DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

February 6, 2024

Ms. Lorelei Kellogg
Acting Director, Medical Assistance Division
New Mexico Human Services Department
2025 South Pacheco Drive
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Re: New Mexico State Plan Amendment (SPA) 23-0006

Dear Lorelei Kellogg:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0006. This amendment proposes to include community-based mobile crisis intervention services authorized by section 9813 of the American Rescue Plan of 2021 and to incorporate additional evidence-based practices. Language is being added to update the Multi-Systemic Therapy service and Peer Support providers. Additionally, language is added to allow involuntary admission to Crisis Triage Centers in alignment with the Senate Bill 310 (SB310) that was passed by the New Mexico Legislature in the 2023 Legislative Session.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations Section 9813 of the American Rescue Plan Act of 2021. This letter is to inform you that New Mexico Medicaid SPA 23-0006 was approved on February 6, 2024, with an effective date of July 1, 2023.

If you have any questions, please contact Dana Brown at 410-786-0421 or via email at Dana.Brown@cms.hhs.gov.

Sincerely,

Digitally signed by James G. Scott -S
Date: 2024.02.06 09:14:13 -06'00'

James G. Scott, Director
Division of Program Operations

cc: Valerie Tapia
Julie Lovato
Erika Price

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0006

2. STATE: NM

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Section 9813 of the American Rescue Plan Act of 2021

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 23 $ 628,001
b. FFY 24 $ 2,512,005

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
State Supplement A to Attachment 3.1A pgs. 21c, 21c1, 21c2, 21c3, 21c4.
State Supplement A to Attachment 3.1A pgs. 21c5, 21c6, 21c7, 21c8,21c9.21c10.
Attachment 4.19-B page 3aa; Attachment 4.19-B page 3aaa

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
State Supplement A to Attachment 3.1A pgs. 21c, 21c1, 21c2, 21c3, 21c4 (TN 19-0002)
Attachment 4.19-B page 3aa TN (19-0002)
~~Attachment 4.19-B page 3aaa~~

9. SUBJECT OF AMENDMENT
New Mexico is updating its state plan to include community-based mobile crisis intervention services authorized by section 9813 of the American Rescue Plan of 2021 and to incorporate additional evidence-based practices. Language is being added to update the Multi-Systemic Therapy service and Peer Support providers. Additionally, language is added to allow involuntary admission to Crisis Triage Centers in alignment with the Senate Bill 310 (SB310) that was passed by the New Mexico Legislature in the 2023 Legislative Session.

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
Authority delegated to the Medicaid Director

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Lorelei Kellogg

13. TITLE
Acting Director, Medical Assistance Division

14. DATE SUBMITTED
8/15/2023

15. RETURN TO
Lorelei Kellogg, Acting Director
Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504-2348

FOR CMS USE ONLY

16. DATE RECEIVED
August 15, 2023

17. DATE APPROVED
February 6, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
Digitally signed by James G. Scott -S
Date: 2024.02.06 09:14:43 -06'00'

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS
The state has authorized a pen & ink change to remove the "Attachment 4.19-B, page 3aaa" reference from Box 8.

8. Multi-Systemic Therapy (MST) is an intensive family and community, evidence-based treatment for youth who are at risk of out-of-home placement or are returning home from an out of home placement. MST addresses the multiple causes of serious antisocial behavior across key systems within which youth are embedded (family, peers, school, and neighborhood).

   Multi-Systemic Therapy-Problem Sexual Behavior (MST-PSB) focuses on aspects of a youth's ecology that are functionally related to the problem sexual behavior. MST-PSB includes reduction of parent and youth denial about the sexual offenses and their consequences, promotion of the development of friendships and age-appropriate sexual experiences, and modification of the individual's social perspective-taking skills, belief system, or attitudes that contributed to sexual offending behavior.

   The MST program includes an assigned MST team for each eligible member. The MST team must have the ability to deliver services in various environments including home, school, homeless shelter, and street location. The MST practitioners must be able to provide 24 hours/day, seven days a week. Services provided to family members or other collaterals are for the direct benefit of the Medicaid beneficiary.

   MST Service Components:

   (A) Treatment Planning – Participating in and utilizing strengths-based treatments/planning which may include assisting the individual and family members or other collaterals with identifying strength and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources and natural supports to address functional deficits associated with their mental illness. This only includes developing the treatment plan for the Medicaid behavioral health services provided to the individual.

   (B) Restoration of social skills
   Youth and families receive individualized, skill-building which is available 24 hours a day, seven days a week in the community setting. Skill-building is designed to decrease symptoms of the mental health diagnosis, reduce maladaptive referral behaviors and increase pro-social behaviors at home and across the multiple interconnected systems. The interconnected systems include the family, extended family, peers, neighbors, and the community that exists in the youth's world. The positives that are found in these systems are used as leverage for change. The MST skill-building services are rehabilitation and support with the restoration of social and interpersonal skills, problem solving, conflict resolution, and emotions/behavior management to prevent institutionalization, enhance personal relationships, establish support networks, develop positive coping mechanisms and strategies, and promote effective functioning in the youth's social environment including home, school, and community.

   (C) Family Therapy and Psychoeducation - The family receives family therapy in order to understand and implement how to assist their child based on the child's medical diagnosis. Psychoeducation includes instruction and training of families to increase their knowledge and understanding of the child's psychiatric diagnosis(es), prognosis(es), treatment, and rehabilitation in order to enhance their cooperation and collaboration with treatment, rehabilitation and favorably affect outcomes.

   Practitioner Qualifications:
   MST practitioners must have at least:

   - Bachelor level staff with a degree in social work, counseling, psychology, or a related human service field and a minimum of three years' experience working with the identified population. A bachelor level behavioral health practitioner is limited to performing functions defined within the scope of his or her RLD practice board licensure or practice. Bachelor's level staff may provide the non-clinical components of MST treatment (treatment planning, skill-building, and family psychoeducation but not family therapy).
   - Master's level behavioral health practitioner may perform all MST interventions.

All clinical staff are required to complete a prescribed five-day MST introductory training and subsequent quarterly trainings.
Any staff person providing MST-PSB must have completed the MST-PSB specific training and be on a specially trained team with national certification from MST Services, LLC for MST-PSB. The MST team must include at a minimum two-thirds master level staff and not exceed more than one-third bachelor level staff unless a formal exception has been granted by MST Services, LLC.

Supervisor Qualifications:
The MST team must include a supervisor who is a master's level independently licensed behavioral health professional or a master's level licensed behavioral health professional working in an agency with access to an independently licensed supervisor supporting the team.

Clinical supervision must include at a minimum weekly supervision provided by an independently licensed master level behavioral health practitioner who is MST trained or an MST trained master's level licensed behavioral health professional working in an agency with access to an independently licensed supervisor supporting the team. This supervision, in accordance with MST supervisory protocol, is provided to team members on topics directly related to the needs of the Medicaid member and their family on an ongoing basis. Weekly supervision must also include one hour of local group supervision and one hour of telephone consultation per week with the MST systems supervisor.

Provider Agency Qualifications: An agency must hold a copy of MST Services, LLC. licensure, or any of its approved subsidiaries, and meet the State licensure and provider enrollment requirements for each MST team. Any team providing MST-PSB must have a specific national certification from MST Services, LLC for MST-PSB.

9. Substance Use Disorder Continuum of Services

The comprehensive continuum of services for the screening, assessment, and treatment of substance use disorders includes several new services based upon the American Society of Addiction Medicine's levels of care (ASAM LOC) including placement criteria, staffing, and standards. These services are designed for an individual's restoration to a functional level within his or her life and community.

1. Screening, Brief Intervention, and Referral to Treatment (SBIRT)
   - A. Definition: SBIRT is a community-based practice designed to identify, reduce, and prevent problematic substance use or misuse and co-occurring mental health disorders as an early intervention. SBIRT is a universal screening specific to age, face-to-face brief intervention for positive screening results, and a referral to behavioral health services if indicated.
   - B. Practitioners delivering the service must be trained in a state-approved educational curriculum and include:
     1. Registered nurses;
     2. Certified nurse practitioners;
     3. Clinical nurse specialists;
     4. Behavioral health practitioners at all educational levels;
     5. Behavioral health interns under the supervision of an independently licensed behavioral health practitioner;
     6. Certified peer support workers;
     7. Certified family peer support workers;
     8. Licensed physician assistants;
     9. Physicians;
     10. Medical assistants; and
     11. Community health workers and Tribal Community Health Representatives (TCHR)

     CHWs and TCHRs are required to obtain credentialing through the NM Department of Health in either a grandfathering or training track. Credentialing includes mastery of the following core competencies: effective communication, interpersonal skills, health coaching, service coordination, advocacy, community health outreach, community knowledge and assessment and clinical support skills. The grandfathering tracks requires 2000 hours of paid or volunteer work as a CHW. The training track requires 100 hours of classes followed by 40 hours of experiential learning. An individual certification is required but there is a 3-year rollout to certify organizations as well. The organization certification will include oversight of the supervision the agencies provide for their CHWs.

2. Peer Support Services
   - A. Definition: Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. Recovery is a rehabilitative process characterized by continual growth and improvement in one's health and wellness, social and spiritual connection, and renewed purpose.

     Family Peer Support Services (FPSS) support parents and other primary caregivers to successfully navigate the child serving behavioral health, education, juvenile justice, child welfare and other systems on behalf of their child. Trained and certified Family Peer Support Workers (FPSW) support parents and caregivers to ensure their voice is heard, and that they are equipped to advocate for their child to identify and gain access to all necessary resources

for their wellbeing. FPSW support parents and caregivers to ensure that their preferences are incorporated into their children's plan of care, including behavioral health, mental health, and educational plans, and that their natural

support systems are strengthened. FPSS help families raising children and youth to gain the knowledge, skills, and confidence to effectively manage their child's needs and ultimately move to more family independence.
Peer support services furnished to a parent and/or other primary caregivers are for the direct benefit of the Medicaid beneficiary.

Youth Peer Support Services (YPSS) offers youth a connection to a peer with demonstrated lived experience whose empathetic response and resiliency provides the additional support, validation, and encouragement necessary for youth people to successfully navigate the behavioral health and other systems and engage with the community during the transition to adulthood. Trained and certified Youth Peer Support Workers (YPSW) work with youth in individual and group settings to increase the levels of trust, relatability, and youth voice in the relationship between youth and provider.

B. Practitioners:
Certified Peer Support Workers, Certified Family Peer Support Workers, and Certified Youth Peer Support workers must be self-identified consumers who are in recovery from mental illness and/or substance use disorders.

1. Certified Peer Support Workers
   a. Must complete the certification program offered at the Behavioral Health Services Division of the Human Services Department.
   b. Must complete the test and be certified by the New Mexico Credentialing Board for Behavioral Health Professionals.
   c. Must complete 20 hours of initial training and 20 hours of education every subsequent year.
   d. Must be supervised by an independent practitioner or someone trained and certified to supervise peers.
   e. Services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

2. Certified Family Peer Support Workers
   a. Must complete the application, training, and certification program offered through the Children, Youth and Families Department Behavioral Health Services division.
   b. Must complete the test and be certified by the New Mexico Credentialing Board for Behavioral Health Professionals.
   c. Must complete 20 hours of initial training and 20 hours of education every subsequent year.
   d. Must be supervised by an independent practitioner or someone trained and certified to supervise peers.
   e. Services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

3. Certified Youth Peer Support Workers
   a. Must complete the application, training, and certification program offered through the Children, Youth and Families Department Behavioral Health Services division.
   b. Must complete the test and be certified by the New Mexico Credentialing Board for Behavioral Health Professionals.
   c. Must complete 20 hours of initial training and 20 hours of education every subsequent year.
   d. Must be supervised by an independent practitioner or someone trained and certified to supervise peers.
   e. Services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals.

3. Dyadic and triadic therapy for a baby or child diagnosed with a behavioral health condition or at risk because of the caregiver's behavioral health condition includes the mother, father, or primary caregiver together with the child. Dyadic and triadic therapies are types of family therapies for the direct benefit of the child. Licensed behavioral health professionals working with their scope of practice under state law may provide dyadic and triadic therapy. These include psychologists, licensed clinical social workers, licensed professional clinical counselors, licensed marriage and family therapist, and licensed addiction counselors.

4. Outpatient withdrawal management (WM):

A. Definition: Withdrawal signs and symptoms are sufficiently resolved so that the patient can be safely managed outside of the clinic; at night has supportive living situation.

1. Ambulatory WM without extended on-site management
   a. Services: a comprehensive medical history and physical examination; medication or non-medication methods of WM; patient education; non-pharmacological clinical support; involvement of family members or significant others in the WM process; and discharge or transfer planning including referral for counseling and involvement in community recovery support
   b. Practitioners:
      i. on call licensed physician, nurse, psychologist
      ii. on-site licensed nurse, counselors, social workers, and certified peer support workers as defined in section 2 of this part.

2. Ambulatory WM with extended on-site monitoring
   a. services include the above services plus an addiction-focused history; sufficient biopsychosocial screening to determine the level of care; an individualized treatment plan; and monitoring and assessment of progress throughout the day
   b. Practitioners:
      i. on call licensed physician, nurse, psychologist
      ii. on-site licensed nurse, counselors, social workers, and certified peer support workers as defined in section 2 of this part.

5. Crisis Stabilization

A. Definition: Crisis Stabilization is an outpatient service providing up to 24-hour stabilization of crisis conditions. Crisis Stabilization includes services that are designed to ameliorate or minimize an acute crisis episode or to prevent incarceration, emergency department, inpatient psychiatric hospitalization, or medical detoxification. Services are provided to eligible recipients who have suffered a breakdown of their normal strategies or resources and who exhibit acute problems or disturbed thoughts, behaviors, or moods which could threaten the safety of self or others. Services include telephone crisis services; face-to-face crisis intervention in a clinic setting; and outpatient crisis stabilization services. Services include crisis triage; screening and assessment; de-escalation and stabilization; brief intervention or psychological counseling; peer support; prescribing and administering medication if applicable; and referral to services. Ambulatory withdrawal management may be included. Some Centers may also offer navigational services for individuals transitioning to the community from correctional facilities upon official release from custody/detention. Inmates of public institutions are not eligible for crisis stabilization services.

B. Staffing: Crisis stabilization community centers must be minimally staffed during all hours of operation with:
1. one registered nurse with experience or training in crisis triage and managing intoxication and withdrawal management if offered;
2. one licensed master's level mental health practitioner;
3. one certified peer support worker; and
4. either on-site or on call one board certified physician or licensed clinical nurse specialist, or licensed certified nurse practitioner.

6. Intensive Outpatient for SUD:

A. Definition: Time limited IOP services utilizing a multi-faceted approach to treatment for an eligible recipient who requires structure and support to achieve and sustain recovery. IOP must utilize a research and evidence-based model approved by the IOP Interagency Council and target specific behaviors with individualized behavioral interventions. IOP covered core services include: individual substance use disorder related therapy; group therapy and psycho-education.

B. Staff: IOP services are provided through an integrated interdisciplinary approach including staff expertise in both addiction and mental health treatment
1. Each IOP program must have an independently licensed clinical supervisor
2. The team may have services rendered by a licensed practitioner~~s~~ whose scope of licensure does not allow him or her to practice independently under the direction of an independently licensed clinical supervisor. Non-independently licensed practitioners include a licensed Master of Social Work (LMSW) licensed by the State's regulations and licensing board or social work examiners; a licensed mental health counselor (LMHC) licensed by the State's regulation and licensing counseling and therapy practice board; a licensed substance abuse

associate (LSAA) licensed by the States regulation and licensing counseling and therapy practice board; and masters level psychology associates.

7. Intensive Outpatient for Mental Health Conditions:

A. Definition: Time limited IOP services utilizing a multi-faceted approach to treatment for an eligible recipient who requires structure and support to achieve and sustain recovery. IOP must utilize a research and evidence-based model approved by the IOP Interagency Council and target specific behaviors with individualized behavioral interventions. IOP covered services include individual therapy; group therapy and psycho-education.

B. Staff: IOP services are provided through an integrated interdisciplinary approach including staff expertise in both addiction and mental health treatment

1. Each IOP program must have an independently licensed clinical supervisor
2. The team may have services rendered by a licensed practitioners whose scope of licensure does not allow him or her to practice independently under the direction of an independently licensed clinical supervisor. Non-independently licensed practitioners include a licensed Master of Social Work (LMSW) licensed by the State's regulations and licensing board or social work examiners; a licensed mental health counselor (LMHC) licensed by the State's regulation and licensing counseling and therapy practice board; a licensed substance abuse associate (LSAA) licensed by the States regulation and licensing counseling and therapy practice board; and masters level psychology associates.

8. Partial hospitalization: 20 or more hours of service/week for multi-dimensional instability, not requiring 24-hour care.

A. Partial hospitalization updated coverage criteria:

1. Extend coverage to youth as part of EPSDT in a psychiatric hospital;
2. Include SUD in addition to mental health;
3. Qualified agency types include acute care hospitals with psychiatric services and psychiatric hospitals as specialty hospitals.

B. Definition: Partial hospitalization is a voluntary, intensive, structured and medically staffed, psychiatrically supervised treatment program with an interdisciplinary team intended for stabilization of acute psychiatric or substance use symptoms and adjustment to community settings. The services are essentially of the same nature and intensity, including medical and nursing services, as would be provided in an inpatient setting, except that the recipient is in the program less than 24-hours a day, and it is a time-limited program. Covered services include:

1. regularly scheduled structured counseling and therapy sessions for an eligible recipient, his or her family, group or multifamily group based on individualized needs furnished by licensed behavioral health professionals, and, as specified in the treatment plan;
2. educational and skills building groups furnished by the program team to promote recovery;
3. age-appropriate skills development in the areas of household management, nutrition, personal care, physical and emotional health, basic life skills, time management, school attendance and money management;
4. drugs and biologicals that cannot be self-administered and are furnished for therapeutic management;
5. assistance to the recipient in self-administration of medication in compliance with state policies and procedures;
6. appropriate staff available on a 24-hour basis to respond to crisis situations, evaluate the severity of the situation, stabilize the recipient make referrals as necessary, and provide follow-up;
7. consultation with other professionals or allied caregivers regarding a specific recipient;
8. coordination of all non-medical services, including transportation needed to accomplish a treatment objective;
9. therapeutic services to meet the physical, social, cultural, recreational, health maintenance, and rehabilitation needs of recipients; and (10) discharge planning and referrals as necessary to community resources, supports, and providers in order to promote a recipient's return to a higher level of functioning in the least restrictive environment.

C. Practitioners: An eligible provider includes a facility joint commission accredited, and licensed and certified by the New Mexico Department of Health (DOH) or the comparable agency in another state. The program must include a registered nurse, a clinical supervisor that is an independently licensed behavioral health practitioner or psychiatric nurse practitioner or psychiatric nurse clinician and independently licensed behavioral health practitioners. The team may also include physician assistants, certified peer support, family peer support, and youth peer support workers as defined in section 2 of this part, licensed practical nurses, and mental health technicians.

9. Accredited Residential Treatment Centers (ARTC) for adults with SUD with three sub-levels:

A. Definition: Accredited Residential Treatment Centers for Adults with Substance Use Disorder are facilities for adult recipients who have been diagnosed as having a substance use disorder (SUD). ARTC services, at all levels of care, include individual, group, and family therapy; medication management; and psychoeducation to facilitate the application of recovery skills, relapse prevention, and emotional coping strategies.

B. Sub-levels of care

1. Level 3.1: Clinically managed low-intensity residential service: 24-hour structure with trained personnel; at least 5 hours of clinical service/week. This level is often a step down from a higher level of care and prepares the recipient for outpatient treatment and community life.
2. Level 3.3, 3.5, and 3.2 withdrawal management are clustered together in a second level of service with specific programming for each sub type:

    a. Level 3.3, clinically managed population specific high intensity residential services: 24-hour structure with trained counselors to stabilize multi-dimensional imminent danger; less intense programming and group treatment for those with cognitive or other impairments unable to use full therapeutic community; and preparation for outpatient treatment.
    b. Level 3.5, clinically managed high intensity residential services: 24-hour care with trained counselors to stabilize multi-dimensional imminent danger; and preparation for outpatient treatment.
    c. Level 3.2 withdrawal management, clinically managed residential withdrawal management: Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.

    The recipient remains in a Level 3.2 withdrawal management program until:

        i. withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
        ii. the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management services is indicated.

3. Level 3.7 and 3.7 withdrawal management are clustered together in a third level of service with specific programming for each sub type.
    a. Level 3.7, medically monitored, intensive residential service delivered by medical and nursing professionals; provides 24-hour evaluation and monitoring services under the direction of a physician or clinical nurse practitioner who is available by phone 24-hours a day. Nurisng staff is on-site 24-hours a day. Other staff may include counselors, social workers, and psychologists available to assess and treat the recipient.
    b. Level 3.7 withdrawal management, medically monitored residential withdrawal management for severe withdrawal; services provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists under the direction of a licensed physician with 24-hour nursing care and physician availability; includes appropriate toxicology tests as well as individual, group, and family therapy.

    The recipient remains in a level 3.7 withdrawal management program until:

        i. withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
        ii. the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management services is indicated.

    Regardless of service level AARTCs must include by an interdisciplinary staff of licensed nurses, counselors, social workers, addiction specialists, certified peer support workers or other health and technical personnel who provide services under the direction of a licensed physician. Facilities must maintain staff, working within their scope of licensure, available on a 24-hour basis to respond to a crisis and provide stabilization services.

10. Crisis Triage Centers (CTCs)

A. Definition: Crisis Triage Centers are community-based alternatives to hospitalization or incarceration. The facilities are either outpatient only (providing crisis stabilization as indicated above), or outpatient and residential, with no more than 16 beds. They serve youth and adults to provide voluntary and involuntary stabilization of behavioral health crises including emergency mental health evaluation, withdrawal management, and care.

Involuntary admissions are for individuals who have been determined to be a danger to self or others as a result of a Mental Illness. Inmates of a public institution are not eligible for CTC services.

Services include physical and mental health assessment, de-escalation and stabilization; brief intervention and psychological counseling; clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems; psychological and psychiatric consultation; other services determined through the assessment process; and may include ambulatory withdrawal management; and, if residential, all level 3 withdrawal management services.

B. The following individuals and practitioners must be contracted or employed by the provider agency as part of its crisis triage center service delivery:
1. an administrator which can be the same person as the clinical director;
2. a full-time clinical director;
3. a charge nurse on duty 24 hours/day, seven days/week this requirement may be met by a through access to a supervising nurse who is available via telehealth;
4. an on-call physician 24 hours/day, seven days/week;
5. a master's level licensed mental health practitioner;
6. two certified peer support workers;
7. a part time psychiatric consultant, hours dependent on the size of the facility; and
8. at least one staff trained in basic cardiac life support (BCLS), the use of the automated external defibrillator (AED) equipment, and first aid.

The ratio of direct care staff to individuals shall increase on the basis of the clinical care needs of the individuals in residence as well as the number of operational beds.

11. Mobile Crisis and Mobile Response and Stabilization Services

Mobile Crisis and Mobile Response and Stabilization Services provided consistent with section 1947 of the Social Security Act will be claimed at the enhanced federal Medicaid assistance percentage for the duration of the enhanced match availability. This includes provision to individuals experiencing a mental health or substance use disorder crisis and furnished outside of a hospital or other facility setting.

1. Community-based Mobile Crisis Intervention Services.

A. Mobile crisis services are intended to provide rapid response, individual assessment, and evaluation and treatment of mental health crisis to individuals experiencing a mental health crisis or substance use disorder crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical in an individual's life, in which the outcome may decide whether possible negative consequences will follow. Crisis services will be available where the individual is experiencing a mental health crisis on 24 hours a day, 7 days a week, 365 days per year basis and not restricted to select locations within any region on particular days or times and must address co-occurring substance use disorders, including opioid use disorder, if identified. Mobile Crisis services are furnished outside of a hospital or other facility setting. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available.

It involves all services, supports, and treatments necessary to provide a timely crisis response, crisis interventions such as de-escalation, and crisis prevention activities specific to the needs of the individual, in a way that is person and family centered. Services follow an integrated culturally, linguistically, and developmentally appropriate approach. Services are trauma informed and may be provided prior to an intake evaluation for mental health services. Additionally, teams must ensure language access for individuals with limited-English proficiency, those who are deaf or hard of hearing, and comply with all applicable requirements under the Americans with Disabilities Act, Rehabilitation Act and Civil Rights Act. At a minimum, mobile crisis intervention services include initial response of conducting immediate crisis screening and assessment, mobile crisis stabilization and de-escalation, and coordination with and referral to health social and other services as needed to effect symptom reduction, harm reduction and/or to safely transition persons in acute crisis to the appropriate environment for continued stabilization.

Community-based mobile crisis services are provided where the person is experiencing a crisis and are not restricted to select locations within the community. Team members are trained in trauma-informed care, de-escalation strategies, and harm reduction; able to respond in a timely manner and, where appropriate, provide screening and assessment; stabilization and de-escalation; and coordination with, and referrals to, health, social, and other services and supports as needed, and health services as needed. Mobile Crisis teams may connect individuals to facility-based care as needed, through warm hand-offs and coordinating transportation only if situations warrant transition to other locations. Services may also include telephonic follow-up interventions for up to 72 hours after the initial mobile response. Follow-up includes, where appropriate, additional intervention and de-escalation services and coordination with and referrals to health, social, emergency management, and other services and supports as needed.

Mobile Crisis teams maintain relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care organizations (if applicable). This coordination is done while ensuring the privacy and confidentiality of individuals receiving mobile crisis intervention services consistent with Federal and State requirements.

B. Children's Mobile Response and Stabilization Services (MRSS) is a child, youth, and family specific behavioral health crisis intervention and prevention service. It provides immediate, in-person response, following mobile crisis requirements defined in paragraph A of this section, to de-escalate crises that are defined by the family. MRSS prevents future crises or out of home placement through stabilization services and supports, follow up, navigation and access to community supports across the system of care. MRSS services are conducted through a cultural, linguistic, and developmentally appropriate, trauma-responsive framework.

MRSS includes up to 56 days of stabilization services, a critical component of MRSS. To maintain care continuity, whenever possible stabilization services are conducted by a member of the MRSS team who initially responded to the family. The stabilization period is meant to identify deeper reasons for safety and stability events, particularly when they are re-occurrent.

The MRSS stabilization process initiates the use of a mobile crisis screening and assessment that helps to identify needs and strengths across life domains and categorizes them in order of urgency. The MRSS stabilization process will address the child and family's urgent and emergent needs through intensive care coordination. The MRSS eight-week stabilization process is not meant to be a limitation of the stabilization period but part of a continuum of care for stabilization, and the individual may at any time transfer to other long-term services and supports for continued care.

C. Staffing for Mobile Crisis and MRSS: Services are furnished by a multidisciplinary mobile crisis team that includes at least two members. The team includes at least one behavioral health care professional able to conduct a mobile crisis screening and assessment within their permitted scope of practice under state law.

Additional team members may include other professionals or paraprofessionals with appropriate expertise in behavioral health or mental health crisis response, including nurses, social workers, peer support specialists, and others, as designated by the State. A team may include a licensed practitioner available via telehealth. A team includes at least two of the following: a licensed Mental Health Therapist; Certified Peer Support Worker; Certified Family Peer Support Worker; Certified Youth Peer Support Worker, Community Support Worker; Community Health Worker; Community Health Representative; Certified Prevention Specialist; Registered Nurse; Emergency Medical Service provider; Licensed Alcohol and Drug Abuse Counselor (LADAC) or Certified Alcohol and Drug Addiction Consultant (CADAC); non-independently licensed behavioral health professionals; Emergency Medical Technicians; Licensed Practical Nurses; other certified and/or credentialed individuals.

All Mobile Crisis Intervention and Mobile Responsive and Stabilization Services must be under the supervision of an independently licensed behavioral health professional who must be available to provide real time clinical assessment in person or via telehealth.

For MRSS teams it is strongly recommended that Certified Family Peer Support Workers, Certified Youth Peer Support Workers, or Certified Peer Support Workers are included in the team whenever possible.
All MRSS team members must complete State of NM Children Youth and Family Department (CYFD) training.

12. Functional Family Therapy

Functional Family Therapy (FFT) is an evidence-based, short term and intensive family-based and manual driven treatment program that has been successful in treating a wide range of problems affecting families in a wide range of multi-ethnic, multicultural, and geographic contexts. FFT enrolls families with youth meeting medical necessity with serious behavior problems such as conduct disorder, violent acting-out, mental health concerns, truancy, and substance abuse. FFT woks to integrate families' voices in all phases of treatment; develop and grow in innovative, collaborative, dynamic and evidence-based practices (EBP); practice evidence-based programs in evidence-based ways to maintain model fidelity; evolve the model in a way that is responsive to the needs of families, communities, and agencies; and provide innovative, real-time cloud-based technology and training for predictability and outcomes. The FFT program helps families collaboratively engage in treatment, learn skills to solve problems, and maintain these changes.

FFT can be conducted in clinic settings as an outpatient therapy or a home-based model. FFT interventions occur in three primary phases (engagement/motivation, behavior change, and generalization), each with measurable process goals and family skills that are the targets of intervention with the length of treatment covered based on medical necessity. Each phase has specific goals and practitioner skills associated with it. The specificity of the model allows for monitoring of treatment, training, and practitioner model adherence in ways that are not possible with other less specific treatment interventions. FFT has a wide range of clinical applications and has been effectively integrated into a wide array of multi-ethnic, multicultural contexts. FFT is listed with the highest rating by the Title IV-E Prevention Services Clearinghouse.

Services are available in-home, at school and in other community settings including a federally qualified health center (FQHC), an Indian Health Service (IHS) facility and a PL 93-638 tribally-operated facility. Services provided to family members or other collaterals are for the direct benefit of the Medicaid beneficiary.

FFT Services Components

(A) Treatment Planning – Participating in and utilizing strengths-based treatments/planning which may include assisting the individual and family members or other collaterals with identifying strength and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources and natural supports to address functional deficits associated with their mental illness. This only includes developing the treatment plan for the Medicaid behavioral health services provided to the individual.

(B) Restoration of social skills

Youth and families receive individualized, skill-building which is available 24 hours a day, seven days a week in the community setting. Skill-building is designed to decrease symptoms of the mental health diagnosis, reduce maladaptive referral behaviors and increase pro-social behaviors at home and across the multiple interconnected systems. The interconnected systems include the family, extended family, peers, neighbors, and the community that exists in the youth's world. The positives that are found in these systems are used as leverage for change.

FFT skill-building received by the youth and family includes frequent therapy assisting the youth and family in learning and demonstrating the benefits of positive, respectful, strength-based relationships. Positive outcomes are anticipated through the therapy which includes conflict resolution and strategies to enhance the relationships within the family. The youth and family will also gain the ability through therapy to extend their acquired competencies into accessing additional resources to prevent relapse as they continue developing their independence.

(C) Family Therapy and Psychoeducation The family receives family therapy in order to understand and implement how to assist their child based on the child's medical diagnosis. Psychoeducation includes instruction and training of families to increase their knowledge and understanding of the child's psychiatric diagnosis(es), prognosis(es), treatment, and rehabilitation in order to enhance their cooperation and collaboration with treatment, rehabilitation and favorably affect outcomes.

Practitioner Qualifications:

FFT practitioners must have at least:

- licensed Master's level behavioral health practitioner may perform all FFT interventions and/or
- Bachelor's level staff. Bachelor's level staff may provide non-clinical components of FFT treatment and must have a degree in social work, counseling, psychology, or a related human services field and must have at least three (3) years of experience working with the target population that is, children/adolescents and their families.

Staffing for FFT services shall be comprised of no more than one-quarter Bachelor's level staff and, at minimum, three-quarters licensed Masters level staff.

Supervisor Qualifications:

The FFT team must include a Clinical Supervisor who is a master's level independently licensed behavioral health professional or a master's level licensed behavioral health professional working in an agency with access to an independently licensed supervisor supporting the team. The Clinical Supervisor must have FFT certification.

Provider Agency Qualifications:
An agency must hold a copy FFT certification, or any of its approved subsidiaries, and meet the State licensure and provider enrollment requirements for each FFT team. An active FFT team requires FFT certification of a Clinical Supervisor and at least two FFT certified treatment providers working collaboratively with one another using the FFT services as defined by the State. Providers must be engaged in training, consultation, and oversight by either of the following training entities: FFT LLC or FFT Partners.

13. Therapeutic Interventions

The Medicaid program provides coverage under the Medicaid State Plan for mental health services rendered to individuals with mental health disorders. The mental health services rendered shall be necessary to reduce the disability resulting from mental illness and to restore the individual to their best possible functioning level in the community.

Therapeutic Interventions are the following Evidence-based practices delivered by qualified Licensed Mental Health Practitioners:

- Trauma-Focused Cognitive Behavior Therapy is a combination of cognitive behavioral therapy, family therapy, and psychosocial education to address the effects of trauma using conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles. Any interventions involving parents and caregivers are for the direct benefit of the beneficiary.

- Eye Movement Desensitization and Reprocessing - An evidence-based psychotherapy that treats trauma-related symptoms. EMDR therapy is designed to resolve unprocessed traumatic memories in the brain. The therapist guides the client to process the trauma by attending to emotionally disturbing material in brief, sequential doses, while at the same time focusing on an external stimulus. The most commonly used external stimulus in EMDR therapy is alternating eye movements; however, sounds or taps may be used as well.

- Dialectical Behavior Therapy - A cognitive behavioral approach to treatment to teach individuals better management of powerful emotions, urges, and thoughts that can disrupt daily living if not addressed in a structured treatment approach. This evidence-based practice includes service coordination, individual, group and family therapy. A DBT provider must include in their program individual DBT therapy, DBT skills groups, twenty-four (24) hour coverage, seven (7) days per week availability for skills coaching, and a clinical consultation team.
  DBT therapists must be independently licensed but may work with Master's or Bachelor's level staff with a degree in social work, counseling, psychology or a related human services field and must have at least three (3) years of experience working with the target population that is, children/adolescents and their families. Unlicensed staff may not provide DBT therapy – they may only provide service coordination and group therapy in conjunction with a trained licensed therapist. An active DBT team requires DBT certification of at least two certified treatment providers working collaboratively with one another using the DBT services as defined by the DBT Services program selected by the State.

Practitioner Qualifications:
The following Mental Health Practitioners who are licensed in the State of New Mexico to diagnose and treat behavioral health acting within the scope of all applicable state laws and their professional license and may provide the above evidence-based practices if applicable certification, for the therapeutic intervention, is obtained:

- Medical Psychologists;
- Licensed Psychologists;
- Licensed Clinical Social Workers (LCSWs);
- Licensed Professional Clinical Counselors (LPCCs);
- Licensed Marriage and Family Therapists (LMFTs);
- Licensed Addiction Counselors (LACs); and
- Advanced Practice Registered Nurses (APRN) (must be a nurse practitioner specialist in Adult Psychiatric &

Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice.

Services provided by licensed behavioral health practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations.

4. **Accredited Residential Treatment Centers for Adults with Substance Use Disorders** – Reimbursement is made at a daily rate established by the agency state audit agent after analyzing the costs to provide services. Room and board costs are not included in the rate and are not reimbursable. Cost that are considered in the rate are: direct service costs, direct supervision costs, therapy costs including all salaries, wages, and benefits associated with health care personnel, admission discharge planning, clinical support costs, non-personnel operating costs including expenses incurred for program related supplies and general administration costs. ARTC's have a cost-based reimbursement and is specific to each agency these rates are not publicly published. During the rate calculation process several key factors are reviewed by the agency and the providers upon approval of rates.
   Except as otherwise noted in the State Plan, the State-developed rates are the same for both governmental and private providers.

5. **Crisis Triage Centers** – Reimbursement is made at service rates that are uniquely determined for each provider based on provider costs as determined by the state agency contracted audit agency. Costs are determined by considering: direct service costs, direct supervision costs, therapy costs including all salaries, wages and benefits associated with health care personnel, clinical support costs, non-personnel operating costs and general administration costs. CTC's have a cost-based reimbursement and is specific to each agency these rates are not publicly published. During the rate calculation process, several key factors are reviewed by the agency and the providers upon approval of the rates.

6. **Evidence-based Practices including Functional Family Therapy, Dialectical Behavior Therapy, Trauma Focused Cognitive Behavior Therapy, and Eye Movement Desensitization and Reprocessing-** Reimbursement for Evidence-based Rehabilitative Services as outlined in item 13.d per Attachment 3.1-A, are paid based upon Medicaid rates established by the State of New Mexico.
   Except as otherwise noted in the State Plan, the State-developed rates are the same for both governmental and private providers. The provider agency's rates were set as of January 1, 2023, and are effective for these services provided on or after that date. All rates are published on the Human Services Department website:
   https://www.hsd.state.nm.us/providers/fee-for-service/

   The rate development methodology will primarily be composed of provider cost modeling, through New Mexico provider compensation studies and cost data. Rates from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in rate development.
   - Staffing assumptions and staff wages.
   - Employee-related expenses—benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation).
   - Program-related expenses (e.g., supplies).
   - Provider overhead expenses.
   - Program billable units.
   - Rural rates will include additional travel considerations for community and home-based services.

   The rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

7. **Mobile Crisis and Stabilization Rehabilitative Services -** Reimbursement for Mobile Crisis and Stabilization Rehabilitative Services as outlined in item 13.d per Attachment 3.1-A, are paid based upon Medicaid rates established by the State of New Mexico.

   Except as otherwise noted in the State Plan, the State-developed rates are the same for both governmental and private providers. The provider agency's rates were set as of July 1, 2023 and are effective for these services provided on or after that date. All rates are published on the Human Services Department website:
   https://www.hsd.state.nm.us/providers/fee-for-service/

   The rate development methodology will primarily be composed of provider cost modeling, through New Mexico provider compensation studies and cost data. Rates from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in rate development.

   - Staffing assumptions and staff wages.
   - Employee-related expenses—benefits, employer taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation).
   - Program-related expenses (e.g., supplies).

- Provider overhead expenses.
- Program billable units.

The rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.