HEALTH CARE AUTHORITY

Michelle Lujan Grisham, Governor
Kari Armijo, Secretary
Dana Flannery, Medicaid Director

Letter of Direction #30-1

Date: **April 14, 2025**

To: **Turquoise Care Managed Care Organizations**

From: **Dana Flannery, Director, Medical Assistance Division**
Nick Boukas, Director, Behavioral Health Services Division

Subject: **Certified Community Behavioral Health Clinic (CCBHC) Demonstration Implementation**

Title: **CCBHC Demonstration Implementation**

This Letter of Direction (LOD) repeals and replaces the LOD issued on November 8, 2024. The purpose is to provide updated guidance to the Turquoise Care Managed Care Organizations (MCOs) to support the implementation of the New Mexico Certified Community Behavioral Health Clinic (CCBHC) Demonstration. This LOD outlines requirements for CCBHC service delivery, payment, reporting, and systems configuration and readiness.

New Mexico's CCBHC Demonstration began on January 1, 2025. For further background, please see the HCA CCBHC website: https://nmrecovery.org/ccbhc. This LOD is effective immediately.

1. CCBHC Demonstration Background

1.1. *Overview*

In June of 2024, the New Mexico Health Care Authority (HCA) was notified by the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) that New Mexico was one of 10 states selected to participate in a four-year federal Certified Community Behavioral Health Clinic (CCBHC) Medicaid Demonstration ("CCBHC Demonstration" or "Demonstration) under Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA) as amended by the Bipartisan Safer Communities Act of 2022 (BSCA).

A CCBHC is a specialty designated clinic that provides a comprehensive range of community-based and outpatient mental health, substance use disorder, and primary care screening services across the lifespan. A CCBHC must be certified by the State in accordance with federally established criteria, and must provide the following nine core services:

1. Crisis Services
2. Outpatient Mental Health and Substance Use Services

3. Person- and Family-Centered Treatment Planning
4. Community-Based Mental Health Care for Veterans
5. Peer, Family Support, and Counselor Services
6. Targeted Case Management
7. Outpatient Primary Care Screening and Monitoring
8. Psychiatric Rehabilitation Services
9. Screening, Diagnosis, and Risk Assessment

Under the Demonstration, a CCBHC will be reimbursed using a prospective payment system (PPS) for qualifying CCBHC services provided to Medicaid and CHIP beneficiaries. New Mexico has selected the PPS-1 methodology, which is a fixed, cost-based clinic-specific daily rate under which a CCBHC receives a PPS payment for a qualifying service provided to a Medicaid/CHIP beneficiary on a given day. The PPS-1 rate is paid once per day per beneficiary regardless of the number of qualifying services provided on that day. Qualifying services are detailed in the New Mexico CCBHC code list, available on NMrecovery.org/CCBHC.

1.2. *CCBHC Service Delivery*

CCBHCs are required to provide the full array of outpatient mental health and substance use treatment services detailed above (e.g., the nine core services) in accordance with the specifications in the NM CCBHC Certification Criteria, to all New Mexicans seeking care regardless of their diagnosis, symptom severity, age, race, ethnicity, disability, sexual orientation, gender expression, developmental ability, justice system involvement, housing status, or ability to pay.

The NM CCBHC Certification Criteria establishes the standards for service delivery that the CCBHC must meet, across six foundational domains, as outlined below:

1. Staffing – The CCBHC must develop a staffing plan that is driven by a community needs assessment. CCBHCs must secure the appropriate licenses, certification(s), and training to support service delivery by qualified personnel.
2. Availability and Accessibility of Services – CCBHCs must meet defined standards for timely and meaningful access to services, provide outreach and engagement, 24/7 access to crisis services, treatment planning, and accept all patients regardless of ability to pay or place of residence.
3. Care Coordination – Turquoise Care MCOs must establish partial or full delegated care coordination contracts with CCBHCs, for MCO members served by the CCBHC. CCBHCs must establish care coordination agreements across services and providers (e.g., Federally Qualified Health Centers (FQHC), inpatient and acute care settings), and render care coordination in accordance with either the NM CareLink model, or the MCO delegated care coordination model standards (see 4.1).
4. Scope of Services – Offer all nine core required services and person-centered, family-centered, and recovery-oriented care either directly, or through Designated Collaborating Organizations (see 1.2.1).
5. Quality and Other Reporting – Meet all federal and New Mexico required quality measures, reporting, and establish a plan for quality improvement and tracking of program requirements.

6. Organizational Authority and Governance – Ensure consumer representation in CCBHC governance and compliance with all state and federal governance regulations.

1.2.1 Designated Collaborating Organizations

A CCBHC may partner with a Designated Collaborating Organization (DCO) to deliver any of the nine core CCBHC services through a formal agreement. CCBHCs must provide at least 51% of all CCBHC encounters directly per Demonstration Year and the CCBHC maintains programmatic, clinical, payment, and regulatory responsibility for the services provided by the DCO to CCBHC clients. DCOs must secure the appropriate license(s), certification(s), and/or approval(s) to provide the associated Medicaid reimbursable services.

During certification, CCBHCs must submit a listing of DCOs to the state and provide a copy of a legally binding contractual agreement that adheres to NM CCBHC Certification criteria and all requirements. HCA provided MCOs with a final list of CCBHC DCOs in November 2024 and will share updates as they occur. Further detail regarding CCBHC/DCO payment is outlined in section 3.2.2.

1.2.2 Catchment/Service Areas

As part of HCA's application process, the prospective CCBHC must identify a planned catchment area(s) for the provision of CCBHC services. The catchment area must include at least one New Mexico county and the CCBHC is expected to serve the entirety of that county, or counties, if they select and are approved for a multi-county catchment

area.

1.2.3 Community Needs Assessment

All prospective CCBHCs must complete a community needs assessment prior to program implementation and every three years thereafter. The CCBHC needs assessment ensures that community-specific behavioral health treatment needs are identified and integrated into CCBHC strategic planning and service delivery so that services are delivered in accordance with the needs and preferences of the populations served. Findings from the needs assessment are intended to provide information relevant to CCBHC staffing requirements, services, and cost reporting. HCA has developed and shared a template and tool to assist CCBHCs and prospective CCBHCs complete their community needs assessments. Visit NMrecovery.org for more information.

1.2.4 *Evidence-Based Practices*

CCBHCs must provide services utilizing evidence-based practices. All CCBHCs must provide Medication for Opioid Use Disorder (MOUD) and are strongly encouraged to implement the following evidence-based practices:

- Trauma – Focused Cognitive Behavioral Therapy
- Multisystemic Therapy
- Dialectical Behavioral Therapy

- Eye Movement Desensitization and Reprocessing Therapy
- Functional Family Therapy
- Assertive Community Treatment
- Coordinated Specialty Care for First Episode Psychosis
- Motivational Interviewing
- Community Reinforcement Approach and Family Training
- Contingency Management

1.3. *Demonstration Years*

Considering New Mexico's CCBHC Demonstration start date of January 1, 2025, its Demonstration Year (DY) definition will reflect the calendar year, as shown below:

- DY1: January 1, 2025 – December 31, 2025
- DY2: January 1, 2026 – December 31, 2026
- DY3: January 1, 2027 – December 31, 2027
- DY4: January 1, 2028 – December 31, 2028

1.4. *Provider Eligibility*

The HCA and the Children's, Youth, and Families Department (CYFD) are responsible for certifying eligible agencies as CCBHCs. Approved providers will be issued a joint approval letter by HCA and CYFD. New or prospective CCBHCs are eligible to enter the demonstration on an annual basis with a start date of January 1, subject to available funding and readiness to implement CCBHC services. Please note that recently updated federal guidance allows states to enroll new Demonstration CCBHCs quarterly. HCA is reviewing this guidance and may, at its discretion, offer a certification period between Demonstration years. More information about the certification process can be found here.

1.5. *Certified CCBHCs*

Five agencies have been certified by HCA/CYFD and entered the CCBHC Demonstration on January 1, 2025. Agencies include:

- University of New Mexico Health System in Bernalillo and Sandoval County
- Carlsbad Lifehouse in Eddy County
- FYI+ in Doña Ana County
- Santa Fe Recovery Center in Santa Fe and McKinley Counties
- PMS Farmington in San Juan County

1.6. *CCBHC Satellite Facilities and Access Points*

Under the Demonstration, payment may not be made to a CCBHC "satellite facility", as defined below:

A facility, established by the CCBHC after April 1, 2024, operated under the governance and financial control of that CCBHC, which provides all or more of the following services: crisis services; screening, diagnosis, and risk assessment; person and family centered treatment planning; and outpatient mental health and substance use services, as defined in the CCBHC Certification Criteria.

Any CCBHC location that meets the above definition must be separately certified as a

CCBHC. CCBHCs may provide services at alternative locations within their designated catchment areas, known as "access sites". Access sites may provide CCBHC services provided they do not meet the definition of a 'satellite facility' (e.g., established after April 1, 2014 and that provide four or more of the CCBHC services described above).

Prospective CCBHCs must be approved for all access sites during certification. HCA will include a listing of access sites in the certification letter and will post clinic locations to nmrecovery.org and the HCA website.

2. General Requirements

2.1. *Adherence to Current MCO Requirements*

Unless stated otherwise, all requirements currently cited in the Turquoise Care Managed Care Services Agreement, Managed Care Policy Manual, NMAC, Systems Manual, Behavioral Health Policy and Billing Manual, or BHSD Billing and Systems Manual shall apply (e.g., claim processing and encounter reporting requirements).

2.2. *MCO-CCBHC Contracting Requirements*

MCOs must contract with all state-certified CCBHCs for the provision of CCBHC Demonstration services. For DY1, these contracts must be effective from January 1, 2025. These contracts must permit subcontracting agreements by the CCBHC with any DCOs.

2.3 *CCBHC Indicator*

CCBHCs will be identified using a "CCBHC Indicator" in the BMS Provider Module, which will be incorporated into the Provider File. In addition to this information being distributed to the MCOs via the Provider File, MCOs may request a copy of the list of state-certified CCBHCs from HCA, or the approval letters from certified providers.

3. CCBHC Payment

3.1. *General Provisions for CCBHC Payment*

MCOs must reimburse CCBHCs with the "CCBHC Indicator", at a minimum at their clinic-specific PPS-1 rate for the provision of qualifying "PPS-triggering" CCBHC Demonstration services. Each CCBHC PPS-1 rate will be established using the Special Procedure Pricing file with rates entered for T1040 by Provider ID. The rate will be sent to the MCOs when a new provider is approved for CCBHC (i.e., certified by the State as a CCBHC). CCBHC PPS-1 rates have been incorporated into the MCO capitation rates. The CCBHC may only receive one PPS-1 payment per day per beneficiary for CCBHC services, regardless of the number of CCBHC services provided that day.

3.2. *CCBHC Payment Operations*

3.2.1. Billing Requirements

To receive PPS-1 payment, CCBHCs, using the "CCBHC Indicator" must submit claims for CCBHC services to the MCO using the CMS-1500, or 837-P with the T1040 CCBHC Demonstration billing code in addition to at least one "PPS-triggering" CCBHC service code. CCBHCs are required to submit <u>all</u> CCBHC service codes and units on the same claim for services provided on a given day even though only one "PPS-triggering" code is required for PPS-1 payment (note: this is

sometimes referred to as "shadow billing").

There are some "cost-only" CCBHC service codes that do not count as a "PPS-triggering" service, but still constitute a CCBHC service and need to be tracked for monitoring/reporting purposes. CCBHCs must submit claims for these codes using the "Q2" modifier. Generally, these codes will be billed on a claim with a T1040 alongside a "PPS-triggering" code. However, there could be instances where these codes are billed outside of a "PPS-triggering" service. In any instance, "cost-only" CCBHC services must be reimbursed by the MCO at $0.

Please see the CCBHC code list posted on the HCA website for details on which codes are "PPS-triggering" codes and which are "cost-only" codes: https://nmrecovery.org/wp-content/uploads/2024/08/NM-CCBHC-Service-Codes_Masterlist8.24.xlsx

3.2.2. Billing, Ordering and Rendering Provider Fields

For CCBHC claims on the CMS-1500 or 837-P:

- The rendering provider field (loop 2310B) should be left blank
- The ordering and referring provider (loops 2420E and 2310A) should also be left blank
- The billing provider ID and Billing NPI must match the Medicaid ID and Billing NPI for all locations certified as a CCBHC (i.e., as identified in the CCBHC Certification letter)

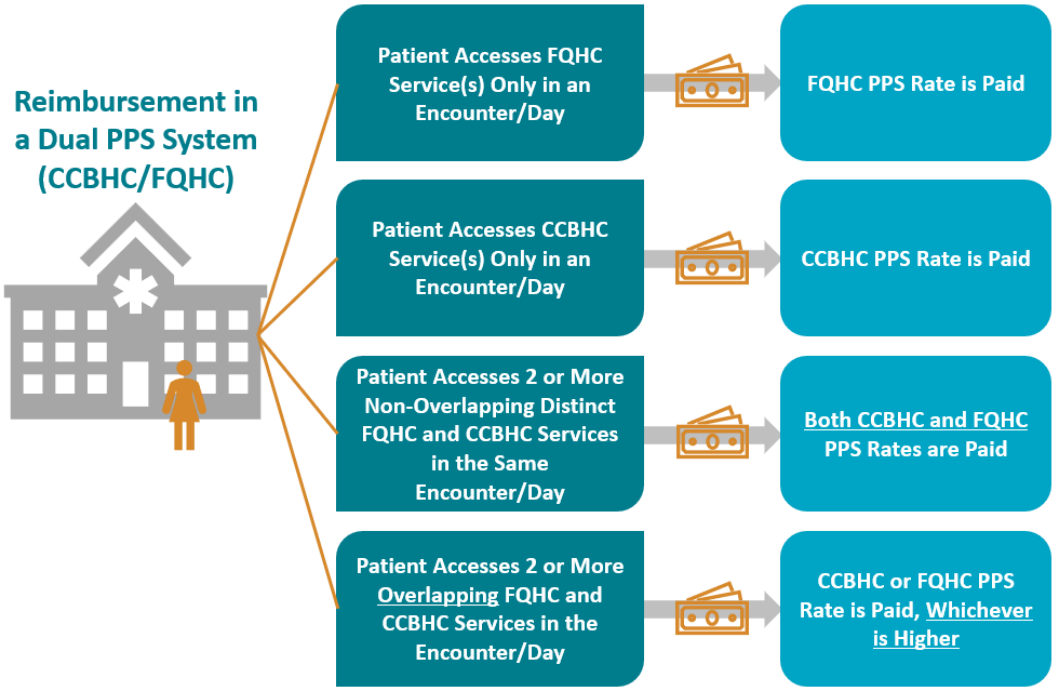
3.2.3. CCBHC and DCO Payment

Because CCBHCs are paid a PPS rate inclusive of all CCBHC services provided by the CCBHC and its DCOs, DCOs are prohibited from fee-for-service billing for CCBHC services provided to CCBHC members. CCBHCs are responsible for claims submission and collecting from DCOs all documentation necessary for CCBHC data collection and billing. Services rendered through a DCO will require a Place of Service 98 placed on the respective line, or lines of the claim. MCOs should ensure processes are in place to identify and provide ongoing monitoring and safeguards against CCBHC and DCO duplicative billing practices.

3.2.4. Payment to Dual CCBHCs and FQHCs

MCOs must avoid duplication of payment to CCBHCs, or its DCOs when the provider is dually certified or enrolled as an FQHC. In these cases, MCOs must ensure that billing practices align with both sets of PPS billing requirements. Pursuant to federal guidance[1], the determination of which PPS should be paid, or if both PPS rates are paid is based on the nature, number, and scope of services provided to an eligible beneficiary on a given day. For dual CCBHC/FQHCs or DCOs, this falls under four primary scenarios, described below:

[1] See Medicaid.gov Section 223 CCBHC Demonstration PPS Guidance dated 2/2024, Section 4



Scenario 1: A beneficiary accesses one or more FQHC services and no CCBHC qualifying services, as defined in CCBHC scope of services list.
Outcome: The MCO must reimburse the FQHC PPS only.

Scenario 2: A beneficiary accesses one or more CCBHC qualifying services, as defined in the CCBHC scope of services list.
Outcome: The MCO must reimburse the CCBHC PPS only, even if those services are also Medicaid FQHC services.

Scenario 3: A beneficiary accesses two or more non-overlapping and FQHC and CCBHC service(s) (e.g., FQHC only service(s) and one or more CCBHC qualifying service(s)).
Outcome: The MCO must reimburse both the CCBHC and FQHC PPS.

Scenario 4: If all of the services provided to a beneficiary during the same day are overlapping CCBHC qualifying services and FQHC services.
Outcome: The MCO must utilize 'higher of' logic and reimburse the dual CCBHC/FQHC at whichever PPS is higher.

3.2.5. Encounter Reporting Requirements

Following CCBHC claims adjudication, MCOs must, in turn, submit CCBHC encounters to the State in accordance with current MCO requirements as referenced in Section 2.1 above. MCOs must ensure all information included in CCBHC claims be transmitted to the State, including all "shadow-billed" and/or "cost-only" codes. This information must be completely passed through without any modification or truncation of billing codes, unit numbers, diagnosis codes, modifiers, etc.

3.2.6. Medicare-Medicaid Crossover Requirements

Under the CCBHC Demonstration, States must reimburse CCBHC services provided to dually enrolled Medicare-Medicaid beneficiaries at the CCBHC PPS rate. HCA is requiring MCOs to pay the difference between a CCBHC's PPS-1 rate and the amount

reimbursed by Medicare for "PPS-triggering" CCBHC services. Since Medicare will pay at the "detail level" of a claim (i.e., the "shadow-billed" codes), the MCO payment responsibility shall consist specifically of a CCBHC's PPS-1 rate less the sum of Medicare reimbursement for all "shadow-billed" codes on a given claim.

3.2.7. Coordination of Benefits/Third-Party Liability Requirements

HCA is requiring the MCOs to pay the difference between a CCBHCs PPS-1 rate and the amount reimbursed by third-party payers (including Medicare—please see 3.2.4 for information regarding Medicare) for "PPS-triggering" CCBHC services. Since third-party payers will pay at the "detail level" of a claim (i.e., the "shadow-billed" codes), the MCO payment responsibility shall consist specifically of a CCBHC's PPS-1 rate less the sum of third-party payer reimbursement for all "shadow-billed" codes on a given claim.

3.3. *Prior Authorization*

MCOs shall not require prior authorization for CCBHC services as indicated in the CCBHC Scope of Service List.

3.4. *Waiver of Timely Filing*

MCOs are instructed to waive timely filing requirements for all CCBHC claims for the first six months of program implementation (i.e., for all dates of service from 1/1/25 – 6/30/2025).

4. Additional MCO Requirements

4.1. *Care Coordination*

CCBHCs may elect and must follow either the New Mexico CareLink or HCA care coordination model. Turquoise Care MCOs are required to establish full or partial care coordination delegation agreements with state-certified CCBHCs. For CCBHCs who enter into MCO delegated care coordination agreements, they must adhere to those agreements and all HCA care coordination requirements. CCBHCs may expand the care coordination population of focus beyond existing MCO-designated populations, based on the results of the CCBHC provider needs assessment, and may use either the CareLink or HCA care coordination model for this population.

Costs for providing care coordination to expanded populations can be included in provider cost reports, using an allocation methodology to ensure no cost duplication between CCBHC PPS, CareLink, and/or MCO Care Coordination reimbursement(s).

MCOs must collaborate with HCA to support training efforts and activities for CCBHC care coordinators.

4.2. *Program Implementation and Oversight*

MCOs shall work in partnership with HCA to provide operational support, programmatic oversight and monitoring, and quality management and improvement initiatives. This includes, but is not limited to:

- Performance oversight and quality improvement efforts, including coordination on any corrective action, performance improvement initiatives, quarterly

monitoring or chart audits, and CCBHC certifications or re-certifications.

- Ensuring timely access and appropriate utilization management and oversight of all Medicaid-covered services for CCBHC service recipients. This could include, but is not limited to the following:
  - Tracking and trending CCBHC utilization, types/units of services rendered, and reimbursement data.
  - Comparing CCBHC utilization to historical utilization for the same or similar service(s).
  - Reviewing services found on the CCBHC service list against claims for the same person on the same day billed by a different organization.
  - Reviewing billed services not found on the CCBHC services list billed by the same organization for the same member.
  - Reviewing member outcomes data and changes to CCBHC member utilization patterns.
  - Timely review, coordination, and/or authorization for Medicaid-covered services provided under the MCO contract that are not part of the CCBHC service array.
  - Reviewing for fraud, waste and abuse.
  - Sharing data, trends and findings with HCA.
- Developing and implementing provider training and technical assistance activities to support expansion and the effective delivery of CCBHC services.
- Educating MCO Provider Liaisons/Representatives about the NM CCBHC initiative.
- Supporting the review of CCBHC quality metrics, cost reports, level of care data, other data, and/or any ad-hoc requests by HCA.
- Participating in regular and any ad hoc planning meetings with the state, CCBHCs, and other stakeholders, as identified.

4.3. *Program Integrity*

Following existing fraud, waste and abuse monitoring processes, MCOs shall perform regular audits of the CCBHCs and support HCA with program and fiscal oversight of the model. CCBHCs must make all records, audits, claims, documentation, and other materials available to contracted MCOs, and HCA and/or CYFD staff, upon request to support these audits.

4.4. *CCBHC Network Expansion*

MCOs shall support HCA in promoting the growth and expansion of the CCBHC model. This includes:

- Identifying prospective CCBHCs in non-participating CCBHC counties and assisting with certification readiness and technical assistance, as appropriate.
- Supporting behavioral health service infrastructure enhancement for prospective CCBHCs to expand service delivery, particularly for crisis services, primary care services, and SUD services.
- Supporting alignment of MCO care coordination efforts, quality, and value-based payment initiatives with the CCBHC program.
- Developing implementation and outcome monitoring efforts to assess CCBHC

effectiveness, gaps, and improvement opportunities.

- Supporting prospective CCBHCs to complete community needs assessments.

4.5. *System Readiness*

MCOs shall ensure that appropriate IT and payment systems and processes are in place to meet all CCBHC billing and reporting requirements. MCOs are required to test system readiness with each CCBHC provider and their respective billing vendor(s) at least 30 days prior to go-live. Results of the testing plan should be reported to HCA.

This LOD will sunset upon inclusion in the MCO Policy Manual, BH Policy & Billing Manual, and/or NMAC.

State of New Mexico
Medical Assistance Program Manual

Supplement

HEALTH CARE AUTHORITY

DATE: **April 14, 2025** **NUMBER: 30-1**

TO: **PROVISIONAL CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS**

FROM: **DANA FLANNERY, DIRECTOR, MEDICAL ASSISTANCE DIVISION**

THROUGH: **KRESTA OPPERMAN, BUREAU CHIEF, BENEFITS AND REIMBURSMENT BUREAU**

SUBJECT: **IMPLEMENTATION OF CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS**

The New Mexico Health Care Authority, Medical Assistance Division (HCA/MAD) is reissuing this Supplement to provide program, billing, and reimbursement guidance for New Mexico Certified Community Behavioral Health Clinic (CCBHC) Demonstration providers. This guidance is being issued in advance of a rule promulgation of 8.321.2 NMAC and is effective from January 1, 2025, the beginning of New Mexico's Demonstration program.

Certified Community Behavioral Health Clinic

1. CCBHC Demonstration Background

1.1. Overview

In June of 2024, the New Mexico Health Care Authority (HCA) was notified by the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) that New Mexico was one of 10 states selected to participate in a four-year federal CCBHC Medicaid Demonstration ("CCBHC Demonstration" or "Demonstration") under Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA) as amended by the Bipartisan Safer Communities Act of 2022 (BSCA).

A CCBHC is a specialty designated clinic that provides a comprehensive range of community-based and outpatient mental health, substance use disorder, and primary care screening services across the lifespan. A CCBHC must be certified by the State in accordance with federal and state established criteria, and must provide the following nine core services:

1. Crisis Services
2. Outpatient Mental Health and Substance Use Services
3. Person- and Family-Centered Treatment Planning
4. Community-Based Mental Health Care for Veterans
5. Peer, Family Support, and Counselor Services
6. Targeted Case Management
7. Outpatient Primary Care Screening and Monitoring
8. Psychiatric Rehabilitation Services
9. Screening, Diagnosis, and Risk Assessment

Under the Demonstration, a CCBHC will be reimbursed using a prospective payment system (PPS) for qualifying CCBHC services provided to Medicaid and CHIP beneficiaries. New Mexico has selected the PPS-1 methodology, which is a fixed, cost-based clinic-specific daily rate under which a CCBHC receives a PPS payment for a qualifying service provided to a Medicaid/CHIP beneficiary on a given day. The PPS- 1 rate is paid once per day per beneficiary regardless of the number of qualifying services provided on that day. Qualifying services are detailed in the New Mexico CCBHC code list, available on NMrecovery.org/CCBHC.

1.2. CCBHC Service Delivery

CCBHCs are required to provide the full array of outpatient mental health and substance use treatment services detailed above (e.g., the nine core services) in accordance with the specifications in the NM CCBHC Certification Criteria, to all New Mexicans seeking care regardless of their diagnosis, symptom severity, age, race, ethnicity, disability, sexual orientation, gender expression, developmental ability, justice system involvement, housing status, or ability to pay.

The NM CCBHC Certification Criteria establishes the standards for service delivery that the CCBHC must meet, across six foundational domains, as outlined below:

1. Staffing – The CCBHC must develop a staffing plan that is driven by a community needs assessment. CCBHCs must secure the appropriate licenses, certification(s), and training to support service delivery by qualified personnel.
2. Availability and Accessibility of Services – CCBHCs must meet defined standards for timely and meaningful access to services, provide outreach and engagement, 24/7 access to crisis services, treatment planning, and accept all patients regardless of ability to pay or place of residence.
3. Care Coordination – CCBHCs may establish shared or full delegated care coordination contracts with the Turquoise Care MCOs, for MCO members served by the CCBHC. CCBHCs must establish care coordination agreements across services and providers (e.g., Federally Qualified Health Centers, inpatient and acute care settings), and render care coordination in accordance with either the NM CareLink model, or the MCO delegated care coordination model standards (see 4.1).
4. Scope of Services – CCBHCs must offer all nine core required services and person-centered, family-centered, and recovery-oriented care either directly, or through Designated Collaborating Organizations (see 1.2.1)
5. Quality and Other Reporting – CCBHCs must meet all federal and New Mexico required quality measures, reporting, and establish a plan for quality improvement and tracking of program requirements.
6. Organizational Authority and Governance – CCBHCs must ensure consumer representation in CCBHC governance and compliance with all state and federal governance regulations.

1.2.1 Designated Collaborating Organizations

A CCBHC may partner with a Designated Collaborating Organization (DCO) to deliver any of the nine core CCBHC services through a formal agreement. CCBHCs must provide at least 51% of all CCBHC encounters directly per Demonstration Year and the CCBHC maintains programmatic, clinical, payment, and regulatory responsibility for the services provided by the DCO to CCBHC clients. DCOs must secure the appropriate license(s), certification(s), and/or approval(s) to provide the associated Medicaid reimbursable services. During certification,

CCBHCs must submit a listing of DCOs to the state and provide a copy of a legally binding contractual agreement that adheres to NM CCBHC Certification criteria and all requirements.

1.2.2 Catchment/Service Areas

As part of HCA's application process, the prospective CCBHC must identify a planned catchment area(s) for the provision of CCBHC services. The catchment area must include at least one New Mexico county and the CCBHC is expected to serve the entirety of that county, or counties, if they select and are approved for a multi-county catchment area.

1.2.3 Community Needs Assessment

All CCBHCs must complete a community needs assessment prior to program implementation and every three years thereafter. The CCBHC needs assessment ensures that community-specific behavioral health treatment needs are identified and integrated into CCBHC strategic planning and service delivery so that services are delivered in accordance with the needs and preferences of the populations served. Findings from the needs assessment are intended to provide information relevant to CCBHC staffing requirements, services, and cost reporting. HCA has developed and shared a template and tool to assist CCBHCs and prospective CCBHCs complete their community needs assessments. Visit NMrecovery.org for more information.

1.2.4 Evidence-Based Practices

CCBHCs must provide services utilizing evidence-based practices. All CCBHCs must provide Medication for Opioid Use Disorder (MOUD) and are strongly encouraged to implement the following evidence-based practices:

- Trauma – Focused Cognitive Behavioral Therapy (TF-CBT)
- Multisystemic Therapy (MST)
- Dialectical Behavioral Therapy (DBT)
- Eye Movement Desensitization and Reprocessing Therapy (EMDR)
- Functional Family Therapy (FFT)
- Assertive Community Treatment
- Coordinated Specialty Care for First Episode Psychosis
- Motivational Interviewing
- Community Reinforcement Approach and Family Training
- Contingency Management

Enhanced reimbursement is available for TF-CBT, MST, DBT, EMDR, and FFT for agencies with the appropriate training(s) and certification(s). For more information, visit: New Mexico Evidence Based Practices | Center of Innovation.

1.3. Demonstration Years

Considering New Mexico's CCBHC Demonstration start date of January 1, 2025, its Demonstration Year (DY) definition will reflect the calendar year, as shown below:

- DY1: January 1, 2025 – December 31, 2025
- DY2: January 1, 2026 – December 31, 2026
- DY3: January 1, 2027 – December 31, 2027
- DY4: January 1, 2028 – December 31, 2028

1.4. Provider Eligibility

The HCA and the Children's, Youth, and Families Department (CYFD) are responsible for

certifying eligible agencies as CCBHCs. Approved providers will be issued a joint approval letter by HCA and CYFD. New or prospective CCBHCs are eligible to enter the demonstration on an annual basis with a start date of January 1, subject to available funding and readiness to implement CCBHC services. Please note that recently updated federal guidance allows states to enroll in new Demonstration CCBHCs quarterly. HCA is reviewing this guidance and may, at its discretion, offer a certification period between Demonstration years. More information about the certification process can be found here.

1.5. Certified CCBHCs

Five agencies have been certified by HCA/CYFD and entered the CCBHC DY1 on January 1, 2025. Agencies include:

- University of New Mexico Health System in Bernalillo and Sandoval County
- Carlsbad Life House in Eddy County
- FYI+ in Doña Ana County
- Santa Fe Recovery Center in Santa Fe and McKinley Counties
- PMS Farmington in San Juan County

1.6 CCBHC Satellite Facilities and Access Points

Under the Demonstration, payment may not be made to a CCBHC "satellite facility", as defined below:

A facility, established by the CCBHC after April 1, 2024, operated under the governance and financial control of that CCBHC, which provides all or more of the following services: crisis services; screening, diagnosis, and risk assessment; person and family centered treatment planning; and outpatient mental health and substance use services, as defined in the CCBHC Certification Criteria.

Any CCBHC location that meets the above definition must be separately certified as a CCBHC. CCBHCs may provide services at alternative locations within their designated catchment areas, known as "access sites". Access sites may provide CCBHC services provided they do not meet the definition of a 'satellite facility' (e.g., established after April 1, 2014, and that provide four or more of the CCBHC services described above).

Prospective CCBHCs must be approved for all access sites during certification. HCA will include a listing of all approved access sites in the certification letter.

2. General Requirements

2.1. Adherence to Current Requirements

Unless stated otherwise, all requirements currently cited in the NMAC, Behavioral Health Policy and Billing Manual, or BHSD Billing and Systems Manual shall apply (e.g., claim processing and encounter reporting requirements).

2.2 CCBHC Indicator

CCBHCs will be identified using a "CCBHC Indicator" in the BMS Provider Module, which will be incorporated into the Provider File. The CCBHC Indicator will be activated by HCA upon successful certification as a CCBHC. HCA will distribute the list of CCBHCs to the MCOs and Conduent via the Provider File, however providers must provide approval letters to MCOs or Conduent, if requested.

3. CCBHC Payment

3.1. General Provisions for CCBHC Payment

Only agencies with an active CCBHC certification from HCA/CYFD are eligible to receive the PPS-1 payment. CCBHCs with the "CCBHC Indicator", will be reimbursed at the minimum of their clinic-specific PPS-1 rate for the provision of qualifying "PPS-triggering" CCBHC Demonstration services. Each CCBHC PPS- 1 rate will be established using the Special Procedure Pricing file with rates entered for T1040 by Provider ID. The CCBHC may only receive one PPS-1 payment per day per beneficiary for CCBHC services, regardless of the number of CCBHC services provided that day.

3.2. CCBHC Payment Operations

3.2.1. Billing Requirements

For FFS beneficiaries, CCBHC providers must submit claims for CCBHC services directly to the State's MMIS. The State's FFS designate will remit PPS-1 payment(s) to the CCBHC providers at their clinic- specific rates. For MCO-enrolled beneficiaries, CCBHC providers must submit claims for CCBHC services to the MCOs. The MCOs will remit PPS-1 payment(s) to the CCBHC providers at their clinic- specific PPS-1 rates.

To receive PPS-1 payment, CCBHCs must submit claims for CCBHC services using the CMS-1500, or 837-P with the T1040 CCBHC Demonstration billing code in addition to at least one "PPS-triggering" CCBHC service code. CCBHCs are required to submit all CCBHC service codes and units on the same claim for services provided on a given day even though only one "PPS-triggering" code is required for PPS-1 payment (note: this is sometimes referred to as "shadow billing") (see Table 1).

There are some "cost-only" CCBHC service codes that do not count as a "PPS-triggering" service but still constitute a CCBHC service and need to be tracked for monitoring/reporting purposes (i.e., they inform CCBHC quality measures). CCBHCs must submit claims for these codes using the "Q2" modifier. Generally, these codes will be billed on a claim with a T1040 alongside a "PPS-triggering" code. However, there could be instances where these codes are billed outside of a "PPS-triggering" service. In any instance, "cost-only" CCBHC services will be reimbursed at $0.

Please see the CCBHC code list posted on the HCA website for details on which codes are "PPS-triggering" codes and which are "cost-only" codes: https://nmrecovery.org/wp-content/uploads/2024/08/NM-CCBHC-Service-Codes_Masterlist8.24.xlsx

Table 1. Example CCBHC Claim:

Procedure Code	Units	Diagnosis Code(s)	Modifier(s)
T1040	1		
G0444	1	F32.1	Q2, GT
H2011	3		
90839	1		
H0030	1	F11.22, F11.182	Q2, GT
98968	1	F11.950	Q2, GT

**T1040 must be in top level of claim*

3.2.1. Billing, Ordering and Rendering Provider Fields

Providers submitting CCBHC claims on the CMS-1500 or 837-P, must ensure:

- The rendering provider field (loop 2310B) is left blank
- The ordering and referring provider (loops 2420E and 2310A) is also left blank
- The billing provider ID and Billing NPI match the Medicaid ID and Billing NPI for all locations certified as a CCBHC (i.e., as identified in the CCBHC Certification letter).

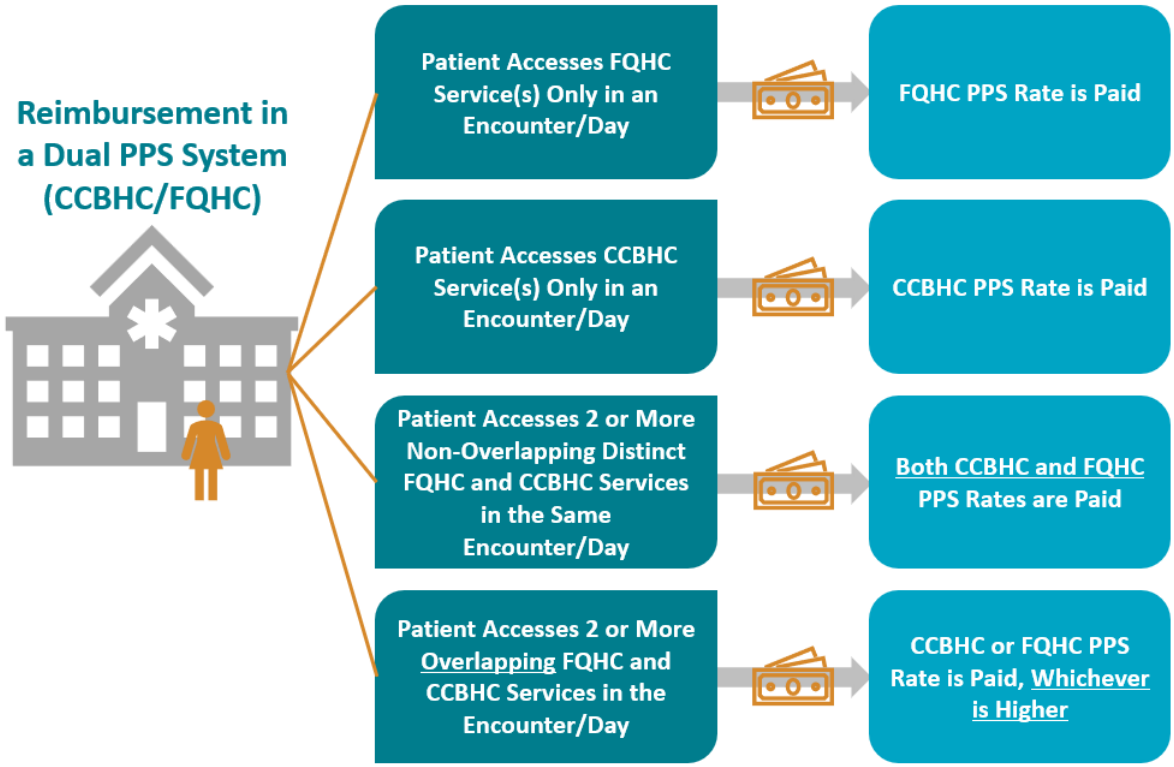
3.2.2. CCBHC and DCO Payment

Because CCBHCs are paid a PPS rate inclusive of all CCBHC services provided by the CCBHC and its DCOs, DCOs are prohibited from fee-for-service billing for CCBHC services provided to CCBHC clients. CCBHCs are responsible for claims submission and collecting from DCOs all documentation necessary for CCBHC data collection and billing. CCBHCs shall ensure that services rendered through a DCO have a Place of Service "98" placed on the respective line, or lines of the claim. CCBHCs should ensure processes are in place to identify and provide ongoing monitoring and safeguards against CCBHC and DCO duplicative billing practices.

3.2.3. Payment to Dual CCBHCs and FQHCs

Providers, or DCOs who are dually certified or enrolled as an FQHC and CCBHC must ensure that billing practices align with both sets of PPS billing requirements. FQHCs should follow existing claims submission guidance for FQHC-only services and ensure that all billing codes for services rendered are provided on the UB-4. CCBHC services delivered by FQHCs should be billed on the CMS-1500, or 837-P and follow claims submissions guidance, as detailed in Section 3.2 of this Supplement. Pursuant to federal guidance[1], the determination of which PPS (CCBHC or FQHC) should be paid, or if both PPS (CCBHC and FQHC) rates are paid is based on the nature, number, and scope of services provided to an eligible beneficiary on a given day. For dual CCBHC/FQHCs or DCOs, this falls under four primary scenarios, described below:

Figure 1. Dual FQHC/CCBHC Reimbursement



[1] See Medicaid.gov Section 223 CCBHC Demonstration PPS Guidance dated 2/2024, Section 4

Scenario 1: A beneficiary accesses one or more FQHC services and no CCBHC qualifying services, as defined in CCBHC scope of services list.
Outcome: Providers may bill the FQHC PPS only via UB-4.

Scenario 2: A beneficiary accesses one or more CCBHC qualifying services, as defined in the CCBHC scope of services list.
Outcome: Providers must bill the CCBHC PPS via the CMS-1500, or 837-P, even if those services are also Medicaid FQHC services.

Scenario 3: A beneficiary accesses two or more non-overlapping FQHC and CCBHC services (e.g., FQHC only service(s) and one or more CCBHC qualifying service(s)).
Outcome: Providers may bill both the FQHC and CCBHC PPS via the UB-4 and CMS-1500, or 837-P.

Scenario 4: If all of the services provided to a beneficiary during the same day are overlapping CCBHC qualifying services and FQHC services.
Outcome: The MCO must utilize 'higher of' logic and reimburse the dual CCBHC/FQHC at whichever PPS is higher via either the UB-4 or CMS-1500, or 837-P.

3.2.4. Encounter Reporting Requirements

Providers must ensure all information required for CCBHC claims are transmitted to the State or MCOs, including all "shadow-billed" and/or "cost-only" codes. This information must be completely passed through without any modification or truncation of billing codes, unit numbers, diagnosis codes, etc.

CCBHCs should inquire with EHR vendors, billing module vendors, and clearinghouses to ensure the respective claims avenues are configured to ensure all claim information completely pass through. This data drives several CCBHC quality measures thus the importance of ensuring an accurate reflection of services delivered.

3.2.5. Medicare-Medicaid Crossover Requirements

Under the CCBHC Demonstration, States must reimburse CCBHC services provided to dually enrolled Medicare-Medicaid beneficiaries at the CCBHC PPS rate. HCA or its designates, will pay the difference between a CCBHC's PPS-1 rate and the amount reimbursed by Medicare for "PPS-triggering" CCBHC services. Since Medicare will pay at the "detail level" of a claim (i.e., the "shadow-billed" codes), the payment responsibility shall consist specifically of a CCBHC's PPS-1 rate less the sum of Medicare reimbursement for all "shadow-billed" codes on a given claim.

3.2.6. Coordination of Benefits/Third-Party Liability Requirements

HCA, or its designates, will pay the difference between a CCBHCs PPS-1 rate and the amount reimbursed by third-party payers (including Medicare—please see 3.2.4 for information regarding Medicare) for "PPS-triggering" CCBHC services. Since third-party payers will pay at the "detail level" of a claim (i.e., the "shadow-billed" codes), the payment responsibility shall consist specifically of a CCBHC's PPS-1 rate less the sum of third-party payer reimbursement for all "shadow-billed" codes on a given claim.

3.2.7 *Waiver of Timely Claims Filing*

Timely filing has been waived for the first six months of program implementation (i.e., for all dates

of service from 1/1/25 – 6/30/2025).

3.3 Prior Authorization

Prior authorization is not required for any CCBHC services as indicated in the CCBHC Code List.

4. Additional Provider Requirements

4.1. Care Coordination

CCBHCs must follow either the New Mexico CareLink or HCA care coordination model. CCBHCs may elect to establish full or shared care coordination delegation agreements with Turquoise Care MCOs. For CCBHCs who enter into MCO delegated care coordination agreements, they must adhere to those agreements and all HCA care coordination requirements. CCBHCs may expand the care coordination population of focus beyond existing MCO-designated populations, based on the results of the CCBHC provider needs assessment, and may use either the CareLink or HCA care coordination model for this population.

Costs for providing care coordination to expanded populations can be included in CCBHC cost reports, using an allocation methodology to ensure no cost duplication between the CCBHC PPS, CareLink, and/or MCO Care Coordination reimbursement(s).

4.2. CCBHC Quality Measures and Reporting

4.2.1 Clinic Required Measures

CCBHCs are required to collect data and report measure outcomes for all required Clinic-Collected Quality Measures (see Table 2). Outcomes will need to be reported in accordance with the published guidelines to the state designated data entity on the provided data reporting template within the designated timeframes.

Table 2. Required Clinic-Collected Quality Measures:

Measure Name	Measure Steward	Manual Page #
Time to Services (**I-SERV**)	SAMHSA	31
Depression Remission at Six Months (**DEP- REM-6**)	MN CM*	40
Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (**ASC**)	NCQA†	51
Screening for Social Drivers of Health (**SDOH**)	CMS	61
Screening for Depression and Follow-Up Plan (**CDF-AD**): Age 18 and Older	CMS	70
Screening for Depression and Follow-Up Plan (**CDF-CH**): Ages 12 to 17	CMS	77

***** *Minnesota Community Measurement*

† *Based on CMS MIPS CQMS #431 (2023), which is derived from a measure stewarded by the National Committee for Quality Assurance (NCQA)*

4.2.2 State Collected Measures

State-Collected Quality Measures reflect data and outcomes for CCBHC clients receiving services. HCA through the state designated data entity, will aggregate and report the measure outcomes for all required State-Collected Quality Measures (see Table 3). While CCBHCs do not need to submit additional information for state-collected measures, certain measures will require

additional coordination with individual CCBHCs to ensure proper data collection and submissions standards are met.

Table 3. Required State-Collected Quality Measures:

Measure Name	Measure Steward	Manual Page #
Patient Experience of Care Survey (**PEC**)	SAMHSA	121
Youth and Family Experience of Care Survey (**Y/FEC**)	SAMHSA	124
Antidepressant Medication Management (**AMM-AD**)	NCQA*	129
Use of Pharmacotherapy for Opioid Use Disorder (**OUD-AD**)	CMS	135
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (**SAA-AD**)	CMS*	140
Plan All-Cause Readmissions Rate (**PCR-AD**)	NCQA*	149
Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (**ADD-CH**)	NCQA†	162
Hemoglobin A1c Control for Patients with Diabetes (**HBD-AD**)	NCQA*	170
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (**IET-AD**)	NCQA*	179
Follow-Up After Hospitalization for Mental Illness (**FUH-AD**): Age 18 and Older	NCQA*	193
Follow-Up After Hospitalization for Mental Illness (**FUH-CH**): Ages 6 to 17	NCQA†	197
Follow-Up After Emergency Department Visit for Mental Illness (**FUM- AD**): Age 18 and Older	NCQA*	203
Follow-Up After Emergency Department Visit for Mental Illness (**FUM- CH**): Ages 6 to 17	NCQA†	208
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (**FUA-AD**): Age 18 and Older	NCQA*	214
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (**FUA-CH**): Ages 13 to 17	NCQA†	219

* *Based on a CMS Medicaid Adult Core Set Measure (2023), which is derived from a measure stewarded by the NCQA*

† *Based on a CMS Medicaid Child Core Set Measure (2023), which is derived from a measure stewarded by the NCQA*

The measure stewards listed above are responsible for maintaining designated measures by updating codes tied to technical specifications and adjusting measures as clinical evidence changes. Additional guidance is published by SAMHSA and is available here: ccbhc-quality-measures-technical-specifications-manual.pdf

4.3. Program Oversight and Monitoring

CCBHCs will work with the HCA, MCOs, and any designates, and participate in operational

support, programmatic oversight and monitoring, and quality management and improvement initiatives. This includes, but is not limited to:

- Participation in all performance oversight and quality improvement efforts, including coordination on any corrective action, performance improvement initiative(s), quarterly monitoring, desk based or chart audits, onsite reviews, and CCBHC certifications or re-certifications. HCA reserves the right to conduct unannounced site visits or reviews at any time to ensure compliance and the delivery of high-quality care under the CCBHC model.
- Accurate and timely reporting of all CCBHC quality metrics and supporting information, as designated by HCA.
    - Participating in the review of CCBHC quality metrics, cost reports, level of care/service utilization data, or other performance data.
    - Implementing continuous quality improvement (CQI) processes to identify, remediate, and ensure quality provision of services to CCBHC members.
- CCBHCs must ensure that all data or information submissions are accurate, timely, and comply with established reporting guidelines.
- Participation in training and technical assistance activities to support expansion, quality improvement, and the effective delivery of CCBHC services.
- Participation in regular and ad hoc planning meetings with the HCA, MCOs, its designates, and other stakeholders, as identified.

4.3.1. Program Integrity

Following existing fraud, waste and abuse monitoring processes, HCA and MCOs shall perform financial and quality audits/reviews of the CCBHCs and support MCOs with program and fiscal oversight of the model. CCBHCs must make all records, audits, claims, documentation, and other materials available, as indicated, to support these reviews.

4.3.2. Incident Reporting and Management

CCBHCs are required to report critical incidents, such as adverse events, client safety issues, and breaches to the appropriate authorities in accordance with Child Protective Services, Adult Protective Services, and pursuant to NMAC 8.308.21.13. These reports must be submitted promptly and include detailed information about the incident and the actions taken in response. CCBHCs must have protocols in place for managing incidents, including conducting investigations, documenting findings, and implementing corrective actions. These protocols should be regularly reviewed and updated as needed to ensure they remain effective.

4.4. System Readiness

CCBHCs shall ensure that appropriate information technology and payment systems and processes are in place to meet all CCBHC billing and reporting requirements. CCBHCs shall participate in all system readiness testing efforts with MCOs at least 30 days prior to go-live.

This Supplement will sunset upon inclusion in the BH Policy & Billing Manual, and NMAC.

Please contact the Medical Assistance Division at MADInfo.HCA@hca.nm.gov if you have any questions regarding this supplement.