN:

***Comprehensive Community Support Services: 8.321.2.18 (A) (1*) Agencies are now eliminated as indicated above.**

***Crisis Intervention: 8.321.2.19 (B) (3) (a)* Agencies are now eliminated as indicated above.**

Psychosocial Rehabilitation Services 8.321.2.32 (A) (b)

***INTENSIVE OUTPATIENT PROGRAM FOR SUBSTANCE USE DISORDERS (IOP): 8.321.2.25 (A) (1)* Agencies are now eliminated as indicated above.**

- on page 2 section E 1st and 3rd sentence can we suggest they change Paragraph (2) and Paragraph (3) to read Subsection B and Subsection C?
- on page 14 Section A 3 can it be written to have a minimum of 10-12 members?
- on page 18 section C 4 is the NOT supposed to be there?
- on page 20 section A.2.a.iv can examples be provided about BH coaching?
- on page 23 Section B 1 the area it has (independently licensed BH practitioner) then goes on to read that non independently licensed can do phone crisis services. can that be made to be less confusing?
- on page 41 section C 3 can the three be changed to 3?
- on page 50 section F if the section about [For PSR, reviews are retrospective] is crossed out do we need the section from To and the way through 1-4 in the NMAC?

For CCSS does the reg still allow for the Agency to provide the 20 hour training or is it now something that needs to be done by the state? if Agency can they add that on page 20 under A 1?

Section 8.321.2.9 General Provider Instruction,

> *Sect. E.2 "The non-independently licensed rendering practitioner with an active license which is not provisional or temporary must be one of the following:"* Strike the yellow comment. It is inconsistent with the following section 3.f.

8.321.2.34 SBIRT
Pg. 53 Covered Services: (2) states SBIRT screening with positive results for alcohol, or other drugs, and co-occurring with depression, or anxiety, or trauma are eligible for: (a) screening; and (b) brief intervention and referral to behavioral health treatment, if needed.

SBIRT training and the Healthy Lifestyle Questionnaire scoring indicates that a positive score on depression, anxiety, or trauma alone warrants a brief intervention. Covered services section should reflect HLQ scoring guidance.

8.310 – General Provider Policies

P. 15: xii) The home of an individual (only for the purposes of treatment of a substance use disorder or a co-occurring mental health disorder, furnished on or after July 1, 2019, to an individual with a substance use disorder diagnosis. – THIS LANGUAGE SUGGESTS THAT MENTAL HEALTH DISORDER CAN ONLY BE TREATED REMOTELY IN HOME IF IT CO-OCCURS WITH SUBSTANCE USE?

(2) Telephone visits: MAD will reimburse eligible providers for limited professional services delivered by telephone without video. No additional reimbursement is made to the originating-site for an interactive telemedicine system fee.

(3) MAD will reimburse for services delivered through store-and-forward. To be eligible for payment under store-and-forward, the service must be provided through the transference of digital images, sounds, or previously recorded video from one location to another; to allow a consulting provider to obtain information, analyze it, and report back to the referring physician providing the telemedicine consultation. Store-and-forward telemedicine includes encounters that do not occur in real time (asynchronous) and are consultants that do not require face-to-face live encounter between patient and telemedicine provider.

HOW DOES A PROVIDER KNOW IF THEY ARE ELIGIBLE TO PROVIDE TELEPHONIC SERVICES AND/OR IF THEIR SERVICES ARE ELIGIBLE FOR STORE AND FORWARD REIMBURSEMENT?