FISCAL IMPACT REPORT

SPONSOR Senate Finance Committee **LAST UPDATED** **ORIGINAL DATE** 2/13/2025

SHORT TITLE Behavioral Health Reform & Investment Act **BILL NUMBER** CS/Senate Bill 3/ec/SFCS

ANALYST Chenier

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*

(dollars in thousands)

Agency/Program	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
HCA Staffing	$191.2	$764.9	$764.9	$1,721.0	Recurring	General Fund
OSI	$30.0	No fiscal impact	No fiscal impact	$30.0	Nonrecurring	Insurance Operations
Total	$221.2	$764.9	$764.9	$1,751.0		

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Senate Bill 3 is a companion to the appropriations contained in Senate Bill 2 and many appropriations included in House Bill 2

Sources of Information

LFC Files

Agency Analysis Received From
Administrative Office of the Courts (AOC)
Office of Superintendent of Insurance (OSI)
Health Care Authority (HCA)
Department of Health (DOH)
Corrections Department (NMCD)
Department of Public Safety (DPS)

SUMMARY

Synopsis of Senate Finance Committee Substitute for Senate Bill 3

The Senate Finance Committee Substitute for Senate Bill 3 (SB3) creates the behavioral health executive committee with members from the Health Care Authority (HCA), Administrative Office of the Courts (AOC), and three behavioral health experts to designate behavioral health regions, review and approve regional plans, establish funding strategies and structures based on regional plans, monitor and track deliverables and expenditures, and establish a project management strategy that shall be led by a project manager at HCA. The committee shall convene and report to the Legislative Finance Committee (LFC) on a quarterly basis.

The bill also directs AOC to coordinate regional meetings, complete sequential intercept mapping, and coordinate the development of regional behavioral health plans. The bill requires each plan to meet a certain number of standards and requires them to be submitted to the Legislature. The bill also requires AOC to designate an agency to report progress on

implementing the plans by June 30, 2027, and every subsequent year.

The bill requires higher education institutions in the regions to coordinate with behavioral health stakeholders to create a behavioral health workforce pipeline for behavioral health services identified within regional plans.

The bill requires HCA to provide AOC with an initial set of generally recognized standards for behavioral health services for adoption and implementation in regional plans. Likewise, the bill requires LFC and HCA to develop an initial set of evaluation guidelines for behavioral health services for adoption and implementation of regional plans.

Money appropriated to carry out the provisions in the bill shall be used to address funding gaps identified in the regional plans, prioritize disproportionately impacted communities, and fund grants of not more than four years.

HCA is required to implement a single enrollment and credentialing process for Medicaid to reduce administrative burden. HCA shall also regularly monitor and audit contracts and grantees to ensure that behavioral health service quality standards are met and to ensure financial and programmatic compliance during the duration of an active regional plan. HCA is also required to complete a behavioral health needs and gaps analysis every two years.

LFC is required to conduct or contract for program evaluations and reviews of the sufficiency of regional plans' program design and implementation plans to ensure they meet stated objectives. LFC is also required to report a real-time review of project progress and deliverables, gaps, and viability of grantees.

This bill contains an emergency clause and would become effective immediately on signature by the governor.

FISCAL IMPLICATIONS

This bill is a companion to Senate Bill 2, which provides for appropriations for several grant programs and the implementation of the sequential intercept model. That bill includes a clause referring to this bill and the associated appropriations are listed in the table below adding up to $200 million. The LFC introduced version of the General Appropriations Act includes $141 million of these appropriations.

Difference Between SB2 and LFC Recommendation

Section of SB2	Agency Appropriated To	Appropriation in SB2 SFC Sub (thousands)	Amount in LFC introduced Version of the GAA	Purpose
1	AOC	$1,700.0	$1,700.0	Sequential intercept resource mapping statewide
2	AOC	$7,000.0	$7,000.0	Grants for treatment courts and associated programs
3	HCA	$10,000.0	$10,000.0	Grants for medication-assisted treatment
4	HCA	$43,000.0	$43,000.0	Grants for certified community behavioral health clinics
5	HCA	$7,500.0	$7,500.0	Grants for twenty-four-hour crisis response facilities
6	NMCD	$1,300.0	$1,300.0	Grants for transitional services covered by Medicaid
7	DPS/HCA	$5,000.0	$5,000.0	Grants for regional mobile crisis response
8	HCA	$11,500.0	$11,500.0	Grants for regional mobile crisis and recovery response

9	HCA	$1,000.0	$0.0	Education and outreach within behavioral health regions
10	DPS	$2,000.0	$2,000.0	Grants for community and intercept resources training
11	UNM	$1,000.0	$2,000.0	Mobile health units and medication-assisted treatment
12	DOH	$1,000.0	$0.0	Mobile health units and medication-assisted treatment
13	DFA	$48,000.0	$50,000.0	Expansion of housing services providers
14	HCA	$3,000.0		988 and 911 Coordination
15	HCA	$9,000.0		Behavioral health patient navigation
16	LFC	$1,000.0		Behavioral health audits and evaluation
17	DOH	$9,000.0		Suicide prevention and youth behavioral health
18	PED	$6,000.0		Suicide prevention and youth behavioral health
19	UNM	$1,800.0		Project Echo behavioral health modules and training
20	HCA	$200.0		Coordination and planning for SB2
21	HCA	$10,000.0		Certified peer support to implement Section 9 for FY26
22	HCA	$10,000.0		Certified peer support to implement Section 9 for FY27
23	HCA	$10,000.0		Certified peer support to implement Section 9 for FY28
	Total	**$200,000.0**	**$141,000.0**	

The state in the last few years also invested significantly in nonrecurring funding for behavioral health services, including $126 million for rural healthcare delivery grants and other services as shown in the table below.

FY20-FY25 Nonrecurring Includes	
Rural Health Care Grants	$126,000
Tribal Health and Behavioral Health Service Expansion	$25,000
Behavioral Health Provider Startup Costs	$20,000
GRO -- SBIRT and CCBHCs	$15,000

AOC stated the funding in SB2 is adequate to support the initial SIM mapping project and fund the staff needed to accomplish the other objectives of SB3 within three years. Recurring funding is necessary to support dedicated staff at AOC for this program. However, SB3 contemplates ongoing oversight and coordination by AOC in, for example, managing the annual reporting to the Legislature for each behavioral health region.

HCA provides the following:

> HCA is already planning to implement a centralized credentialing system for all provider types, including behavioral health. The design, development, and implementation (DDI) of the system would require $4,370,036 for the first 12 months. Maintenance and operation (M&O) for subsequent years will require an additional estimated cost of $5,529,506. … [T]he estimated additional operating budget impact for the Medicaid cost allocation model: 90 percent federal funds ($3,933,000) and 10 percent state funds ($437,000) for DDI; 75 percent federal funds ($4,147,100) and 25 percent state funds ($1,382,400) for M&O.

SIGNIFICANT ISSUES

During the interim, LFC staff published a report on the state's behavioral health needs and gaps. The significant findings from that report:

- New Mexico has invested substantially in behavioral health and expanded programs and access, putting total funding near the top among states.
- Seventeen state agencies and local communities all have behavioral health responsibilities.
- While many communities have comprehensive plans, the state lacks an "all-of-government" approach.
- Fragmentation makes it hard to target investments to greatest need, resulting in program and geographic gaps.
- The state's continued high rates of behavioral health disorders increase the urgency to address these issues.

Additionally, the Behavioral Health Collaborative, originally created to coordinate services between the large number of agencies responsible for spending behavioral health funds has not met in over a year. At the same time, the state's behavioral health rankings are slipping as shown in the table below.

2023 and 2024 New Mexico Behavioral Health Rankings (Lower Rank is Better)

	Behavioral Health 2023		Behavioral Health 2024	
	Rank	2023 Rate	Rank	Rate
Overall Mental Illness Prevalence, Adults and Children	36		44	
Adult Substance Use Disorder	32	17%	49	23%
Youth with Major Depressive Episode	42	19%	46	23%
Youth Substance Use Disorder	47	8%	51	16%

Sources: State of Mental Health in America 2023 and America's Health Rankings

HCA raises the following concerns:

Recognized by the federal government, single state agencies (SSAs) are designated to oversee and coordinate behavioral health services within a state. This recognition allows them to access federal funding, grants, and technical assistance crucial for supporting mental health and substance use programs within their state. SSAs are responsible for a variety of critical functions designed to promote behavioral health access and quality for residents. For example:

- SSAs develop and implement policies that guide behavioral health services across the state, ensuring alignment with federal guidelines and state-specific needs.
- SSAs coordinate the delivery of mental health and substance use services,

ensuring accessibility, quality, and integration across various providers and settings.

- SSAs manage state and federal funds allocated for behavioral health services, ensuring efficient use and compliance with financial regulations.
- SSAs monitor and improve the quality of behavioral health services through data analysis, performance evaluation, and implementing evidence-based practices.
- SSAs oversee crisis intervention and emergency mental health services, ensuring readiness and effective response during emergencies.
- SSAs collaborate closely with other state agencies, healthcare providers, community organizations, and advocacy groups to create a comprehensive behavioral health system that meets the diverse needs of the population.
- SSAs advocate for individuals with mental illness and substance use disorders, representing the state's interests in national discussions on behavioral health policy and funding.

AOC notes the following:

In order to fulfill the role envisioned by SB3, AOC would have to create a new division staffed by experienced professionals specializing in behavioral health data and public policy. AOC must carefully tailor all behavioral health-related activities to avoid constitutional conflicts with executive and legislative functions and authorities.

Section 3 also requires AOC to complete sequential intercept model resource mapping regionally. This is a large undertaking that would require three years or more to map the entire state given AOC's experience with current pilot programs. Although intermittent mapping has occurred in the past, information quickly becomes outdated and survey activities must be renewed regularly. AOC must therefore be prepared to undertake a comprehensive mapping project to ensure accurate data informs the plan development phase. SIMs mapping must be repeated regularly to remain effective.

EC/rl/hg/rl/hg/SL2