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

HEALTH CARE AUTHORITY

Letter of Direction #30

Date: **November 8, 2024**

To: **Turquoise Care Managed Care Organizations**

From: **Dana Flannery, Director, Health Care Authority, Medical Assistance Division**

Nick Boukas, Director, Behavioral Health Services Division

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

Title: **CCBHC Demonstration Implementation**

The purpose of this Letter of Direction (LOD) is to provide 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 will begin on January 1, 2025. For further background, please see the HCA CCBHC website: https://nmrecovery.org/ccbhc. This LOD is effective from January 1, 2025, however, systems and payment readiness and testing work must begin 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 MCO 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, 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 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 will provide MCOs with a final list of CCBHC DCOs in November 2024. 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. Provisionally Certified CCBHCs

Seven agencies have been provisionally certified and are eligible to enter the CCBHC DY1 for 1/1/25, subject to full certification by HCA/CYFD in November 2024. Eligible agencies include:

- All Faiths Children's Advocacy Center in Bernalillo County
- University of New Mexico Health System in Bernalillo and Sandoval County
- Carlsbad Lifehouse in Eddy County
- FYI+ in Doña Ana County
- Mental Health Resources (MHR) in Curry County (Requested to delay entry to 1/1/26)
- 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). To accommodate this directive, the CCBHC PPS-1 rates are being 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 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").

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. *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.

3.2.3. *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.

3.2.4. *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.

3.2.5. *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.

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 financial 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.

HCA directs MCOs to provide biweekly updates on the status of implementation every other Friday beginning November 1st, 2024, until otherwise directed by HCA.

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