NEW MEXICO
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COMMITTEE

Behavioral Health Criminal Justice Services and Funding

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Overview

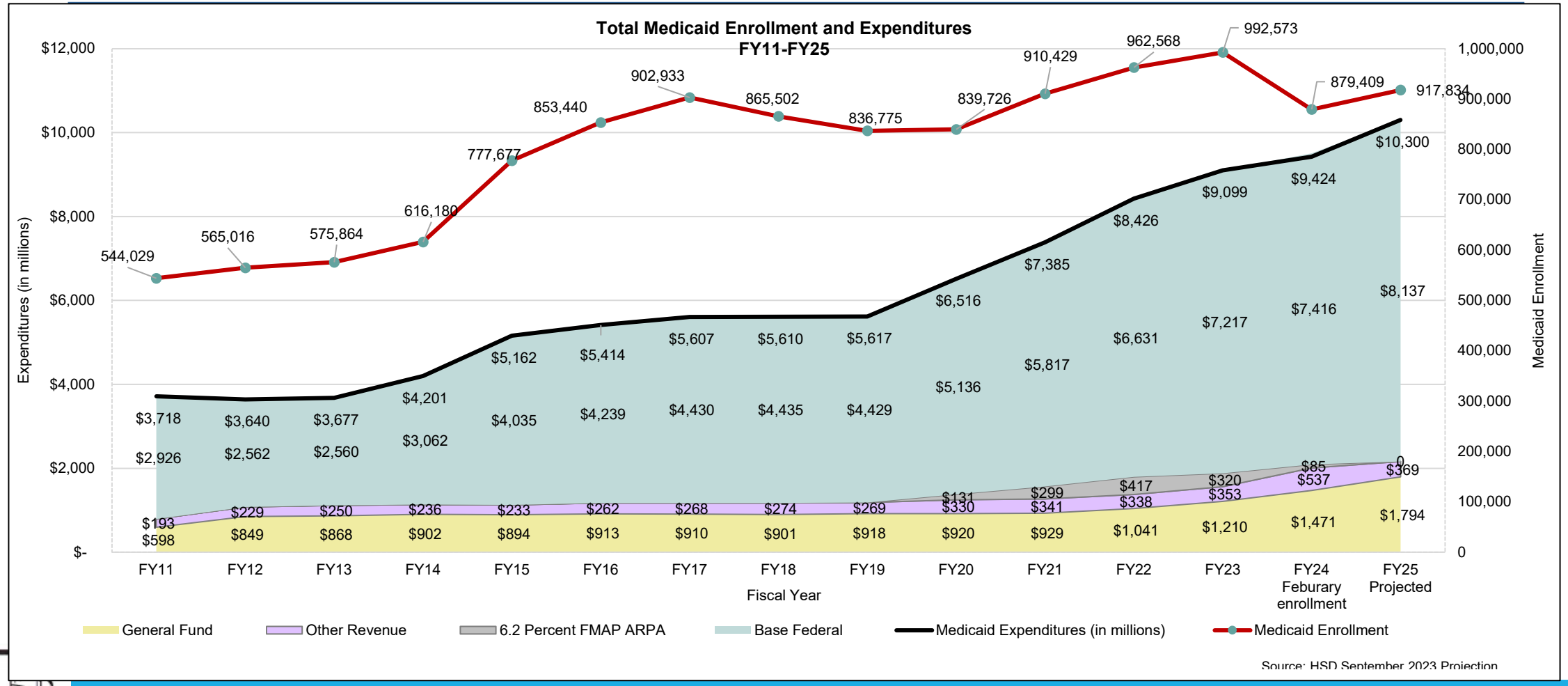
- Medicaid and Behavioral Health Overview
- Behavioral Health Funding
- Needs and Gaps
- Behavioral Health and Criminal Justice LFC Research and Recommendations

Medicaid Enrollment

MAJOR ENROLLMENT CATEGORIES

- Feb 2024 enrollment - 879,409 – April 2024 enrollment 878,841
- About 282K enrolled in the expansion/other adult group
- 160K Medicaid adults
- 354K children
- Others with partial benefit

Medicaid Enrollment Revenue and Expenditures– Approximately 42% of NM Population is Covered by Medicaid

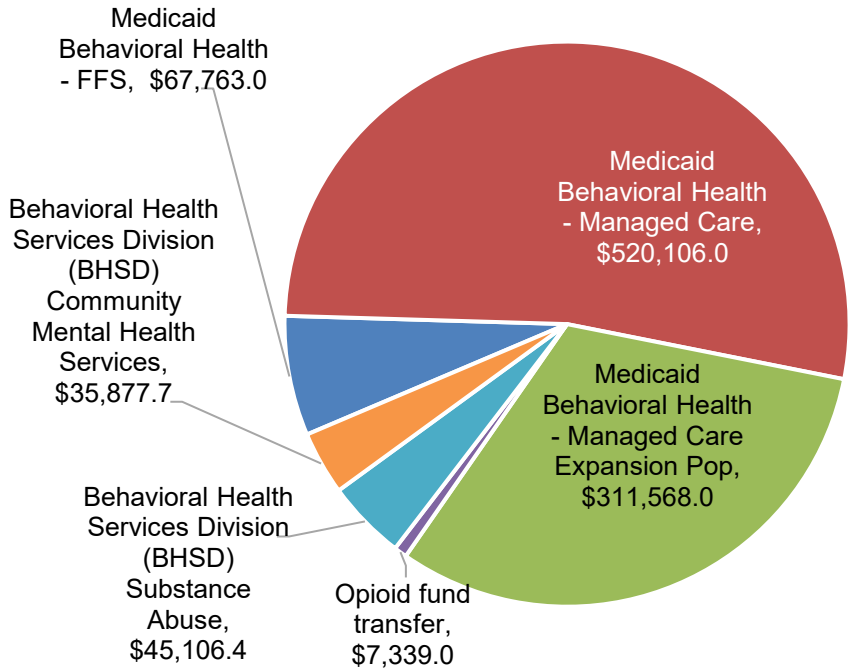


Behavioral Health Collaborative

- In 2004, the Legislature created an Interagency Behavioral Health Purchasing Collaborative to develop and coordinate a single statewide behavioral health system, managed by a CEO (currently vacant).
- The 17 collaborative agencies house programs with services contracted through a single entity with $190 million contracted out in FY25.
- Collaborative key responsibilities include:
  - Needs and gaps analysis
  - Contract for delivery of services
  - Development of a master plan

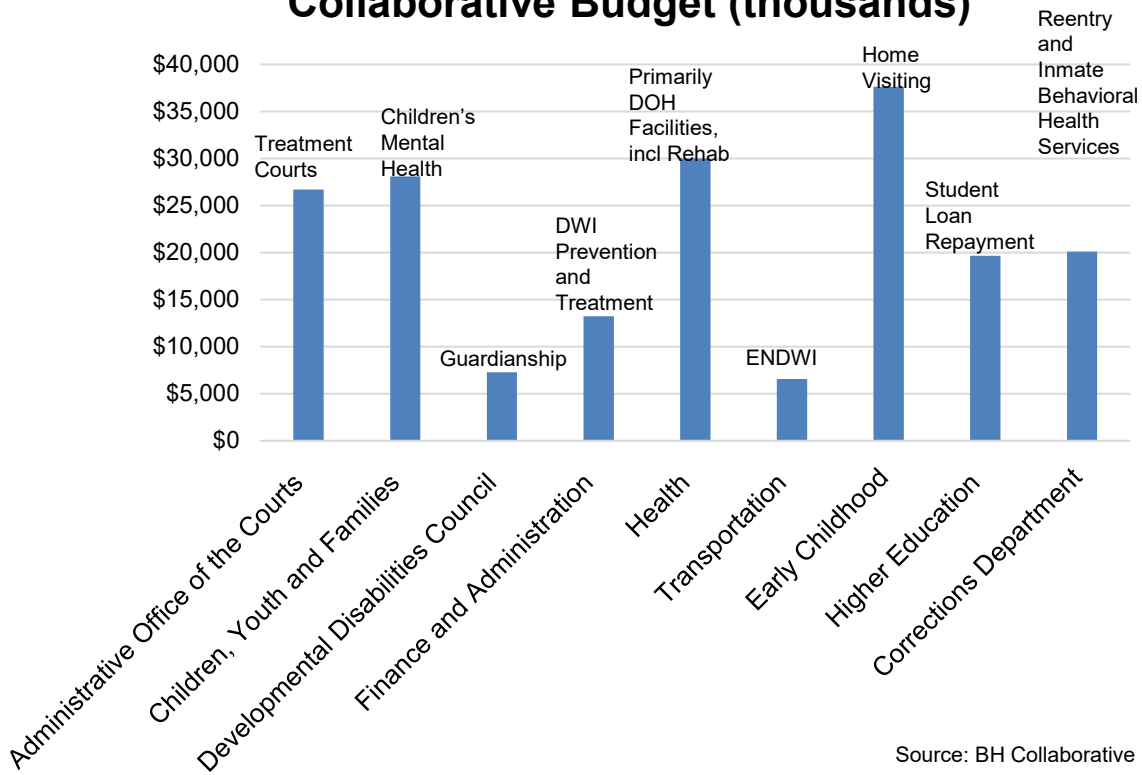
Collaborative Agencies are Budgeted to Spend Nearly $1.1 billion in FY25, a 25 Percent Increase since FY22

FY25 Medicaid and Behavioral Health Services Division Budget (thousands)
Total = $987 million



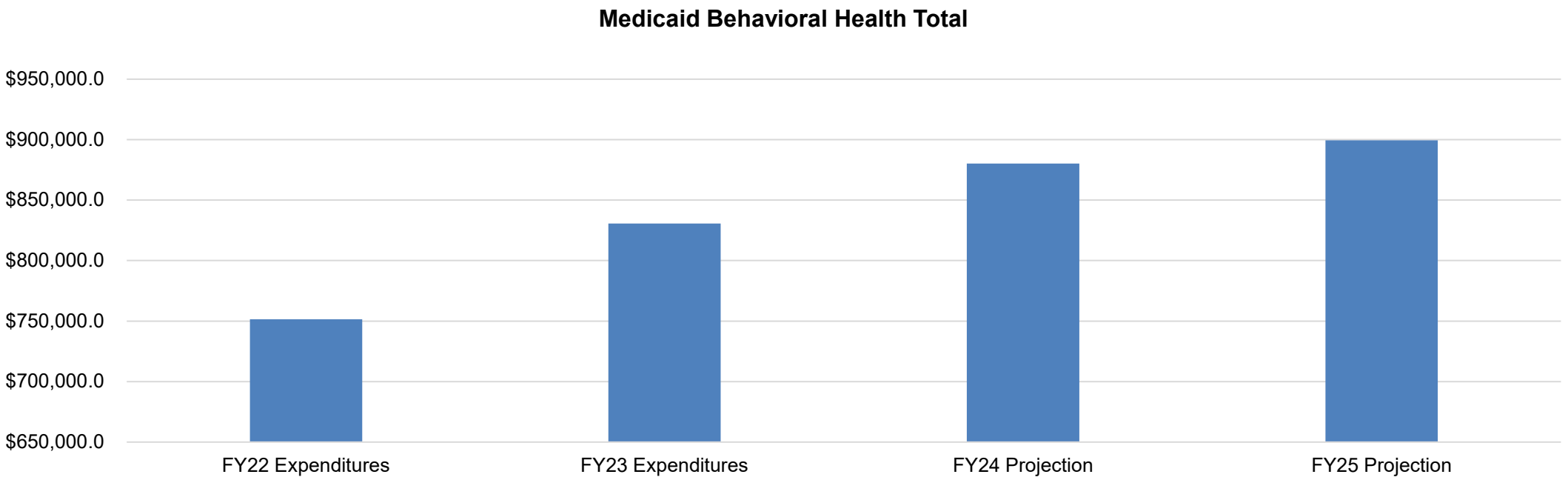
Source: BH Collaborative Budget and HCA Budget Projections

FY25 Non-HCA Behavioral Health Collaborative Budget (thousands)



Source: BH Collaborative

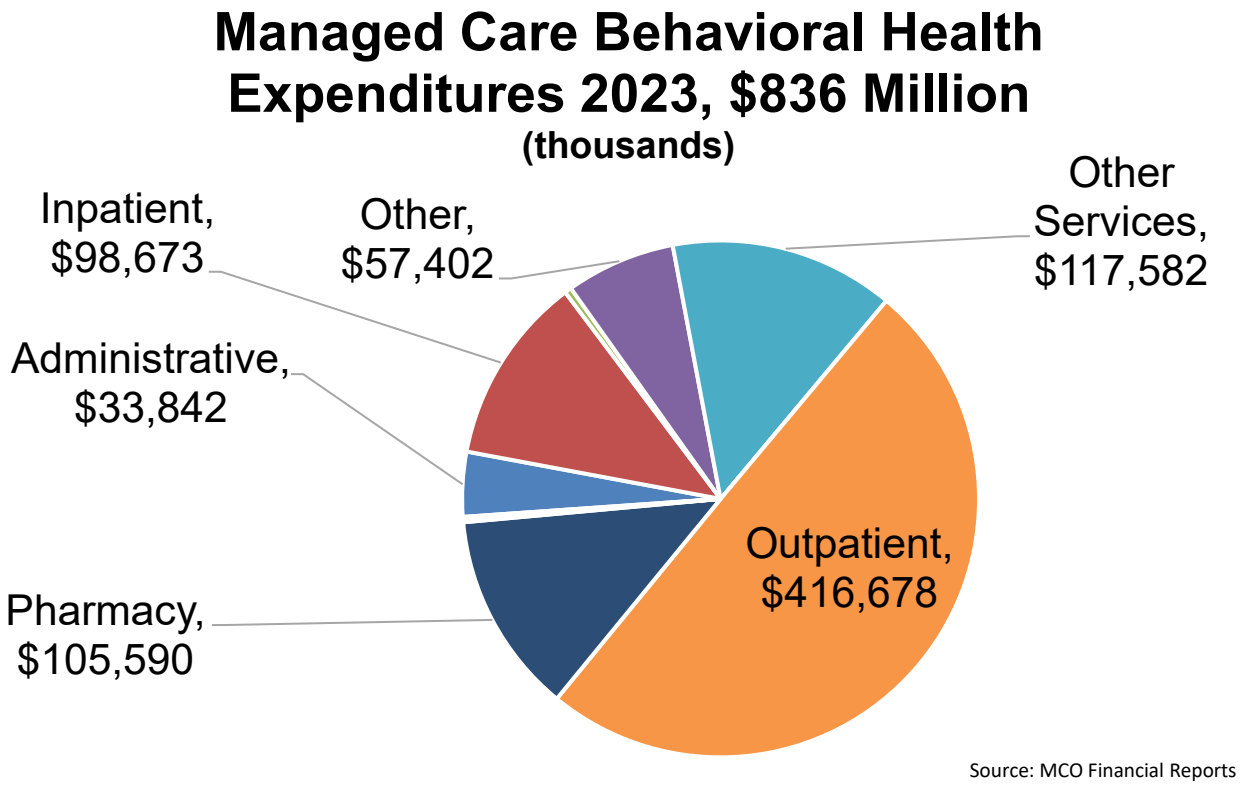
Medicaid Behavioral Health Spending Growth



Source: Medicaid Projections

Between FY22 and FY25, projected spending for the behavioral health program will grow by 25%, increases in recent years are mostly related to increased provider rates.

Medicaid Behavioral Health Spending



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

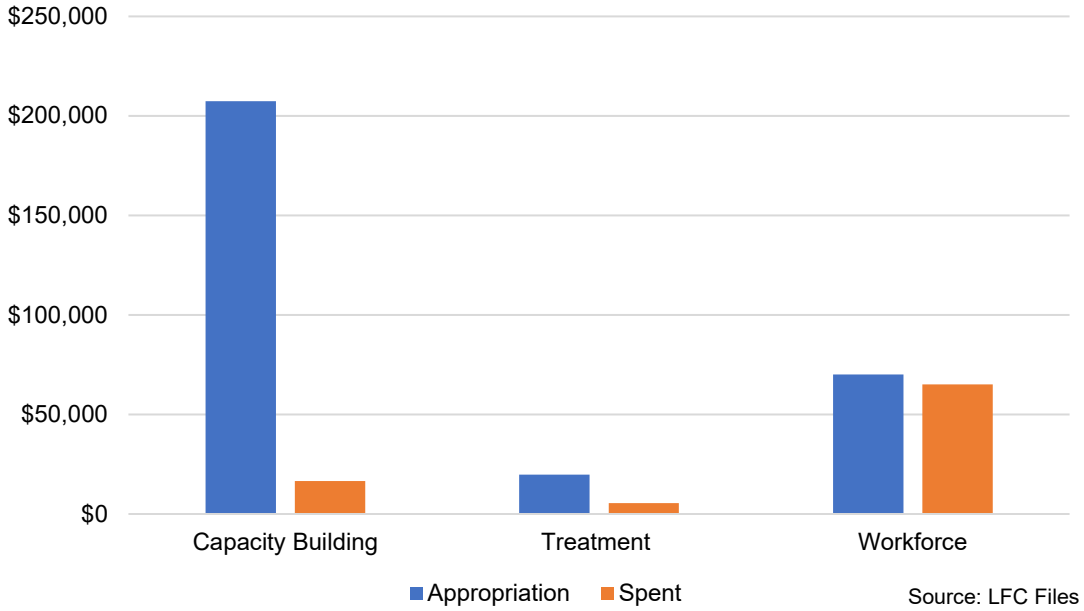
Other Includes	
Other Professional BH Services	$55,673.8
Care Coordination - Medical	$25,555.6
Indian Health Service	$24,653.3

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

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

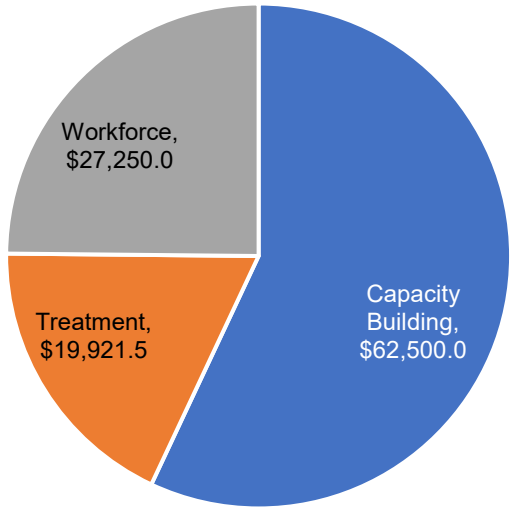
Collaborative Agencies Received $407 Million in Nonrecurring BH Funding Between FY23 and FY25

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.

What Are the Needs and Gaps?

- 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

Behavioral Health Needs

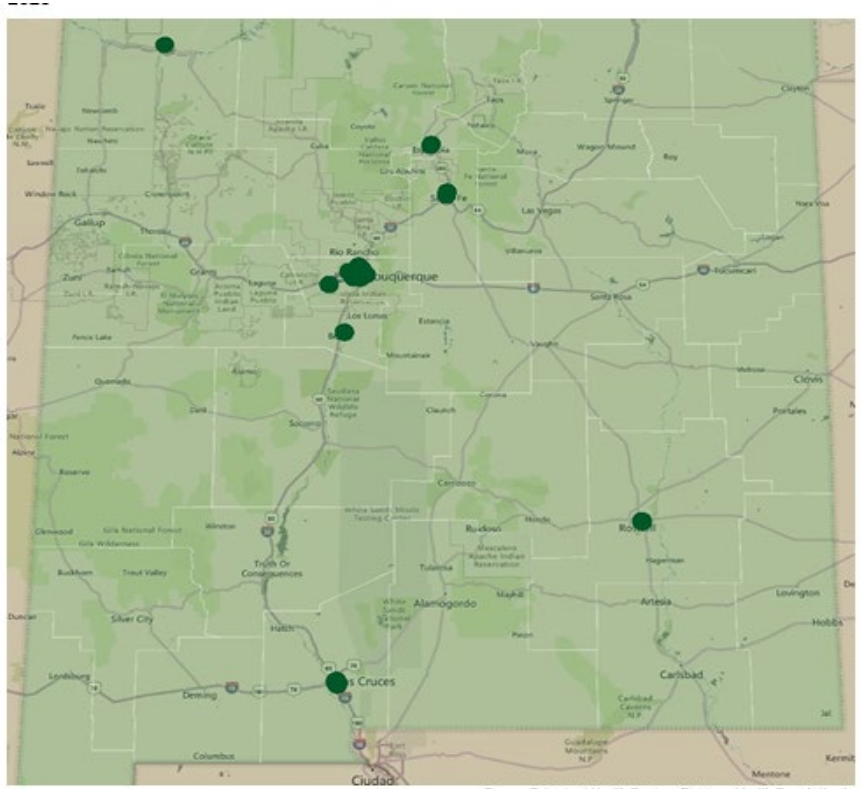
- A fall 2023 LFC Medicaid accountability report found that utilization in a few key areas of physical and behavioral health have decreased since 2019.
- Without better access measures, utilization can be used to approximate whether Medicaid members are accessing the services the state is paying for.
- 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%

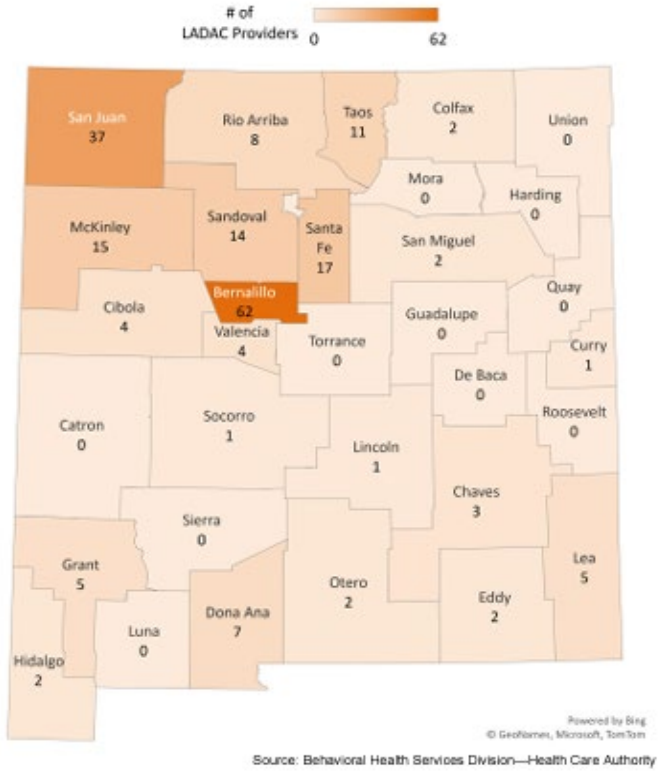
However, continued provider shortages and access challenges

New Mexico Behavioral Health Prescribing Providers by County December 2023



Source: Behavioral Health Services Division—Health Care Authority

Medicaid Licensed Alcohol and Drug Abuse Counselor Providers by County 2023



Source: Behavioral Health Services Division—Health Care Authority

Behavioral Health Managed Care Providers – Capacity Generally Growing

Change in Medicaid Managed Care Behavioral Health Proivders 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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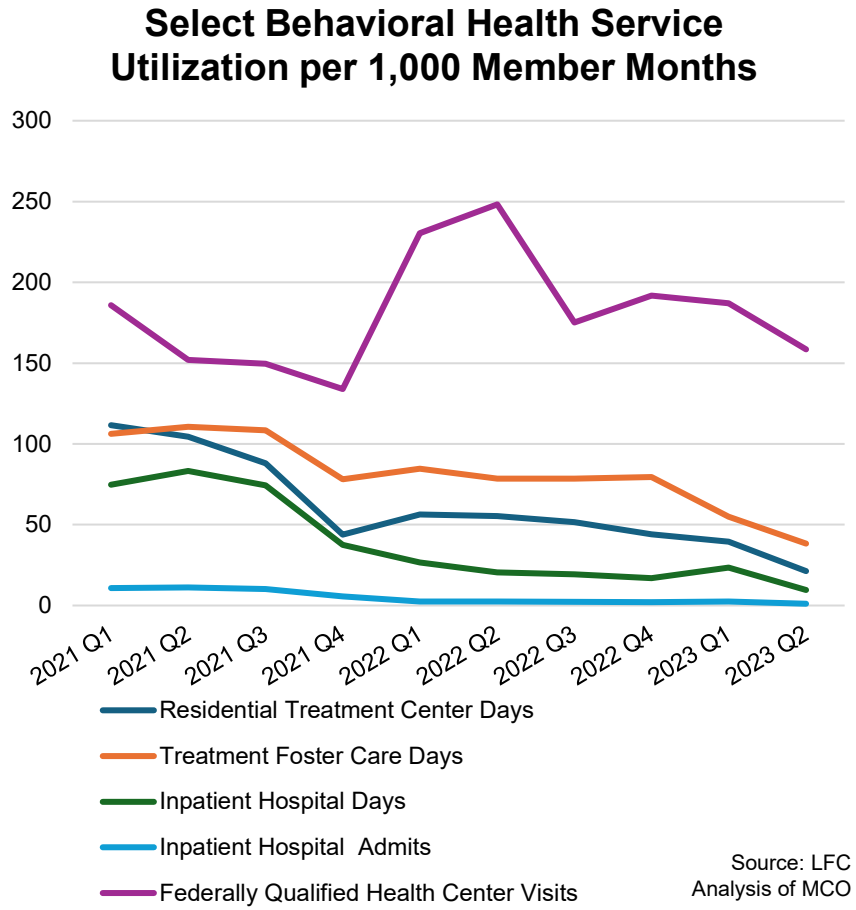
Grand Total		8%	4%	-3%

Utilization of Provider Networks

- 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.



Source: LFC Analysis of MCO

HSD- Medical Assistance Division Accountability in Government Act Program Inventory

Spending

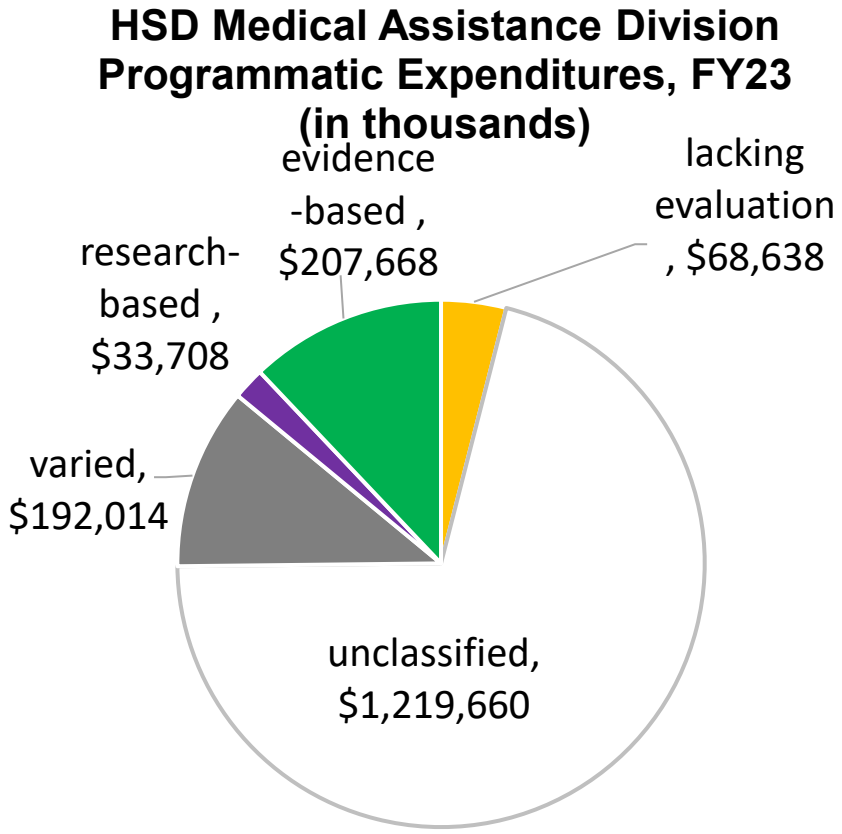
- 12% of MAD's programmatic spending ($241 million) was on evidence--based programming.
- 71% of MAD's programmatic spending ($1.2 billion) was on unclassified Medicaid services.

Program Summary

- MAD reported expending the most on psychotherapy, an unclassified program, reported as multiple different Medicaid service codes and accounts for at least $900 million of expenditures.
- MAD served the most people through various therapy billing codes.

Challenges

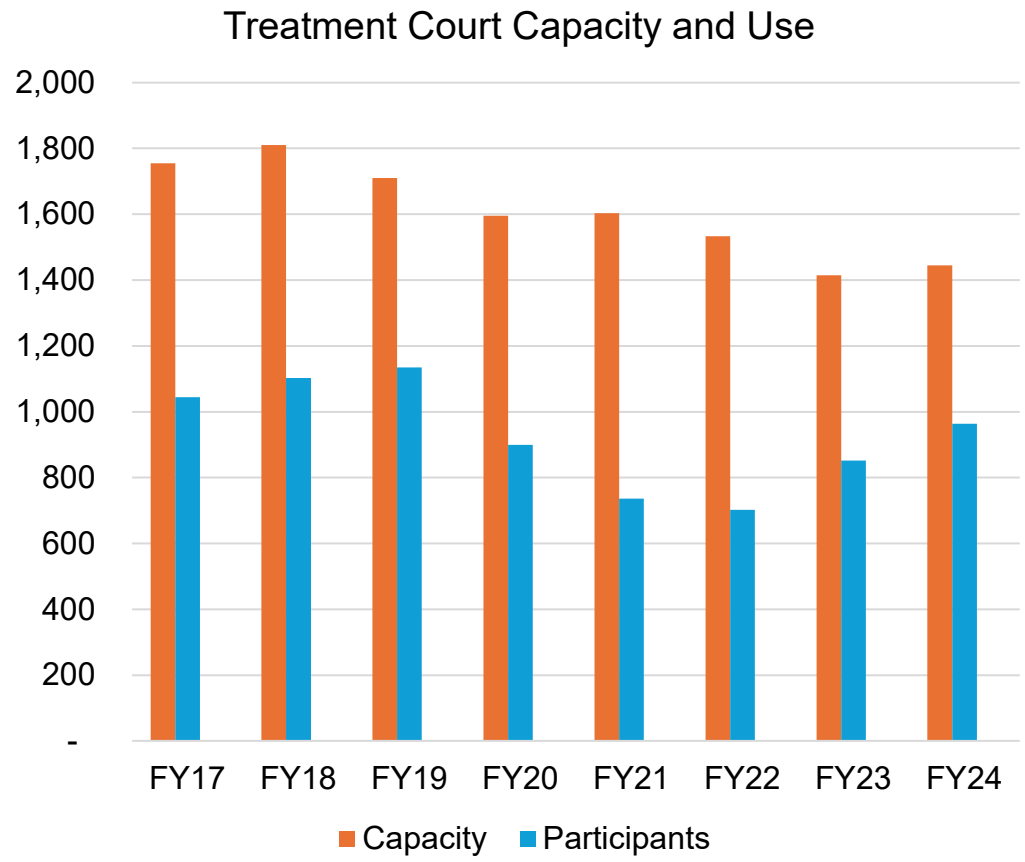
- The agency did not classify 76 of the 92 (83%) Medicaid services provided, which accounts for $1.2 billion in total expenditures (71%).
- The agency does not have service specific data for three programs included in the inventory, and so MAD should amend contracts to better collect data on types of services provided within programs.



Source: LFC analysis of BHSD data

Treatment Courts

- Between FY22 and FY25 treatment court funding increased about 42 percent.
  - However, between FY18 and FY25 treatment court capacity and use decreased by 20 percent and 13 percent, respectively.



Prior LFC Evaluations and Research: Prison Revolving Door

- 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.

Prior LFC Evaluations and Research: Prison Revolving Door, Options

- 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.

Issues Identified in Prior LFC Evaluations and Research: Limited Access to Care in High-Need Communities

- 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.

Issues Identified in Prior LFC Evaluations and Research: Limited access to care in high-need communities', options

- 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.

Issues Identified in Prior LFC Evaluations And Research: Ensure Public Safety Prior to Adjudication

- 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.

Issues Identified in Prior LFC Evaluations and Research: Ensure Public Safety Prior to Adjudication, Options

- 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.

A Few More Items to Leave you With

- Lack of community-based treatment options continues to be an issue for both adults and children (e.g., *Kevin S.* Lawsuit)
- There continues to be significant unspent balances from nonrecurring appropriations (e.g., $ 20 million to boost behavioral health provider capacity).
- DOH substance abuse rehabilitation centers continue to have low numbers of clients despite the need and capacity.

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For More Information

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

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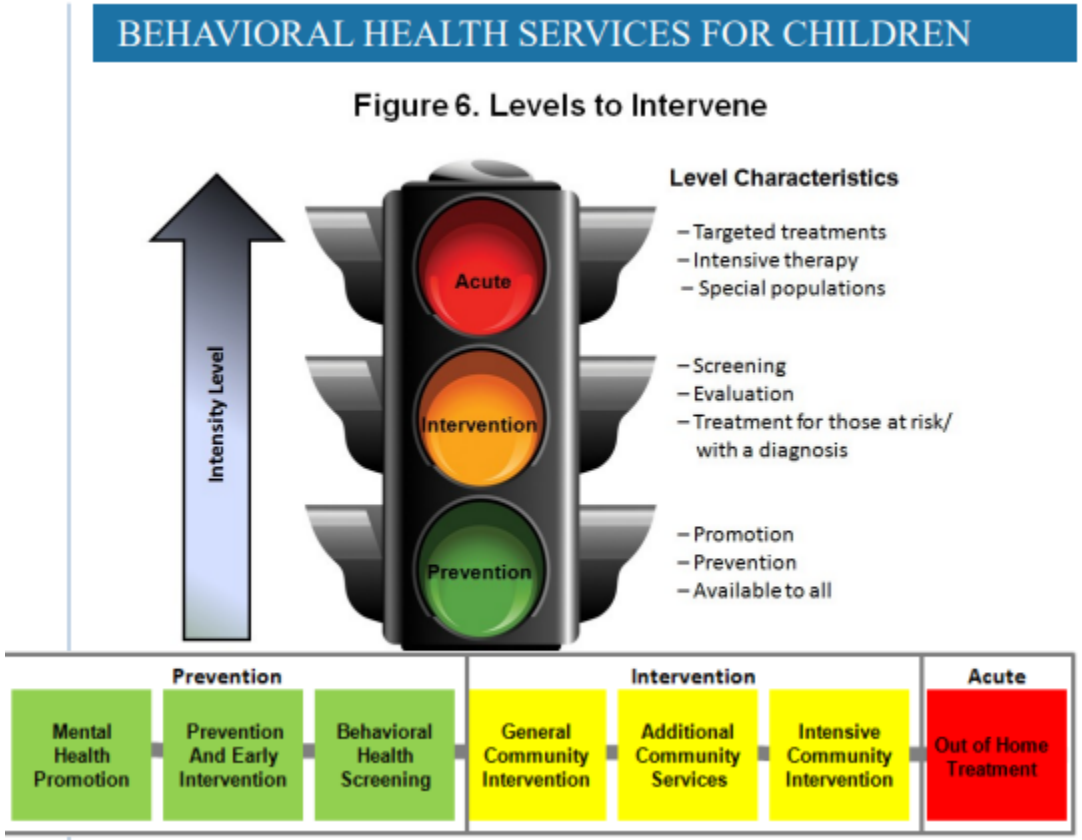
Appendices

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