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FISCAL IMPACT REPORT

SPONSOR Wirth/Sharer/Stewart **LAST UPDATED** **ORIGINAL DATE** 1/27/2025

SHORT TITLE Behavioral Health Reform & Investment Act **BILL NUMBER** Senate Bill 3

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			$30.0	Nonrecurring	**Insurance Operations**

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

Is a companion to the appropriations contained in Senate 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)

SUMMARY

Synopsis of Senate Bill 3

Senate Bill 3 directs the Administrative Office of the Courts (AOC) to designate behavioral health regions, coordinate regional meetings, complete sequential intercept resource mapping detailing how individuals come into contact and move through the criminal justice system, 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 the Superintendent of Insurance (OSI) 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 to develop an initial set of evaluation guidelines for behavioral health services for adoption and implementation of regional plans.

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

FISCAL IMPLICATIONS

It is assumed 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 $140 million.

Section of the Bill	Agency Appropriated To	Appropriation Amount	Purpose
1	AOC	$1,700,000	Sequential intercept resource mapping statewide
2	AOC	$7,000,000	Grants for treatment courts and associated programs
3	HCA	$10,000,000	Grants for medication-assisted treatment
4	HCA	$43,000,000	Grants for certified community behavioral health clinics and other providers
5	HCA	$7,500,000	Grants for twenty-four-hour crisis response facilities
6	NMCD	$1,300,000	Grants for transitional services covered by Medicaid
7	DPS	$5,000,000	Grants for regional mobile crisis response
8	HCA	$11,500,000	Grants for regional mobile crisis and recovery response
9	HCA	$1,000,000	Education and outreach within behavioral health regions
10	DPS	$2,000,000	Grants for community and intercept resources training
11	UNM	$1,000,000	Mobile health units and medication-assisted treatment
12	DOH	$1,000,000	Mobile health units and medication-assisted treatment
13	DFA	$48,000,000	Expansion of housing services providers
	Total	**$140,000**	

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:

> Implementation of the bill would require a minimum of 6 FTE, resulting in $764.9 thousand state general fund annually for salary and benefits.
>
> 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.
>
> Finally, the bill does not optimize, leverage, or reinforce coordination with the Medicaid program as the primary payor of behavioral health services for New Mexicans, foregoing millions in federal matching funds and risking greater service fragmentation. The proposed framework does not fully consider the crucial opportunity of Medicaid in drawing down $3.40 for each general fund dollar spent. To do this, services must be evidence-based, documented, and correctly billed by an enrolled provider. HCA suggests language in the bill to clarify whether this would be an expectation of the funded regional plans.

OSI stated it would need to contract with a third party to meet the obligations of this proposed legislation, including staffing and expertise. The estimated additional budget impact section assumes a consultant fee to cover the cost of initial research. Recurring funding will be necessary to regularly evaluate generally recognized standards of care.

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.
- However, 17 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:

It is unclear who would have primary oversight and accountability for the state's behavioral health system under the proposed framework. Though the HCA would officially remain the designated Single State Authority, it appears HCA may take on a newly diluted role under the proposed framework, with authority for the state's behavioral health system largely shifting out of the agency and moving to the courts and local governments.

The bill reassigns the role of the HCA as the state's behavioral health expert and main point of accountability to other entities and agencies including the federal government. Specifically, the bill, as written in Section 3.A-D, would authorize the AOC to assume decision making authority over behavioral health services that reach beyond the intent of sequential intercept resource mapping. In so doing, it would impact HCA's ability to serve as the single state authority (SSA) for behavioral health services and ensure a broad continuum of care for New Mexicans. This can also create confusion for providers receiving direction and guidance from different state agencies. There would have to be significant coordination to avoid conflicting guidance and maintenance of state and federal requirements.

Recognized by the federal government, 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 of SB3 requires AOC to define behavioral health regions for the state. The courts are not subject matter experts concerning either the criteria or data needed to competently evaluate and designate these regions. County and judicial district-focused regions might not directly correspond with regional behavioral health needs. For example, more rural parts of the state may benefit from regional consolidation of treatment resources covering multiple judicial districts or counties.
>
> 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.

PERFORMANCE IMPLICATIONS

OSI states that OSI Bulletin #2024-013 states:

> OSI requires that "generally recognized standards" used in medical necessity determinations incorporate the most recent versions of clinical practice guidelines developed by nonprofit professional associations for the relevant clinical specialty. For coverage determinations concerning service intensity, level of care placement, continued stay, transfer, and discharge.

OTHER SUBSTANTIVE ISSUES

HCA reports the language, as currently written in Section 7, that directs "a managed care organization shall not limit the number of new behavioral health patients that a behavioral health service provider serves," is potentially restrictive. While there are no limitations in the Medicaid

Managed Care Services Agreement for the number of members a behavioral health service provider may serve, managed care organizations may have quality of care concerns, primarily, the continuity of care provided to the members. (Continuity of care ensures individuals can be seen ongoing in alignment with their clinical needs). The impact of this can be that clinics may not be able to see unlimited numbers beyond their capacity and impacting their ability to see individuals ongoing. The Medical Assistance Division recommends language that ensures continuity of care for the members (i.e., no limitations of the members a provider may see provided members are able to see the behavioral health provider on a regular cadence based on clinical guidelines).

EC/rl/hg