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

SPONSOR SPAC **ORIGINAL DATE** 03/13/15 **LAST UPDATED** 03/18/15 **HB**

SHORT TITLE Behavioral Health Investment Zones **SB** 566/SPACS

ANALYST Boerner

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY14	FY15	FY16	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		Minimal	Minimal	Minimal	Recurring	DOH Operating Funds

(Parenthesis ( ) Indicate Expenditure Decreases)

Similar to SB666 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.
Similar to SB522 except 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 Division (HSD)
Corrections Department (NMCD)
Public Education Department (PED)

SUMMARY

Senate Bill 566 amends the section of statute relating to the Interagency Behavioral Health Purchasing Collaborative adding provisions to be included as part of the Collaborative's master plan for statewide delivery of services. Specifically, the bill requires, to the extent practicable and using available resources, the implementation of an alternative methodology to allocate non-Medicaid behavioral health funding through investment zones established by combined incidence of mortality related to alcohol use, drug overdose, suicide or other factors based on epidemiological data. The bill specifies the prioritization of resources to high-risk and high-need areas contributing local government resources, including in-kind.
The bill charges DOH with providing epidemiological and other data necessary to establish the

investment zones.

The bill also requires additional information about the designated investment zones be included in the Collaborative's mandatory quarterly reporting to the LFC and interim Legislative Health and Human Services Committee. Information required includes number of communities participating in providing local matching funds, services delivered, number of people receiving investment zone services and any information on outcomes from investment zone expenditures and services.

The bill indicates investment zones should be identified no later than July 1, 2016 and beginning July 1, 2016, the Collaborative shall establish an amount of non-Medicaid funding available and begin prioritizing available funding to identified high-need areas, prioritizing evidence-based, research based, or promising practices.

The Collaborative would also be required to:

- Meet quarterly and at the call of the chair and co-chair;
- Prioritize high-risk and high-need investment zones and areas contributing local government resources, including in-kind resources;
- Annually establish an amount of non-Medicaid behavioral health funding available for use in designated investment zones, taking into account available resources, including contributions from local governments for investment zone funding and statewide behavioral health needs;
- Prioritize the delivery of behavioral health services that are identified as evidence-based, research based or promising practices.

The bill defines a number of terms including "evidence-based," "research-based," and "promising."

FISCAL IMPLICATIONS

DOH routinely collects and reports on the type of data needed to fulfill the requirements described in this bill and should be able to carry out the obligations within the department's existing operating budget.

The table below indicates a total of $41.5 million was spent on non-Medicaid behavioral health expenditures in FY14**.** SB 566 could help insure state expenditures on behavioral health services are targeted where and how the greatest impact can be achieved.

Total HSD Behavioral Health Spending
(non-administrative)

($ millions)	FY14 Project Actuals			FY15 Operating Budget			FY16 Budget Request		
	GF	FF	Total	GF	FF	Total	GF	FF	Total
Medicaid BH	88.8	235.4	324.3	93.9	299.9	393.8	105.2	366.8	472.1
BHSD (non-Medicaid)	41.5	19.0	60.5	35.9	22.5	58.3	36.9	18.3	54.2
Total	130.3	254.4	384.8	129.8	322.4	452.2	141.1	385.1	526.2

Source: HSD Sept 2014 Budget Hearing Presentation

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.

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
Total	$537,808,000

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 566 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 SB 566 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.

OTHER SIGNIFICANT ISSUES

HSD notes portions of the non-Medicaid spending for BH services are not easily transferred between regions of the state. For example, federal mental health block grants are subject to various criteria that can affect their allocation, independent of geography. The Children, Youth and Families Department has $12.6 million in its 2015 budget to address child protective needs and these funds are not easily transferred as well. The Administrative Office of the Courts budgets $13 million for BH services in the drug courts and a redistribution of dollars would probably also be disruptive to the operation of the courts. Nevertheless, this bill would allow the Collaborative to determine which funds might be appropriate for the investment zone approach.

ADMINISTRATIVE ISSUES

HSD states there is a possible IT impact for the department depending upon whether the investment zones in this bill would affect the fund pools currently set up in OptumHealth New Mexico and used by the HSD Behavioral Health Data Warehouse.

LEGAL ISSUES

HSD notes that to the extent that portions of non-Medicaid funding would be apportioned not by individuals' conditions and needs but in part by overall community need and match, two people with the same diagnosis and needs but living in different areas of New Mexico could receive very different levels of service which might have implications for equal protection considerations. It could also impose increased burdens on other forms of BH services in those areas of reduced priority, compromising those other systems' performance as well. In general, optimal management of limited BH funding comes through apportionment based on individual circumstances and needs, rather than through geography and formula.

CEB/bb/je/aml/je