F I S C A L I M P A C T R E P O R T

SPONSOR Munoz **ORIGINAL DATE** 3/09/15 **LAST UPDATED** 03/18/15 **HB**

SHORT TITLE Behavioral Health Investment Zones **SB** 522

ANALYST Boerner

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY15	**FY16**		
	$1,000.0	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY14	FY15	FY16	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		NFI	NFI	NFI		

(Parenthesis ( ) Indicate Expenditure Decreases)

Similar to SB666, SB566 and HB108 which require implementation of an alternative methodology to allocate non-Medicaid behavioral health funding through investment zones established by combined incidence of mortality. Each bill prioritizes resources to high-risk and high-need areas and take into account available resources, including in-kind contributions. **However, SB 522** contains a $1 million dollar appropriation, establishes specific tiered zones, requires all behavioral health services be evidence-based, and requires at least 25 percent matching funds from local governments.

SOURCES OF INFORMATION
LFC Files

Responses Received From
Department of Health (DOH)
Human Services Department (HSD)
Indian Affairs Department (IAD)
Aging and Long Term Services Department (ALTSD)
Children, Youth, and Families Department (CYFD)
NM Corrections (NMCD)

SUMMARY

Senate Bill 522 amends the section of statute relating to the interagency behavioral health purchasing collaborative and directs the collaborative to create a master plan for delivery of behavioral health services statewide that divides the state into behavioral health investment zones based on alcohol, drug, and suicide death rate information provided by DOH. The plan is required to be updated every two years and adopted by the DOH as part of the statewide health plan.

The collaborative would be required to:

- establish a funding formula to prioritize resources to higher tier areas ("tier 3" zones would be areas of highest risk and "tier 1," lowest risk);
- ensure all behavioral health services delivered are evidence-based;
- require at least 25 percent matching funds from any local government receiving general fund for investments zones;
- adopt rules for standards of delivery provided through contracted behavioral health entities; and
- report annually to the legislature on the status of the plan's implementation, progress in addressing behavioral health needs, an inventory of all revenues and expenditures, and performance measures related to clinical outcomes before and after implementation of the tiered investment zones plan.

FISCAL IMPLICATIONS

The appropriation of $1 million dollars contained in this bill is a recurring expense to the general fund. Any unexpended or unencumbered balance remaining at the end of fiscal year shall revert to the general fund. SB 522 appropriates $1 million to DOH, "to fund the creation and prioritization of investment zones…". Since DOH already collects and maintains much of the data necessary to meet the requirements of this bill, the amount of the appropriation may be unnecessarily high.

HSD expressed concerns that it is not clear what funding would be subject to allocation to investment zones as established in this bill. For example, investment zones are limited to certain areas of the state to include, "areas under county policy power jurisdiction that is contiguous with the boundaries of a county that is not a Class A county or for which the secretary of health designates the boundaries if located in a class A county. A class A county is one with a full assessed valuation over $74 million and having a population of 100 thousand or more. Not all areas of the state will be eligible to be investment zones and it is not clear whether the bill intends for the funding in those areas to be reallocated to the investment zones or whether the funding in those areas would be exempt from reallocation.

HSD also points out that Medicaid funds most of most behavioral health services in the state, about $452 million in 2015. Federal regulations specify that services be delivered to Medicaid eligible individuals based on medical necessity and do not make allowances for funding based on alternative criteria. DOH is the second major agency, funding BH services at $38 million in 2015 for the operation of the state hospital in Las Vegas and several treatment facilities. It would be extremely problematic to shut down these facilities and to reallocate the operational funding to other areas of the state.

The Collaborative is required by law to provide the legislature with a budget of all state spending on behavioral health services. The following is a list of agencies that include funds for behavioral health services in their FY15 operating budget. As written, SB 522 could adversely impact the programs and services funded through the following allocations:

Administrative Office of the Courts	$13,184,300
Dept. of Finance and Administration	$7,135,000
Department of Health	$38,565,800
Human Services Dept.	$452,182,400
Children, Family and Youth Dept.	$12,670,200
Corrections Department	$6,362,600
Dept. of Transportation	$3,539,100
Dev. Disability Planning Council	$4,168,600

HSD notes the cost for implementing a state-wide contract might be problematic since SB 522 requires non-standard delivery of behavioral health services to ensure special attention to regional differences. Such specialized services increase the cost of delivering the service, and the economies of scale no longer apply to a state-wide approach because the actual operation is regionally delivered with numerous variables.

Finally, HSD states it is unclear why SB 522 would require the Collaborative to set a ceiling on local government behavioral health spending.

SIGNIFICANT ISSUES

DOH provided the following background information regarding the adverse behavioral health outcomes in New Mexico and analyses demonstrating how the proposal in this bill appears to be consistent with best practices regarding targeting expenditures to improve behavioral health outcomes.

The goal of SB 522 is to create a framework for allocating behavioral health resources, which would prioritize spending on evidence-based practices and target high-needs areas of the state. A September 24, 2014 Results First report from the New Mexico Legislative Finance Committee, "*Evidence-Based Behavioral Health Programs to Improve Outcomes for Adults*," reviewed behavioral health care in New Mexico and recommended "resource allocation, and reallocation, to prioritize spending on evidence-based practices that have been proven to improve outcomes and then targeting of efforts to high-risk high-needs areas of the state." The report describes behavioral health care in New Mexico, gives examples of investment zones, and lists evidence-based adult behavioral health programs identified in the Results First Clearinghouse Database (www.nmlegis.gov/lcs/lfc/lfcdocs/resultsfirst/Evidence-Based%20Behavioral%20Health%20Programs%20to%20Improve%20Outcomes%20for%20Adults.pdf).

New Mexico leads the nation in adverse behavioral health outcomes. New Mexico has the highest alcohol-attributable death rate in the nation (Stahre M, Roeber J, Kanny D, Brewer RD, Zhang X. Contribution of excessive alcohol consumption to deaths and years of potential life lost in the United States. *Prev Chronic Dis*. 2014;11:E109). New Mexico also has third highest drug

overdose death rate in the nation and the fourth highest suicide rate in the nation (CDC 2012 Underlying Cause of Death File, wonder.cdc.gov). These conditions have a large impact on health in New Mexico. In 2013, approximately 1,150 people died of alcohol-attributable causes, 449 died of drug overdose, and 427 committed suicide in New Mexico (ibis.health.state.nm.us). To place this in context, this equates to an average of three people dying of alcohol-attributable causes every day, one person dying of drug overdose every day, and one person committing suicide every day.

Behavioral health issues are not distributed evenly throughout the state. Three counties in New Mexico have alcohol-attributable rates over 100 deaths per 100 thousand population: Rio Arriba County (126 per 100 thousand population), McKinley County (113 per 100 thousand population), and Guadalupe County (101 per 100 thousand population). These rates are approximately twice the state rate (53 per 100 thousand) and approximately four times the national rate of 28 deaths per 100 thousand (DOH 2009-2013 BVRHS; CDC ARDI, www.cdc.gov/alcohol/ardi.htm; Stahre M, Roeber J, Kanny D, Brewer RD, Zhang X. Contribution of excessive alcohol consumption to deaths and years of potential life lost in the United States. *Prev Chronic Dis*. 2014;11:E109).

The counties with the highest rates of drug overdose death in 2009-2013 were Rio Arriba (66.9), Mora (61.4) and Sierra (49.6). In that period, the statewide rate for New Mexico was 23.3 and the national rate in 2012 was 13.1 deaths per 100 thousand population (ibis.health.state.nm.us; wonder.cdc.gov). The counties with the highest rates of suicide death in 2009-2013 were Catron (71.7), Mora (39.4) and De Baca (37.9). In that period, the statewide rate for New Mexico was 19.8 and the national rate in 2012 was 12.6 deaths per 100 thousand population (ibis.health.state.nm.us; wonder.cdc.gov). Additionally, Bernalillo County had the highest number of deaths in the state for all three conditions (ibis.health.state.nm.us). In public health, total number of deaths and the death rate are typically both used in planning (http://nmhealth.org/publication/view/data/474/).

A potential implication of the bill is that the DOH would need to ensure that the investment zone designations fit into the geographic boundaries outlined in the bill. SB 522 defines the investment zones as the county for non-class A counties (a class A county having a final, full assessed valuation of over $75 million and having a population of 100 thousand persons or more) or an area designated by the Secretary of Health in class A counties. DOH already calculates the death rates described in the bill at both a county and sub-county level (http://nmhealth.org/publication/view/data/474/).

A second potential implication of SB 522 is that areas with low rates of suicide, drug overdose and alcohol death may receive reduced behavioral health funding or resources. However, this would be dependent on the Behavioral Health Collaborative and the funding environment.

PERFORMANCE IMPLICATIONS

HSD noted SB 522 would require the Collaborative to ensure all funds are used for evidence-based services; however, other services like assessments, treatment planning, care coordination and medications are essential to support evidence-based services. SB 522 makes no allowances for these services.

The bill's requirement for 25 percent local match for state general fund expenditures in the local

area could serve as a disincentive to safety net services in local communities. Requiring local match for behavioral health services such as children's behavioral services, facility based services, and services provided in drug courts may result in less access to these important services.

Section 1, (B)(5) requires the collaborative to contract for the operation of one or more behavioral health entities to ensure availability of services throughout the state. This is an ongoing problem because certain regions of the state are not economically sustainable for providers, let alone profit viable, and a corporation operating state-wide would need heavy subsidies to survive.

CEB/bb