HUMAN SERVICES DEPARTMENT

Michelle Lujan Grisham, Governor
Kari Armijo, Acting Secretary
Lorelei Kellogg, Acting Medicaid Director

August 15, 2023

James G. Scott, Director
Division of Program Operations
Medicaid & CHIP Operations Group
Centers for Medicare and Medicaid Services
601 E. 12th St., Room 355
Kansas City, MO 64106

Dear Mr. Scott:

Enclosed please find documents related to New Mexico State Plan Amendment (SPA) 23-0006 Evidence-Based Practices (EBP).

New Mexico is updating its state plan to include community-based mobile crisis intervention services authorized by section 9813 of the American Rescue Plan Act of 2021 and to incorporate additional evidenced-based practices including Functional Family Therapy, Trauma-Focused Cognitive Behavior Therapy, Eye Movement Desensitization and Reprocessing, and Dialectical Behavior Therapy. Language is also 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.

HSD followed a process that included public notification, tribal notification and web posting. Documentation of these activities is attached.

Please refer to the attachments for the transmittal form and notices.

We appreciate your consideration of this state plan amendment. Should you have any questions on this amendment, please contact Valeria Tapia at: Valerie.Tapia@hsd.nm.gov or (505) 257-8420.

Sincerely,

Lorelei Kellogg
Acting Medicaid Director

cc: Nikki Lemmon, CMS

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,

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)

None (new)

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

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

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL

21. TITLE OF APPROVING OFFICIAL

22. REMARKS

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 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. The MST team must include at a minimum the following staff with the respective qualifications:

   1. 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.
   2. MST trained level behavioral health staff able to provide 24 hours/day, seven days/week.
   3. Master's level behavioral health practitioner required to perform all MST interventions.
   4. 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.

   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. Clinical staff are required to complete a prescribed five-day MST introductory training and subsequent quarterly trainings.

   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.

   Agencies that can bill for MST include BHA, CMHC, CSA, FQHC, Tribal 638, and IHS facilities.

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.

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. FPWS 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.

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:

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 be supervised by an independent practitioner or someone trained and certified to supervise peers.
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 be supervised by an independent practitioner or someone trained and certified to supervise peers.
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 be supervised by an independent practitioner or someone trained and certified to supervise peers.

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. Independently licensed practitioners represent the dyadic and triadic providers.

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

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 groups.

a. Staff:
   i. on call physician, nurse, psychologist
   ii. on-site nurse, counselors, social workers, peer support workers

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. Staff:
      i. on call physician, nurse, psychologist
      ii. on-site nurse, counselors, social workers, peer support workers

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. 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.

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 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 non-independent practitioners under the direction of the IOP supervisor including LMSW, LMHC, LADAC, CADC, LSAA, and master's level psych associates.

7. Intensive Outpatient for Mental Health Conditions: All conditions as IOP for SUD apply.

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.

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).

   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.

         Services are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, peer support workers or other health and technical personnel under the direction of a licensed physician.

a. Level 3.7: medically monitored intensive inpatient services: 24-hour nursing care with physician availability for significant problems; 16 hour/day counselor availability.
b. Level 3.7 withdrawal management: medically monitored inpatient withdrawal management: Severe withdrawal, 24-hour nursing care and physician visits; unlikely to complete withdrawal management without medical monitoring.

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.

10. Crisis Triage Centers (CTCs)

A. Definition: Crisis Triage Centers are community-based alternatives to hospitalization or incarceration authorized by 2014 NM HB212 Crisis Triage Center legislation. 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.

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

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. 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. 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 New Mexico 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 aged 11-18 with serious behavior problems such as conduct disorder, violent acting-out, mental health concerns, truancy, and substance abuse. FFT works 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 is an intervention that consists of 12 to 20 family sessions over the course of three to eight months. 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. 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.

Providers must be engaged in training, consultation, and oversight by either of the following training entities: FFT LLC or FFT Partners. 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.

FFT program staff must include a licensed Master's level 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. 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 program model services as defined by the State.

13. Licensed Mental Health Practitioners (LMHPs) providing approved Evidence-based Practices (Trauma-Focused Cognitive Behavior Therapy, Eye Movement Desensitization and Reprocessing, Dialectical Behavior Therapy).

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.

Evidence-based practices:

- Trauma-Focused Cognitive Behavior Therapy is a 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. *Trauma Focus Cognitive Behavioral Therapy Certification Program, as reference in website,* (https:/www./tfcbt.org) is an acceptable qualification. New Mexico may recognize alternative certification or training programs as appropriate.

- 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. EMDRIA (EMDR International Association) sets the standards and requirements for EMDR therapy training. EMDRIA certifies individual clinical practitioners in the practice of EMDR therapy by ensuring all basic requirements, initial training, and ongoing certification are met, as reference in website, (https://www.emdria.org). EMDRIA establishes two levels of training for practitioners in EMDR therapy. For the purposes of providing EMDR therapy under New Mexico Medicaid, either level (EMDRIA Approved Basic Training, or EMDR Certification) are acceptable qualifications. The standard level of training, which allows a practitioner to provide EMDR therapy, is referred to as "EMDRIA Approved Basic Training." New Mexico may recognize alternative certification or training programs as appropriate.

- 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. DBT®-Linehan Board of Certification is an acceptable qualification. New Mexico may recognize alterative certification or training programs as appropriate. 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, 24/7 availability for skills coaching, and a clinical consultation team.

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 may provide the above evidence-based practices if certification is obtained from the listed source:

- 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).

For Dialectical Behavior Therapy, all agencies must be able to provide 24 hours/day, seven days/week availability for skills coaching. 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.

All services provided while a person is a resident of an Institution for Mental Disease (IMD) are considered content of the institutional service and are not otherwise reimbursable by Medicaid. Services provided by licensed behavioral health practitioners via telehealth technologies are covered subject to the limitations as set forth in state regulations.