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

SPONSOR Munoz **ORIGINAL DATE** 02/24/15 **LAST UPDATED** 03/18/15 **HB**

SHORT TITLE Behavioral Health Investment Zones **SB** 666

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		DOH Operating Funds

(Parenthesis ( ) Indicate Expenditure Decreases)

Similar to 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.
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 Department (HSD)

SUMMARY

Senate Bill 666 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 funding, the implementation of an alternative methodology to allocate non-Medicaid behavioral health funding through investment zones that takes into consideration the risks and needs of geographical areas based on epidemiological data.

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 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; and
- the delivery of behavioral health services that are identified as evidence-based research based on promising practices;

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

The Collaborative would have until July 1, 2016 (the first day of FY17) to develop the investment zones in preparation for implementation of funding the new zones in FY17.

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 666 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 666 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 666 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.

HSD also points out this bill would require the Collaborative to prioritize funding for evidence-based or promising services, where “promising” means that preliminary analysis points to having potential for becoming evidence-based. Many kinds of services do not yet have strong evaluations due to limited budgets in New Mexico and nationally for research and evaluation and the long time spans required to complete scientific analyses. This bill provides discretion for the Collaborative to prioritize based on preliminary statistical analyses; however, funding for formal analyses in the long term is rarely available.

The bill’s requirement for prioritizing fund allocation based on local match, including in-kind match, could expand funding for BH services overall, but also could compromise efforts to allocate funds to zones based on high needs and risks. Poorer areas may struggle to compete with richer areas in preparing match offers, with the potential that persons in areas most in need might have reduced access to such services as children’s BH services, facility based services, and services provided in drug courts may result in less access to these important services.

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.

TECHNICAL ISSUES

Page 8, line 7 states language indicating the Collaborative shall "prioritize the delivery of behavioral health services that are identified as evidence-based research based on promising practices" could be more clear and suggests clarifying it to say "identified as evidence-based programs or based on promising practices" would be more consistent with the definitions provided later on page 8.

CEB/bb