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Behavioral Health and Criminal Justice Past LFC Recommendations

Jon Courtney, Deputy Director, LFC
Eric Chenier, Principal Analyst, LFC

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Overview

Needs and Gaps

Behavioral Health Funding

Behavioral Health and Criminal Justice LFC Research and Recommendations

New Mexico ranks poorly on key behavioral health metrics.

The number of behavioral providers is slowly growing.

A focus on providing more high-quality evidence-based services is needed.

Improved data and analysis will tell us where to focus our efforts.

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

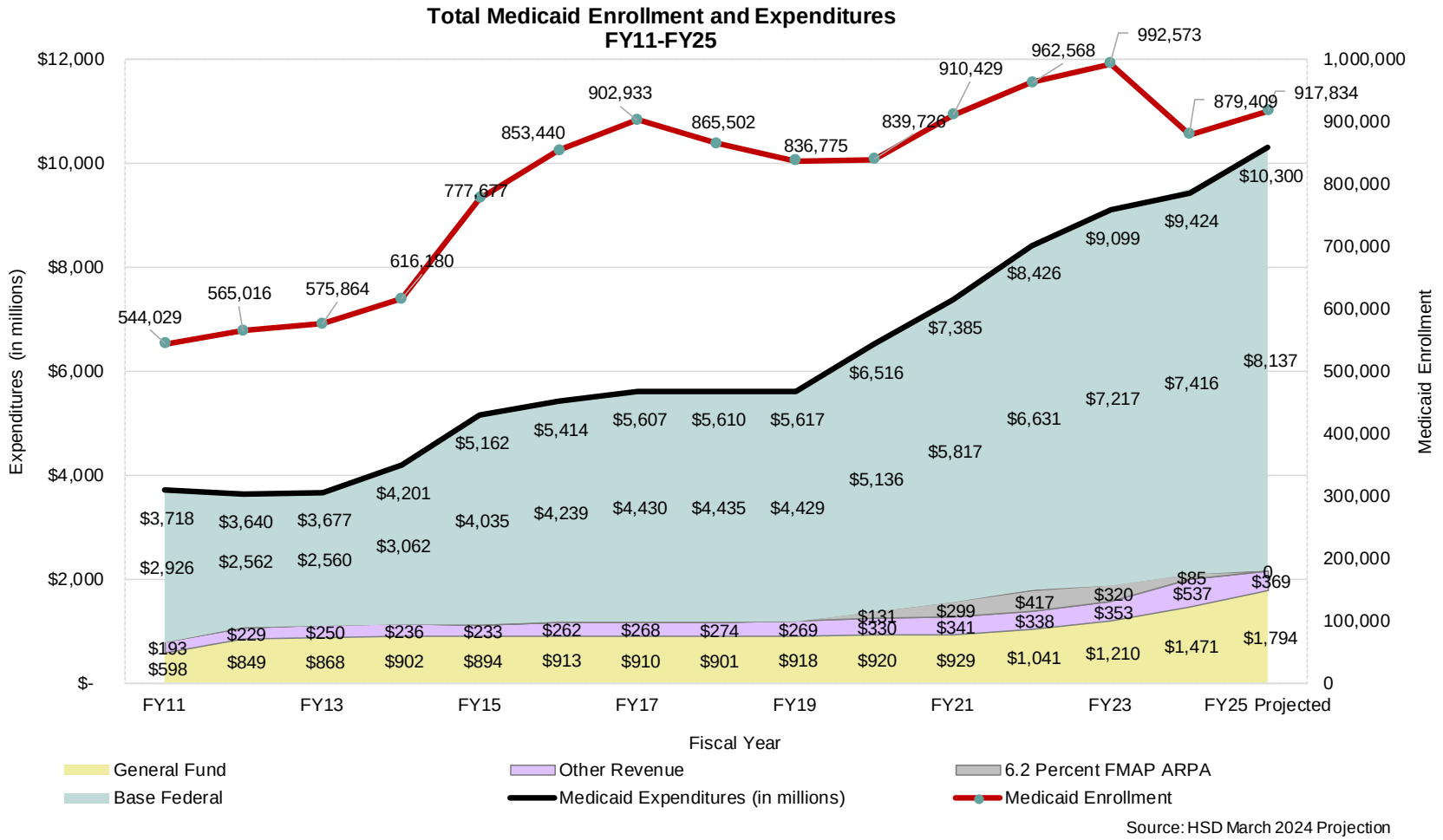
	Behavioral Health	
	Rank	Rate
Overall Mental Illness Prevalence, Adults and Children	36	
Adult Substance Use Disorder	32	17%
Youth with Major Depressive Episode	42	19%
Youth Substance Use Disorder	47	8%

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

What Are the Gaps?

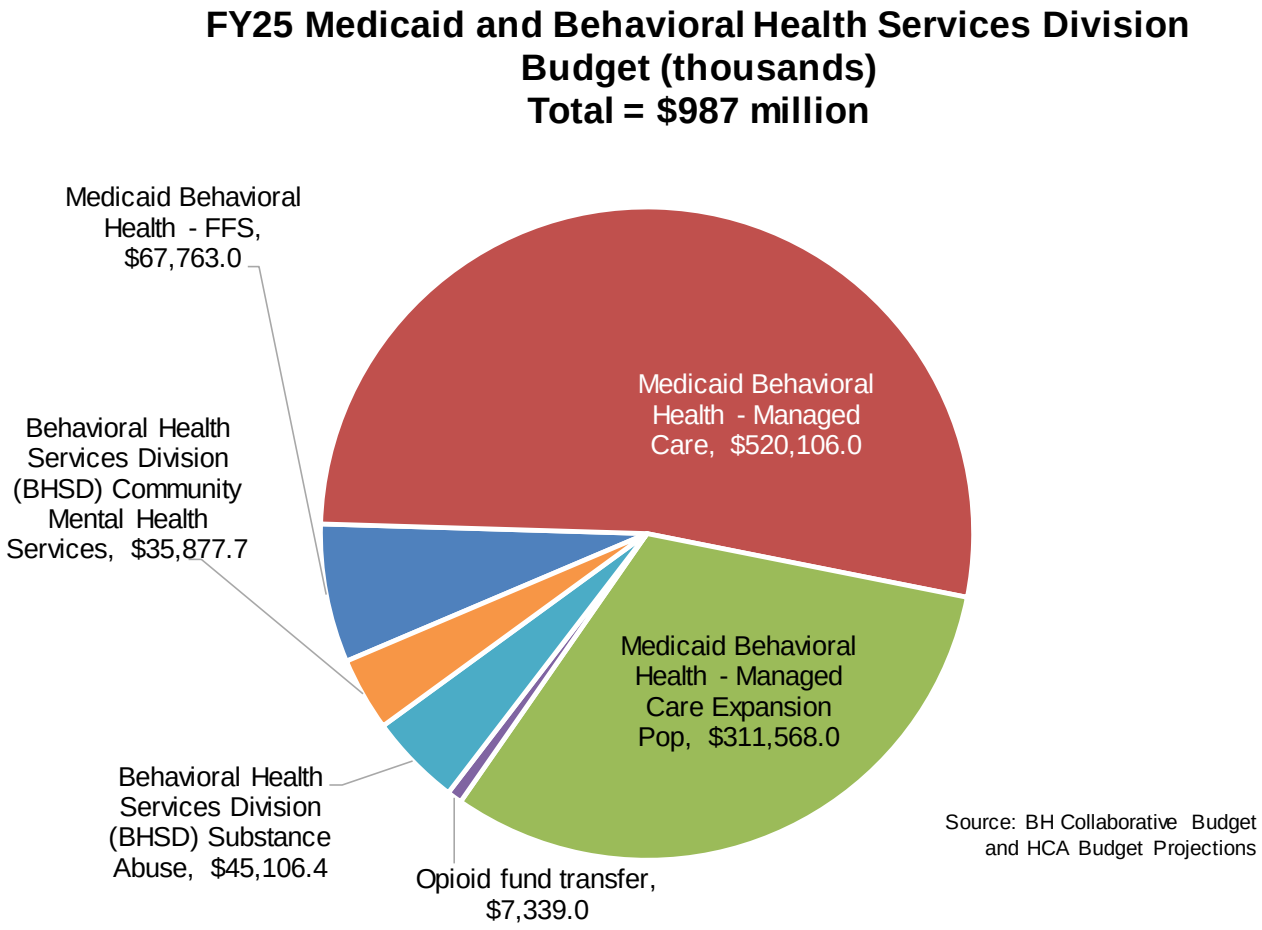
Medicaid is by Far the Largest State Program

- Feb 2024 enrollment - 879,409 – April 2024 enrollment 878,841
- Medicaid can be used to pay for targeted interventions to prevent CJ involvement and prevent reentry
- Medicaid is the largest payor for behavioral health and substance use programming
- The Legislature made significant investments to startup more evidence-based providers and programming
- Evidence-based interventions are slow to ramp up and not widely adopted

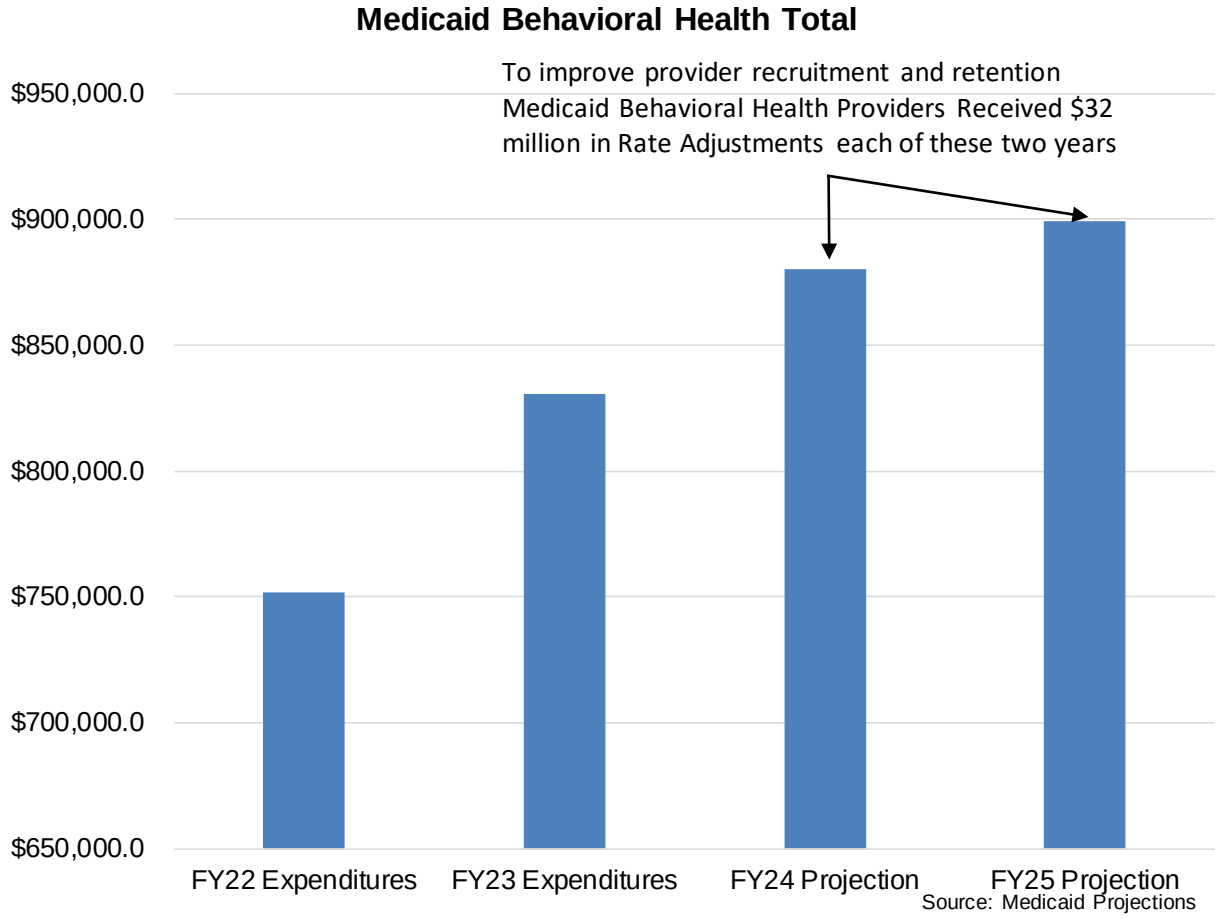


Source: HSD March 2024 Projection

Medicaid Enrollment: 42 Percent of State's Population



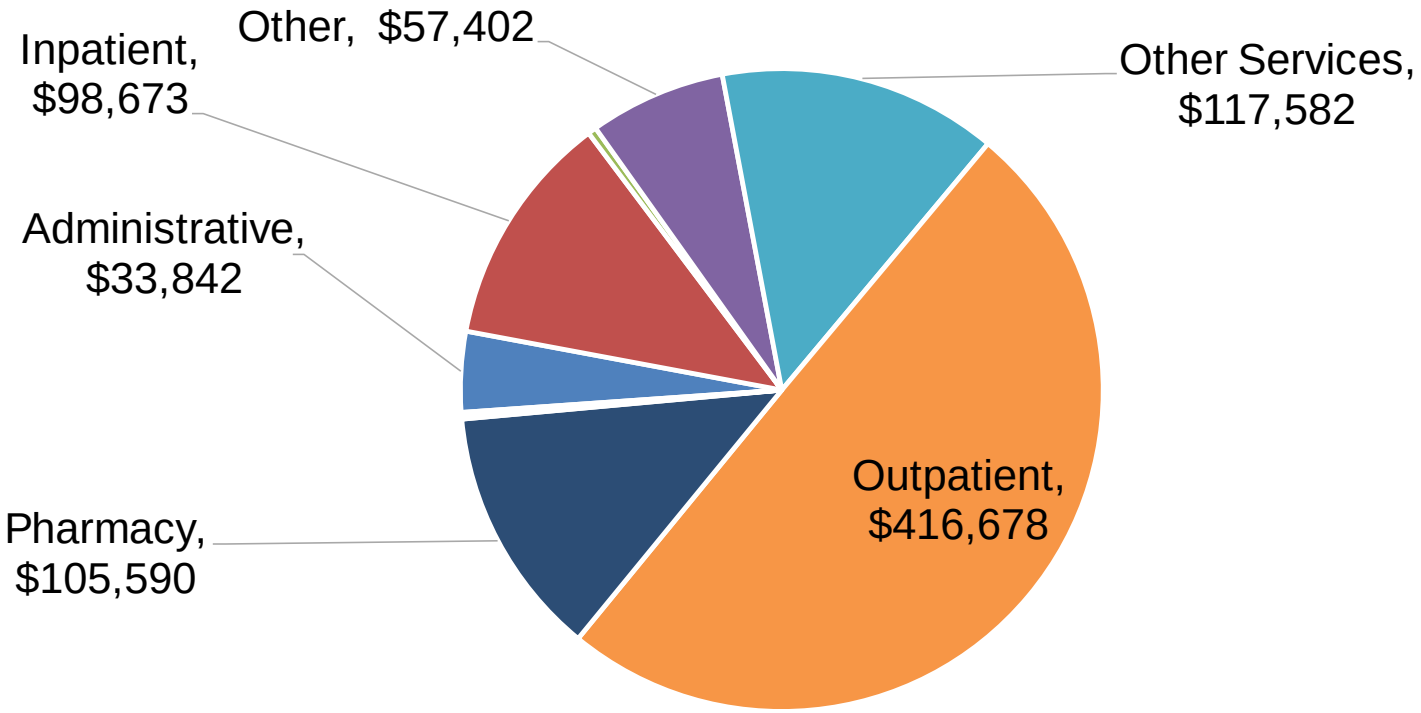
Source: BH Collaborative Budget and HCA Budget Projections



Source: Medicaid Projections

Collaborative Agencies are Budgeted to Spend Nearly $1.1 billion in FY25, a 25 Percent Increase since FY22

Managed Care Behavioral Health Expenditures 2023, $836 Million
(thousands)



Source: MCO Financial Reports

Outpatient Services Includes

Evaluations and Therapies	$168,263.4
Applied Behavior Analysis	$59,609.7
Federally Qualified Health Centers (FQHC's)	$36,577.3
Comprehensive Community Support Services (CCSS)	$33,304.2
Intensive Outpatient Program (IOP)	$30,417.1
Outpatient Facility Treatment	$27,254.5
Foster Care Therapeutic	$19,012.9
Telehealth	$12,520.8
Assertive Community Treatment (ACT)	$11,362.7
Multi-Systemic Therapy (MST)	$8,825.7
Psychosocial Rehab Services	$3,225.1

Other Includes	
Other Professional BH Services	$55,673.8
Care Coordination - Medical	$25,555.6
Indian Health Service	$24,653.3

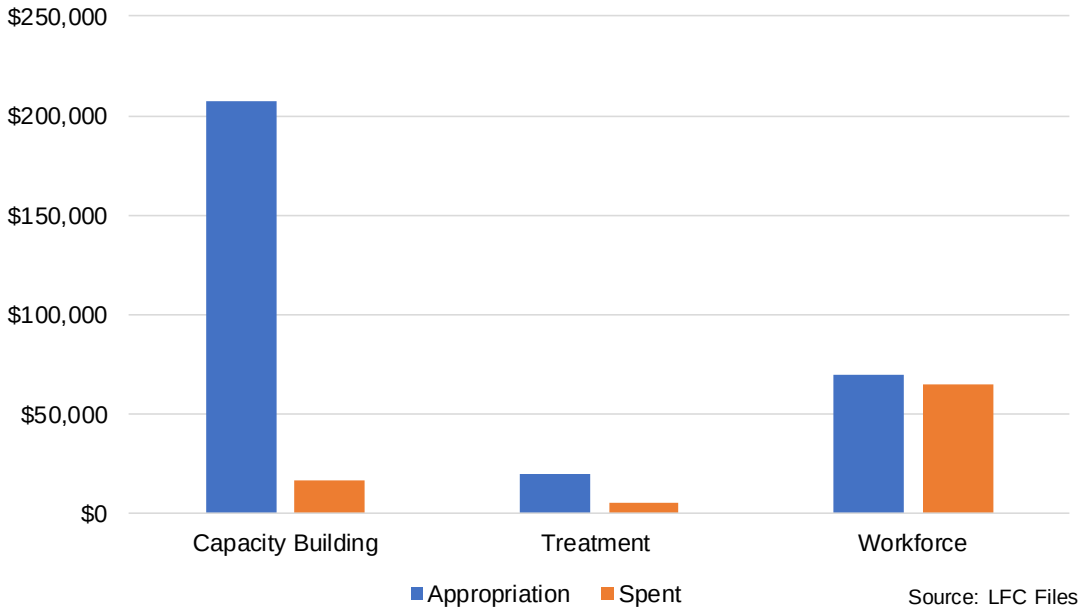
Inpatient includes	
Other Residential	$45,001.9
Hospital Inpatient Facility	$24,791.2
Residential Treatment Center, ARTC and Group Homes	$14,019.9
Inpatient and Residential Professional Charges	$9,537.6
Partial Hospitalization Program	$5,322.5

Medicaid Behavioral Health Spending

Outpatient services is the largest spending category in both the Behavioral Health Program (41%) and the Expansion Adults BH Program (42%)

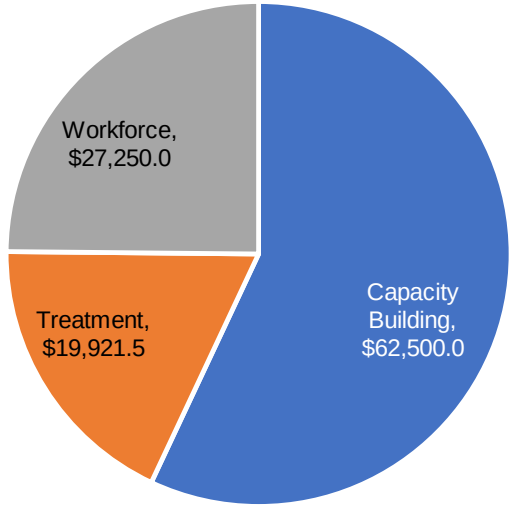
Collaborative Agencies Received $407 Million in Nonrecurring BH Funding Between FY23 and FY25

Nonrecruring Behavioral Health Appropriations FY23 and FY24



Source: LFC Files

FY25 Nonrecurring Behavioral Health Appropriations



FY23-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

Source: LFC Files

FY23 and FY24 workforce appropriations were primarily for endowments, explaining the high percentage of expenditures.

- A fall 2023 LFC Medicaid accountability report found that utilization in a few key areas of physical and behavioral health have decreased since 2019.

- Without better access measures, utilization can be used to approximate whether Medicaid members are accessing the services the state is paying for.

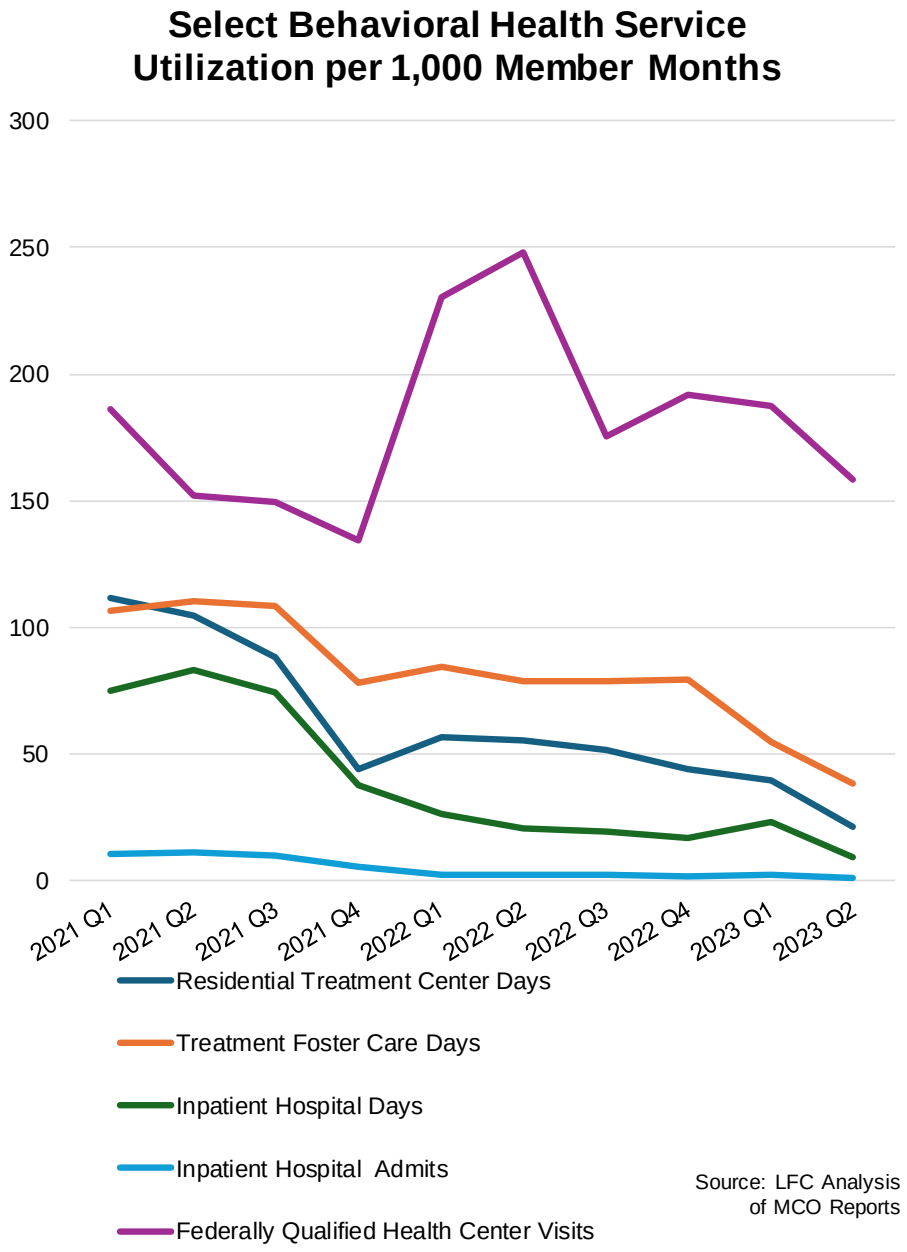
- However, because the utilization metrics the Health Care Authority tracks are units of service, the state does not know if more or fewer clients are receiving care.

Utilization

Behavioral Health Practitioner Visits per 1,000 Members		Emergency Room Visits for Nonemergency Needs	
2022		2022	
620		57%	
2019	250.7	2019	61%

Behavioral Health Needs

Utilization of Provider Networks



Source: LFC Analysis of MCO Reports

- Provider networks are expanding but:
  - Utilization of BH services was down 52 percent between Q1 2021 and Q3 2023.
  - Provider expansion is mostly attributable to Western Sky's network, which is no longer a Medicaid MCO.
  - Continued monitoring is needed as Turquoise Care comes online.

Behavioral Health Managed Care Providers – Capacity Generally Growing

Change in Medicaid Managed Care Behavioral Health Providers by Population Size

County Designation		Change in percent of Providers 2019-2020	Change in percent of Providers 2020-2021	Change in percent of Providers 2021-2022	Change in percent of Providers 2022-2023
Metro - Counties in metro areas of 250,000 to 1 million population		4%	7%	9%	10%
Metro - Counties in metro areas of fewer than 250,000 population		17%	-3%	10%	10%
Nonmetro - Urban population of 20,000 or more, adjacent to a metro area		42%	-18%	17%	0%
Nonmetro - Urban population of 20,000 or more, not adjacent to a metro area		4%	18%	15%	8%
Nonmetro - Urban population of 5,000 to 20,000, adjacent to a metro area		12%	6%	9%	3%
Nonmetro - Urban population of 5,000 to 20,000, not adjacent to a metro area		10%	10%	4%	4%
Nonmetro - Urban population of fewer than 5,000, adjacent to a metro area		286%	-74%	57%	-27%
Nonmetro - Urban population of fewer than 5,000, not adjacent to a metro area		18%	0%	-11%	15%
Out of State		71%	34%	-7%	6%
Grand Total		11%	6%	9%	9%

Change in Medicaid Caseload by Population Size

County Designation		Change in Medicaid Population 2020-2021	Change in Medicaid Population 2021-2022	Change in Medicaid Population 2022-2023
Metro - Counties in metro areas of 250,000 to 1 million population		8%	5%	-3%
Metro - Counties in metro areas of fewer than 250,000 population		9%	4%	-3%
Nonmetro - Urban population of 20,000 or more, adjacent to a metro area		6%	3%	-3%
Nonmetro - Urban population of 20,000 or more, not adjacent to a metro area		9%	4%	-3%
Nonmetro - Urban population of 5,000 to 20,000, adjacent to a metro area		7%	4%	-3%
Nonmetro - Urban population of 5,000 to 20,000, not adjacent to a metro area		4%	3%	-4%
Nonmetro - Urban population of fewer than 5,000, adjacent to a metro area		-9%	10%	-13%
Nonmetro - Urban population of fewer than 5,000, not adjacent to a metro area		4%	0%	-5%
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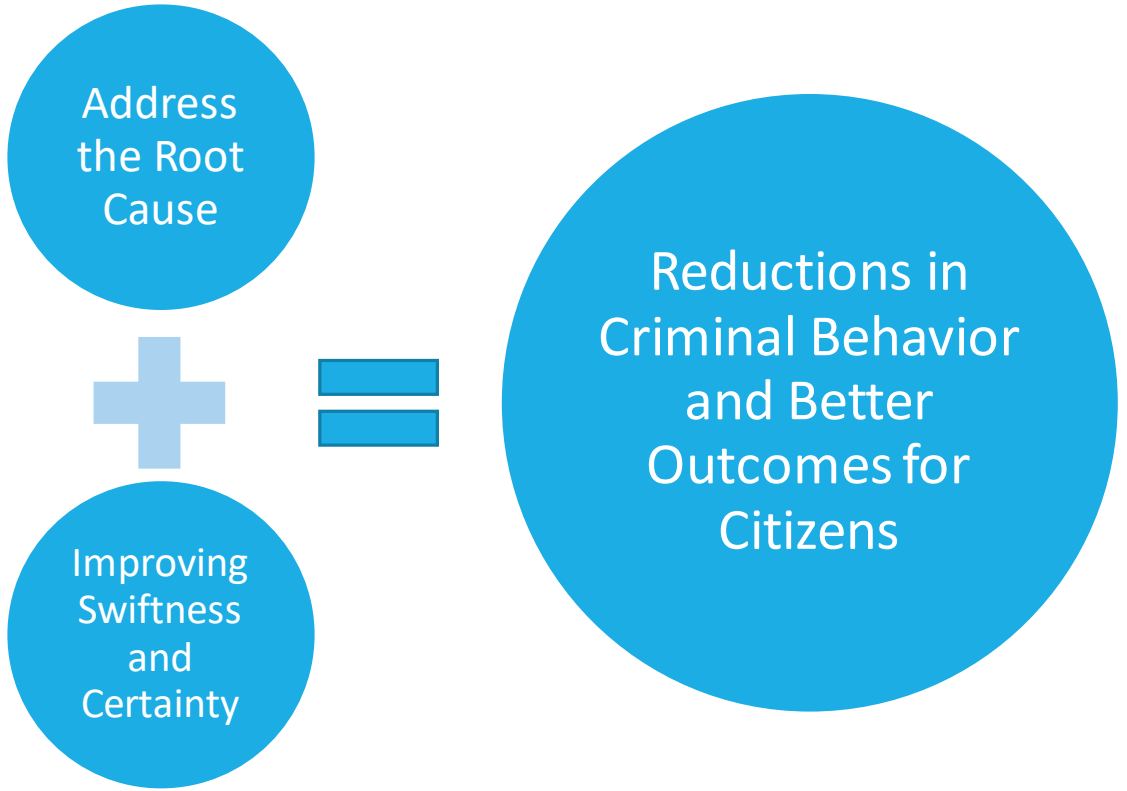
Grand Total		8%	4%	-3%

What works to reduce crime?



"The certainty of being caught is a vastly more powerful deterrent than the punishment"

- National Institutes of Justice

NM Crime Rates

NM violent crime rates are up but still lower than the 1990s

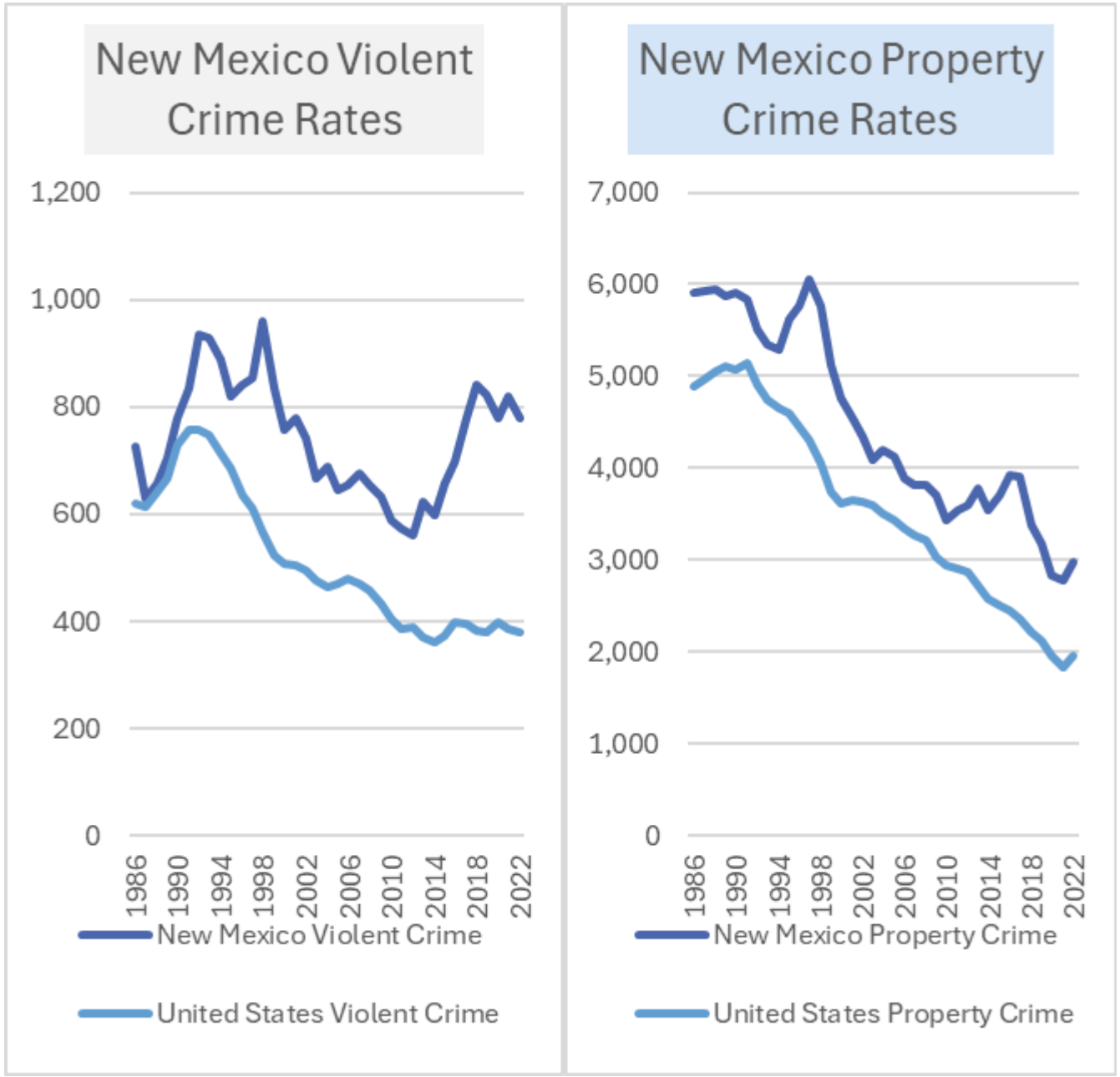
Nationally there is evidence that there is less reporting of certain crime types reflecting a likely undercounting in data

Over the last decade NM has seen worsening crime trends compared to the US in most categories except for rape and larceny

Crime Percent Change 2012-2022

Crime	NM	US
Homicide	115%	34%
Aggravated Assault	44%	10%
Rape	19%	47%
Robbery	25%	-42%
Larceny	-20%	-29%
Burglary	-41%	-60%
Motor Vehicle Theft	107%	23%

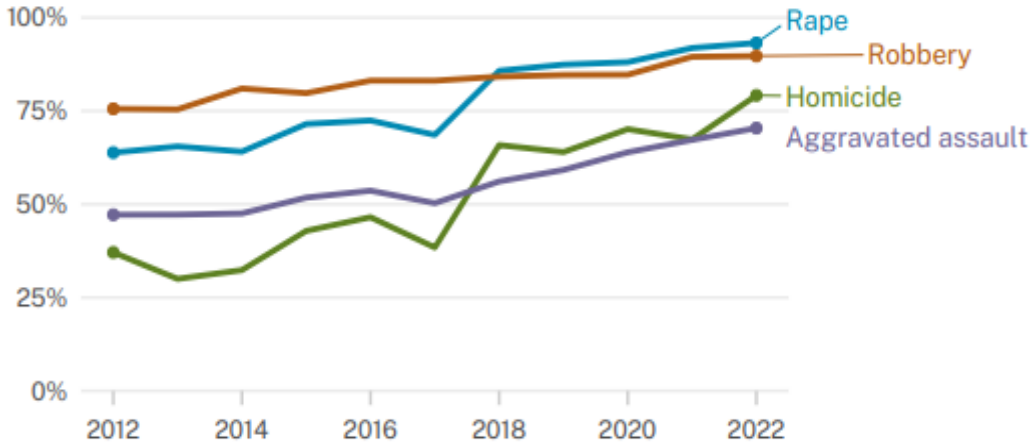
Source: FBI UCR, JRI



Research and Recommendations

- Swiftness and certainty needs to be improved as evidenced by deteriorating rates of crimes solved
- Services to address root cause and upstream issues need improvement:
  - Improved Access (service availability and low uptake)
  - Less Underutilization
  - Addressing Implementation Challenges

Figure 25. Unsolved rate of violent crime reported to police
New Mexico

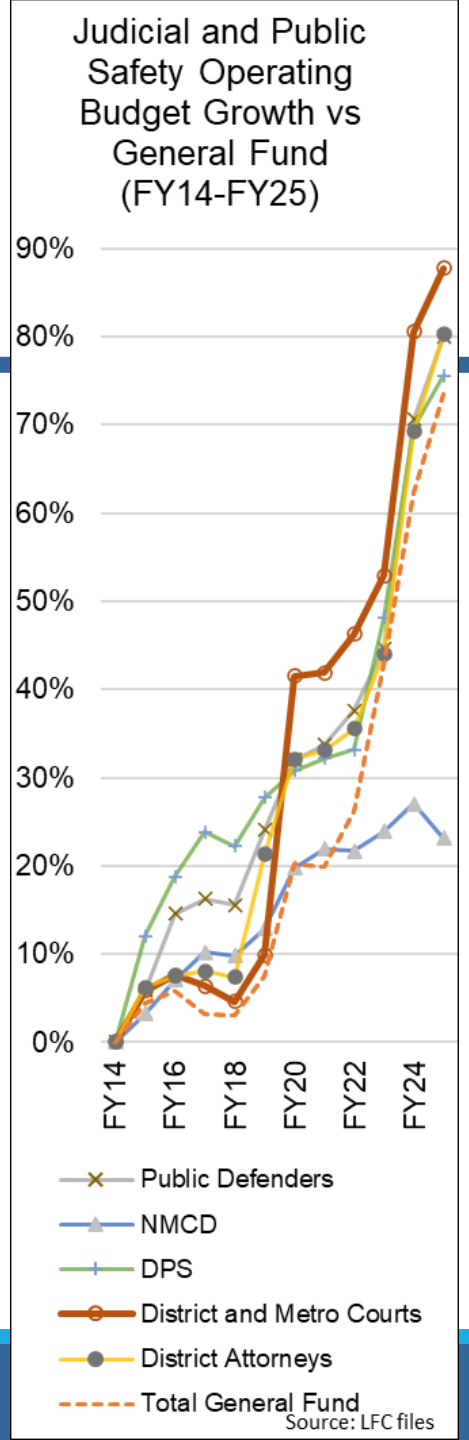


FBI Uniform Crime Reporting Program SRS

Figure from Justice Reinvestment Initiative

Criminal Justice Investments

- The legislature has continued to grow most criminal justice recurring budgets at a quicker pace than GF spending.
- These totals do not include nonrecurring spending which will be discussed in the next presentation.
- The exception is NMCD who have seen a significant decrease in population in recent years.



Prison Revolving Door

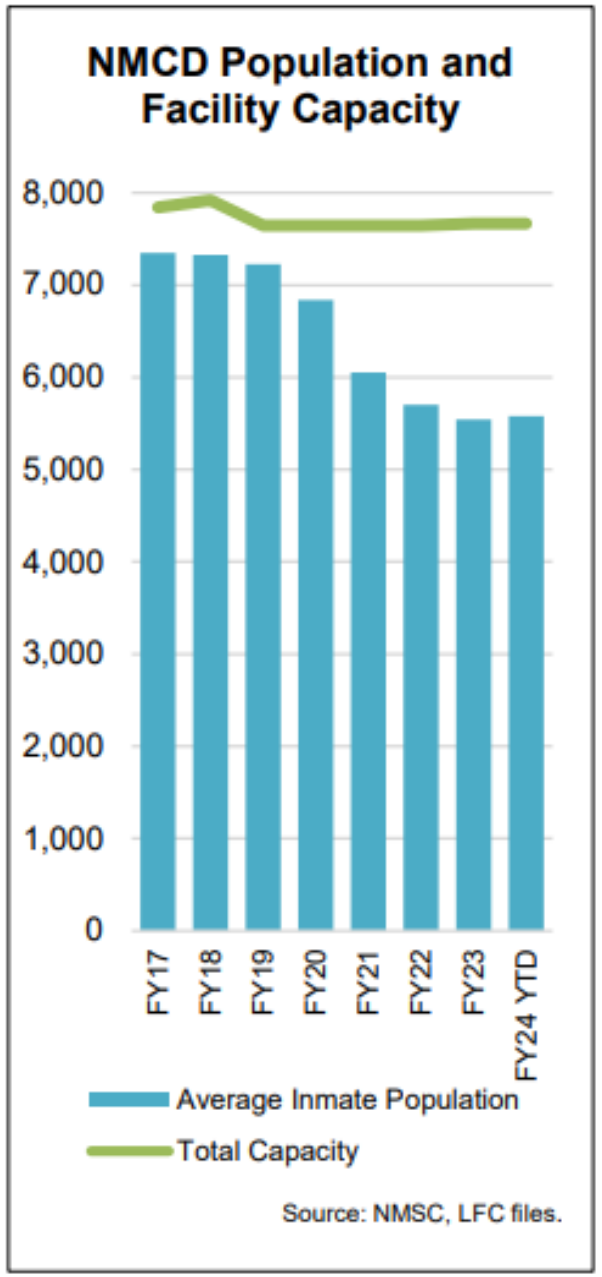
Issues: NMCD does not consistently use a validated risk assessment tool for appropriate inmate security risk classification (a recent validation study found the department overrides its assessment 45 percent of the time).

NMCD does not use needs assessments to reduce the risk of recidivism and determine appropriate services, such as education or job training.

One-third of new prison admissions are for technical parole violations with most related to substance use disorder (SUD).

State law allows for high caseloads and there is no treatment requirement for intensive parolee supervision. Intensive supervision is only effective when caseloads are manageable, and offenders receive services.

Other states allow Medicaid coverage for incarcerated individuals 90 days prior to release.



- Recommendations:
  - Require NMCD to use a validated risk assessment tool on all inmates to determine appropriate security classification.
  - Require NMCD use needs assessments on all inmates prior to release to determine needs and reduce reincarceration.
  - Require NMCD to seek alternatives to reincarceration before revoking parole for a substance use violation.
  - Set caseload standards for intensive supervision and require services such as behavioral health treatment.
  - Seek a Medicaid state plan amendment to allow for Medicaid coverage 90 days prior to the release of incarcerated individuals, allowing for a smoother transition into services.

Judiciary

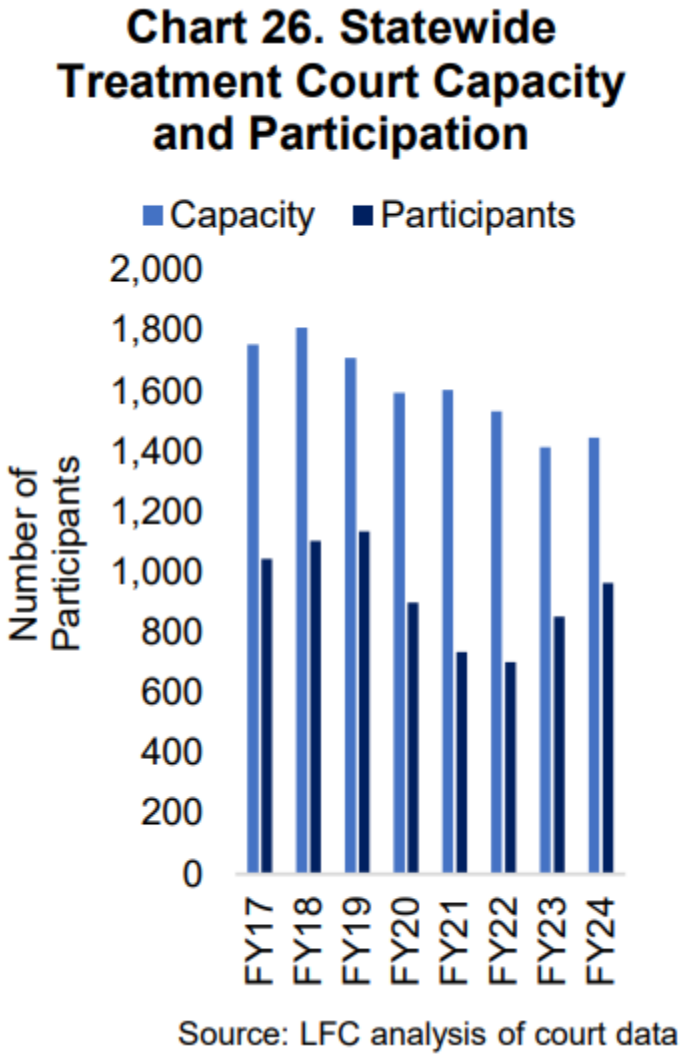
Issues: Standards for pretrial services are not in statute.

Pretrial risk tools do not have statutory guardrails about validation, reevaluation, or use in decision-making.

Pretrial services lack needs assessments.

There is no standard approach for who requires 24-hour ankle monitors.

There is little statutory basis for pretrial metrics and performance data, or how criminal justice coordinating councils should use performance measures now part of the General Appropriations Act.



- Recommendations:
  - Outline minimum standards for pretrial services, with the AOC providing certification programs that meet these standards. Grant the Supreme Court additional rule-making authority for services.
  - Require periodic validation of risk assessments and implement needs assessments for services
  - Require rules for when and for whom to mandate 24-hour live monitoring pre-release via ankle monitors.
  - Require reporting and use pretrial performance data to improve safety and report findings on public-facing dashboards.

Limited Access to Care in High-Need Communities

Issues: Successful treatment of SUD often requires screening assessment, detoxification, outpatient and inpatient treatment, medication- assisted treatment, counseling, recovery support and other services.

Pharmacies often limit the types of medication-assisted treatment drugs available in areas with high rates of opioid use disorder.

Currently providers must become credentialed for providers through each managed care organization (MCO) separately before seeking reimbursement from that MCO.

- Recommendations:
  - Require Medicaid-funded certified community behavioral health clinics in high-need communities to ensure access to the full array of services. ($15m in startup GRO funding + SAMHSA grants are already in the budget.)
  - Authorize the pharmacy board and DOH to require pharmacies in high-need locations to make available medication-assisted treatment.
  - Require Medicaid to implement single credentialing to reduce the need to work with multiple MCOs to become reimbursable within their networks.

Youth

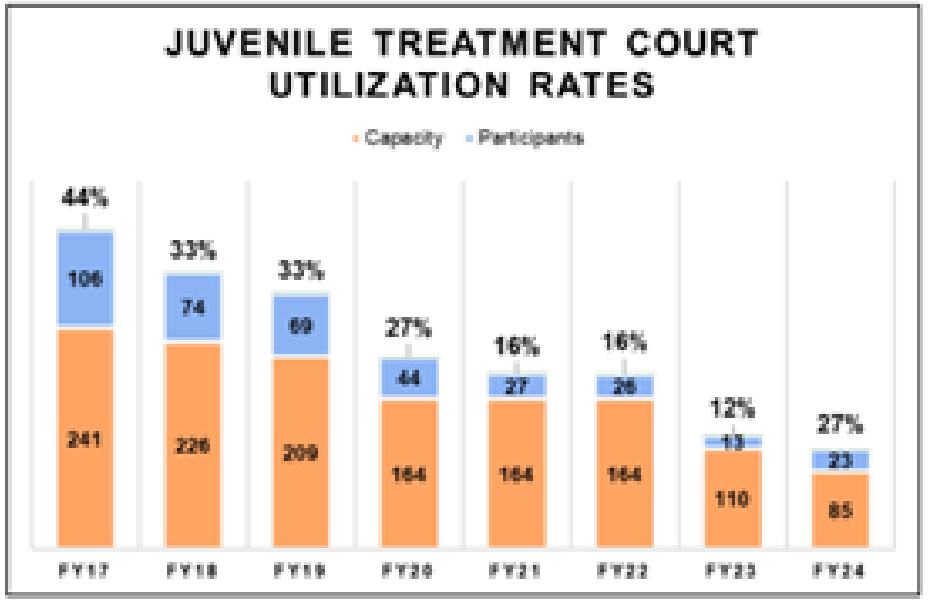
Issue: The US has seen dramatic **decreases** in youth crime over the last 20 years but NM experienced increased crimes involving firearms and referrals to the CJ system

Other key issues for youth including high levels of chronic absenteeism which is associated with higher CJ system involvement

What works: Connecting youth to services in school and intervening early in juvenile justice situations

Current situation: CYFD JJ has stopped using their validated screening instrument

Many juvenile problem courts have ceased operations.



- Recommendations:
  - HCA, CYFD, and the Early Childhood Education and Care Department should consider continuing targeted expansion of evidence-based prevention programs and improve performance reporting to the Legislature on these programs.
  - CYFD should improve access to proven programs like family function therapy and multisystemic therapy and continue using their validated risk assesment
  - Public schools should consider implementing high-dosage tutoring, and additional learning time for absent students.

Notable Vetos

The Governor has line item vetoed several parts of appropriations for criminal justice related agencies and appropriations.

Vetoes include taking out guardrails for programming, changing uses of funding, and removing reporting requirements

- Numerous vetoes of "evidence-based" in both recurring and nonrecurring program spending (multiple years).
- A requirement for $1.5 million at DOH to be used ~~for services~~ to address alcohol misuse (FY25).
- Requirement for law enforcement agencies to be in compliance with statutory reporting requirement prior to receiving part of a $106.5 million appropriation to law enforcement programs (FY24).
- Requirements to report to the LFC on Hepatitis C outcomes attached to a $27 million special appropriation (FY24). Note Hep C outcomes have declined and NMCD is currently missing performance targets.
- Language requiring $10.7 million at NMCD be used to implement ~~evidence-based~~ programming (FY23).
- A $100 thousand appropriation to TRD to provide inmates near release with valid state identification (FY21)
- A $300 thousand appropriation to study re-entry programming (FY21).

Summary

- Despite continued investment in behavioral health and criminal justice, issues with staffing and programming to impact crime remain.
  - Issues with access to services
  - Issues with recruitment and retention
  - Problems with implementation and capacity
  - Issues with data collection

- State and local agencies should continue to work on improving screening, access to services, and staffing strategies to better implement programs.

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For More Information

- https://www.nmlegis.gov/Entity/LFC/Default
  - Session Publications – Budgets
  - Performance Report Cards
  - Program Evaluations

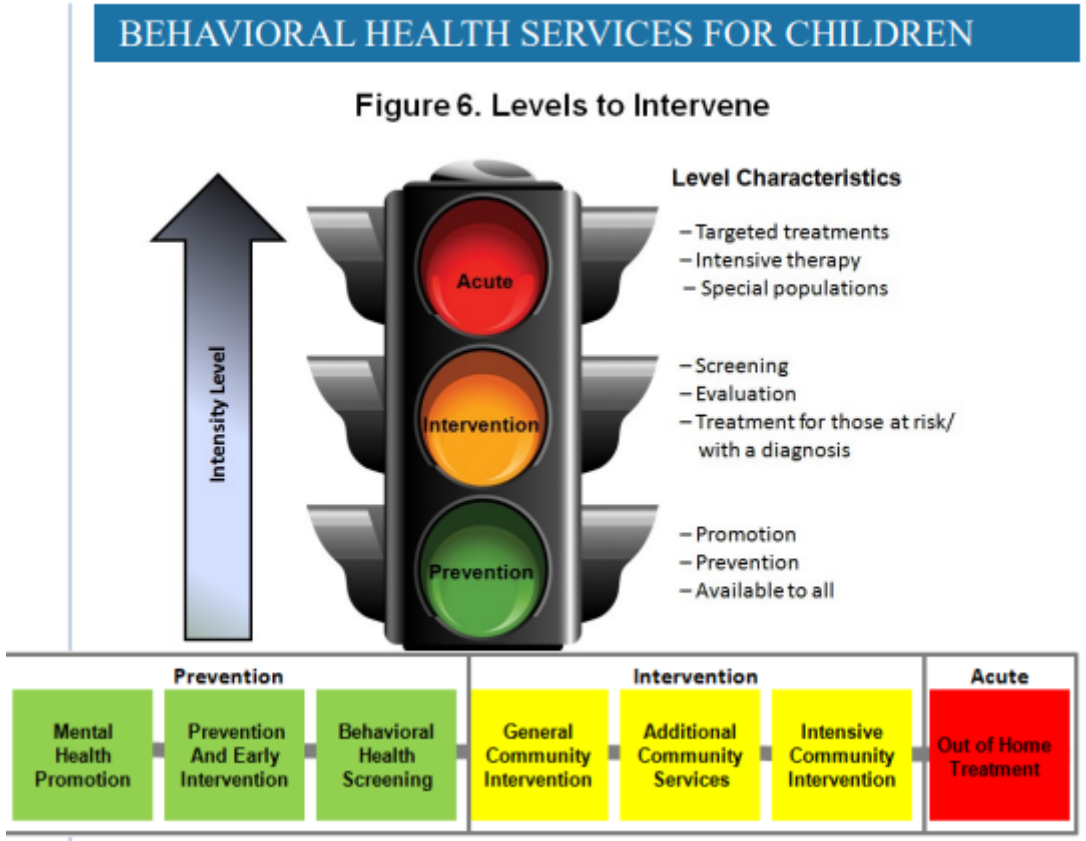
325 Don Gaspar – Suite 101
Santa Fe, NM 87501
505-986-4550

Appendices

Federal Medical Assistance Percentage

- Federal Medical Assistance Percentage (FMAP) – The federal government's reimbursement rate for state expenditures on Medicaid. The rate is dependent on the population served with differing rates for children, income levels, adult expansion, and other groups.
- Base and enhanced rates – Changes each year based on a state's economic performance on per capita personal income. For federal FY25 New Mexico's rate decreased 0.91 percent, costing about $68.9 million in state general funds.
- Blended Rate – Accounts for the different FMAP rates for different populations by weighting the number in each group. For FY25 the blended rate is 77.71 percent. With every state dollar spent the federal government reimburses $3.45.

Medicaid Eligibility Groups		
Threshold (FPL)	**Population**	**FMAP 2025**
100%	Traditional Base	71.68%
138%	Adult Expansion	90.00%
190%	Children 6-19 (Medicaid)	80.18%
240%	Children 0-6 (Medicaid)	80.18%
240%	Children 6 to 19 (CHIP)	80.18%
250%	Pregnancy Services	71.68
300%	Children 0-6 (CHIP)	80.18%
	Native Americans	100%



Selected Children's BH New Mexico Results First Cost Benefit Analysis

	Program Name	Return on Investment per dollar spent
Promotion and Prevention	Nurse Family Partnership	$10
	Other Standards Based Home Visiting Programs	$1
Intervention	Cognitive Behavioral Therapy (CBT) for Child Trauma	$8
	Group CBT for Child Depression	$24
	Group CBT for Anxious Children	$10
	Eye Movement Desensitization and Reprocessing for Child Trauma	$9
	Multisystemic Therapy for Youth with Serious Emotional Disturbance	$2
	Brief Strategic Family Therapy	$2
	Parent Child Interaction Therapy for Children with Disruptive Behavior	$3
	Motivational Interviewing	$29
	Seeking Safety	$33
	Multisystemic Therapy for Juvenile Offenders	$3
	Functional Family Therapy for Youth in State Institutions	$11
	Functional Family Therapy for Youth on Probation	$8
	Juvenile Drug Courts	$5
Acute Intervention	Multidimensional Treatment Foster Care	$2
	Relapse Prevention	$4

Source: LFC

Turquoise Care Vs. Centennial Care

- Turquoise Care is the name of the Medicaid Managed Care Program that replaced Centennial Care
- Going from three Managed Care Organizations (MCO) to four, with Molina and United Health Care added and Western Sky Community Care dropped
- Adding Benefits such as:
  - Supportive Housing
  - Continuous Eligibility for children under six years old
  - Expansion of Home Visiting
  - Evidence-Based Behavioral Health services treatment modalities
- Presbyterian will be the MCO for children in state custody