Joint Public Comment on 7.35.4 NMAC
Submitted by Healing Advocacy and Rudick Law Group

The draft rule reflects a clear commitment to patient access, and we commend the Department for making access the organizing principle of how the fund will be administered. Our recommendations aim to carry that commitment through to the application and claims process.

Summary of recommendations

1. **Proof of eligibility (7.35.4.9):** let a current Medicaid, SNAP, TANF, or WIC award letter establish both New Mexico residency and income eligibility.
2. **Other-payer documentation (7.35.4.10):** accept a signed patient attestation that the patient is uninsured or ineligible for insurance, and apply a reasonable-knowledge standard to the other-payer attestation.
3. **Audit scope (7.35.4.16):** limit patient interviews to facts needed to verify eligibility and billed services, and clarify that on-site reviews concern records, not treatment sessions.
4. **Clarity for applicants:** define who may apply, who signs the authorization and attestation, and what "enrolled" and "claimant" mean.

1. Let one benefits award letter establish both residency and income (7.35.4.9)

Recommendation: Accept a current award letter showing enrollment in New Mexico Medicaid, SNAP, TANF, or WIC as proof of both New Mexico residency under 7.35.4.9(B)(3) and income eligibility under 7.35.4.9(C).

Each of these state-administered programs requires New Mexico residency for enrollment. A current award letter from the New Mexico Health Care Authority therefore already shows that a state agency has verified the applicant lives in New Mexico. As drafted, however, the same letter satisfies only the income requirement, and the applicant must locate a second document to prove residency.

For the population this fund will serve, the difference between one document and two is significant. Patients at or below 200 percent of the federal poverty guidelines are more likely to lack a current state ID, to move frequently, or to have utility accounts in another household member's name. Every additional document is another point where an otherwise eligible application can stall.

Suggested language (new subparagraph in 7.35.4.9(B)(3)):

> (d) a current eligibility verification, approval, certification, or award letter from the administering governmental entity that demonstrates current enrollment in New Mexico Medicaid, the Supplemental Nutrition Assistance Program (SNAP), the

> Temporary Assistance for Needy Families (TANF) program, or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). A letter submitted under this subparagraph shall also satisfy the proof of income eligibility requirement in Subsection C of this section.

We have intentionally left SSI out of the residency list. SSI is federally administered and does not itself verify state residency, though it remains appropriate as proof of income under Subsection C. With a fourth option added, the lead-in to Paragraph (3) should read "one of the following" rather than "either."

2. Accept a patient attestation of uninsured status (7.35.4.10)

Recommendation: Add a signed patient attestation that the patient is not eligible for, or does not otherwise have, health insurance to the forms of proof accepted under 7.35.4.10(B).

The draft requires proof of denial or ineligibility from another payer. For a patient who has never been eligible for coverage, no such document exists: people do not apply for coverage they know they cannot receive. This will arise often for New Mexico residents who are not U.S. citizens. Many are ineligible for Medicaid but otherwise meet every requirement of the fund.

Requiring these patients to produce a coverage denial, or to document why they are ineligible, would either exclude them or effectively require them to disclose immigration status. The fund has no need for that information, and asking for it would deter eligible patients from applying.

An attestation keeps the fund's payer-of-last-resort design intact. Claimants must still disclose all other payments (7.35.4.10(C)), patients attest to the accuracy of their applications (7.35.4.9(B)(6)), and the Department retains its audit and recovery authority (7.35.4.16, 7.35.4.18).

Suggested language (insert as new Paragraph (5) of 7.35.4.10(B) and renumber the current Paragraph (5) as (6)):

> (5) a signed attestation by the patient that the patient is not eligible for, or does not otherwise have, health insurance or other coverage for the service or product; or

Related: a reasonable-knowledge standard for the other-payer attestation. Subsection A requires efforts to obtain payment from "all other payers who may be legally responsible," and Subsection B requires an attestation covering "legally liable and potentially liable third parties" and "other sources of funding." These phrases ask the claimant, often a provider or patient without legal training, to reach a legal conclusion about every potential payer. In a system with limited funds, that uncertainty could lead to denial of otherwise valid claims. We recommend two changes:

- Qualify the attestation in Subsection B so that it extends to third parties the claimant knows of, or reasonably should know of, after reasonable inquiry.
- Publish guidance identifying the payers and funding sources the Department expects claimants to pursue. This would also give practical meaning to "other sources of funding."

3. Limit audit interviews and on-site reviews to what eligibility and payment require (7.35.4.16)

Recommendation: Limit the scope of patient interviews under 7.35.4.16(C)(3) to facts relevant to fund eligibility and the services billed, and clarify that on-site reviews under 7.35.4.16(C)(4) concern records rather than active treatment.

We understand the Department intends patient interviews only to verify eligibility and confirm that billed services were furnished. The rule does not yet say so. As drafted, Paragraph (3) would permit questions about a patient's medical or behavioral health condition, treatment history, or experience during a psilocybin session. None of that is needed to audit a payment, and all of it is protected private health information. Patients should not have to weigh access to the fund against the prospect of that kind of questioning.

Suggested language:

> (3) interview claimants and patients, provided that a patient interview shall be limited to facts necessary to verify the patient's eligibility for the fund and whether the services or products claimed were furnished as billed, and shall not include questions regarding the patient's medical or behavioral health condition, history, or experience of treatment;

4. Clarify who applies, who attests, and key terms

The rule addresses several audiences at once: patients, certifying clinicians, practitioners, healing centers, and producers. Clear answers to who does what are an equity measure in their own right. A patient reading the rule should be able to tell quickly where to start and which steps are theirs.

- **Identify the applicant (7.35.4.9(A)).** State who may submit an application. For example: "An application may be submitted by the qualified patient, the patient's caregiver or authorized representative, or the clinician's billing employee or contractor, on the patient's behalf."
- **Require the patient's own authorization (7.35.4.9(B)(5)).** The authorization to verify eligibility information concerns the patient's income, residency, and benefits. Privacy best practice calls for a release signed by the patient, even when a provider or representative submits the application.

- **Apply a knowledge standard to the attestation (7.35.4.9(B)(6)).** A provider applying on a patient's behalf can attest only that the information is true and complete to the best of the provider's knowledge, based on the patient's representations. We suggest: "an attestation that the information submitted is true and complete to the best of the applicant's knowledge."
- **Define "enrolled" (7.35.4.8(A)(1), (D)(1)).** The rule does not define when a patient is enrolled or how current enrollment is verified. We suggest tying enrollment to a current, valid medical psilocybin program identification number, and providing that the Department will verify enrollment from its own records. If funds run short, clarity about when a patient enrolled may matter for how applications are prioritized.
- **Confirm that "qualified patient" carries its statutory meaning (7.35.4.2, 7.35.4.8(A)).** The term is defined by statute and incorporated through 7.35.2.7 NMAC. Stating that fund eligibility is determined separately under 7.35.4.8 would prevent the term from being read to include the income test.
- **Use "claimant" consistently (7.35.4.10 through 7.35.4.12).** The term appears to mean the provider or entity seeking payment, but in places it can be read to include the patient. A short definition, together with a note identifying any steps patients take themselves, such as travel claims under 7.35.4.14(C), would make the process easier to follow.

Setting coverage rates for non-covered services

The rules anticipate rate setting for services without a direct Medicaid analog, most obviously the psilocybin medicine itself and the administration day monitoring costs. Reimbursement for these components of care will be a key function of the Fund as the products and services that are universally not covered by health insurance. A session usually runs six to eight hours with continuous in-person support. Rates set below the cost of complying with program rules on an administration day would leave few providers able to accept fund patients.

The price points developers of synthetic psilocybin are discussing suggest the total cost of treatment could be high to form the baseline for The Fund's rate. We offer the alternative analogs below to help the Department set a reasonable rate.

Analogy	Justification	Additional Considerations
Spravato (esketamine) monitoring	The closest medical model of a supervised psychoactive treatment with required in-office monitoring (2-hour observation period)	Spravato is reimbursed in NM in two ways. Medicare patients are billed under a bundled G-code that bills the drug, medical evaluation on administration day, and observation period at $952.00 or 85% of that for nurse practitioners. Medicaid and commercial insurance patients are typically coded with a standard outpatient code and a prolonged clinical staff tracking code every 15 minutes for the two hours, which typically translates to between $150.00-$525.00 per 2-hour session. How might this compare to

		what is reasonable and sustainable under The Fund?
Emergency Mental Health Evaluation and Care Detention (43-1-10 Hold)	Requires the kind of professional attention to a person in an altered state of consciousness	Billing under this analog often involves prolonged observation and would be adjusted to an appropriate period of observation. For community mental health centers or crisis stabilization units operating under New Mexico Human Services/Health Care Authority guidelines, specific HCPCS codes may apply to this period of observation if structured through state-contracted behavioral health programs. Would The Fund receive a similar billing structure for post-dosing observation?
Peer support	A floor for non-clinical presence and basic observation	The 15-minute increment billing protocol would be challenging in a 6 - 8 block of time.

We would welcome the opportunity to collaborate directly to develop these rates with the Department.