Behavioral and Mental Health in New Mexico

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What does Behavioral and Mental Health (BH) have to do with domestic terrorism?

- This is not a partisan issue.
- Contributing factors to domestic terrorism include:[1]
  - Access to deadly weapons
  - Mental and behavioral health issues identified in perpetrators
- We need to expand and redefine "mental and behavioral health" to include real-world scenarios.
- Mental and behavioral health issues affect Americans and New Mexicans every day.

1. https://nij.ojp.gov/topics/articles/research-domestic-radicalization-and-terrorism

BH is a <u>major issue</u> as it relates to criminal justice-involved individuals and New Mexicans generally

- Only 23.1% of New Mexicans' mental healthcare needs are being met, leaving 1,211,555 New Mexicans without adequate mental health care access.[2]
- Only 44.2% of New Mexico adults 18 years or older with a mental illness received mental health treatment each year from 2010 to 2014.[3]
- Among adults who perceived a need for treatment but did not receive it during 2008 to 2014, the top reason for not receiving treatment was cost (61.1%), followed by accessibility (31.6%) and personal reasons (32.2%), including not having felt the need for treatment at the time, thinking treatment wouldn't help, and being concerned about being committed or having to take medicine.[4]
- According to the Legislative Finance Committee, over 70% of youth in New Mexico who seek treatment for a substance use problem have a co-occurring mental health disorder.

2. 2017 New Mexico Behavioral Health Needs Assessment, pg. 9.
3. *Id.*
4. *Id.*

- New Mexico's death rate from alcohol-related chronic disease has been first or second in the nation for the past 15 years, and is 1.5 to 2 times the national average.[5]

- Treatment rates for substance abuse are far lower than those for mental illness. Only 7.6% of New Mexico individuals 12 years or older with alcohol dependence or abuse received treatment each year from 2010 to 2014, and only 12.3% of those with drug dependence or abuse received treatment. [6]

- In New Mexico, only 61.5% of Medicaid clients with an active behavioral health diagnoses had an outpatient visit with a behavioral health care provider during 2014 or 2015, while 51% had received medications for a behavioral health condition.[7]

- Only 30% of the State's licensed behavioral health providers serve Medicaid managed care enrollees.[8]

5. Id.
6. Id.
7. Id.
8. David R. Scrase, MD "Behavioral health value-based purchasing improving access to services in New Mexico," Power Point presentation, September 2019.

History of Major Events in New Mexico's Behavioral Health System:

2000

Behavioral health services are administered through regional care coordination entities contracted by managed care companies. The New Mexico Medicaid Behavioral Health Advisory Committee issues report on managed behavioral health care options and improved cross-agency coordination of services. The Committee 2001 made system-wide proposals considered essential to the effective functioning of any behavioral health model for the state, including topics related to access, quality, financing, and treatment of consumers and interagency coordination.

2003

Governor Richardson directed all agencies tasked with the delivery, funding or oversight of behavioral health care services including, mental health and substance use disorders services and treatment to work collaboratively to create a single behavioral health service delivery system throughout the state.

2004

The New Mexico Legislature passes House Bill 271, establishing the Behavioral Health Purchasing Collaborative and Behavioral Health Planning Council.

2005

Behavioral health is separated from physical health. The Collaborative selects ValueOptions New Mexico, Inc. as the single statewide entity to manage mental health and substance use disorders programs and funding from six separate state agencies.

2008

The Collaborative selects OptumHealth New Mexico to replace ValueOptions as the single state- wide entity. After the go-live of the OptumHealth New Mexico system, significant issues arose. A Directed 2009 Corrective Action Plan was imposed on OptumHealth, with consultant, Alicia Smith and Associates
to monitor.

2012

The HSD submits an 1115 Medicaid waiver application to the Centers for Medicare and Medicaid Services. The New Mexico plan is called Centennial Care.
CYFD funding is no longer directing funds through the Collaborative, but is administered by the agency. Federal government approves New Mexico's Medicaid Waiver proposal. Governor Martinez announces New Mexico will expand access to Medicaid for up to 170 thousand eligible New Mexicans under the Patient Protection and Affordable Care Act. Fifteen behavioral health providers have Medicaid payments suspended due to billing concerns. Many of the affected providers close down, and the state brought in Arizona-based providers to address the system gaps this caused.

2014

Centennial Care integrates physical and behavioral health and selects four MCOS to manage Medicaid funding and providers and one third party administrator to manage state general and federal grant funds. This change coincided with Medicaid expansion and the establishment of the New Mexico Health Insurance Exchange.

Source: LFC Files

The Result of the 2013 “Purge” of BH Services in New Mexico

1. Loss of a majority of BH healthcare providers throughout the State of New Mexico, especially in rural areas.[9]

2. Many BH patients, especially those reliant on Medicaid, were declined access to basic services, including prescription medication management, consultation with social workers and basic continuum of care services. [10]

3. New Mexico's already fragile BH infrastructure, which was particularly vulnerable in rural areas, was further decimated to the point of near-extinction.[11]

9. "The Purge," 2019 PBS Documentary produced and directed by Ben Altenberg.
10. *Id.*
11. *Id.*

New Mexico’s Main BH Challenges:

1. Workforce:

New Mexico has a significant shortage of BH providers and healthcare workers, especially psychiatrists, social workers and care coordinators in rural areas.[12]

a) There is insufficient support for rural workforce development and current economic incentives in place are ineffective
b) Complicated credentialing and accreditation process administered mostly by the Managed Care Organizations (MCOs) takes too much time and confuses potential applicants
c) Training processes are uncertain and undefined

12. New Mexico Health Care Workforce Committee Report 2018 Annual Report.

2. Infrastructure:

Many BH providers face difficult issues related to a lack of or insufficient supportive infrastructure needed to provide services

a) Broadband internet access: a lack of broadband internet access in rural areas prevents providers from utilizing electronic medical records and participating in the statewide Healthcare Data Exchange (HDE);
b) Capital requirements and front end start up costs are prohibitive for smaller providers, preventing them from entering the market.

3. <u>Continuum of Care</u>

Because of a lack of workforce and other systemic issues such as infrastructure issues, overburdensome startup costs, insufficient provider and MCO oversight and other issues, NM is unable to provide continuum of care services in most areas around the state. In some cases, there is no service availability at all.

a) All recent BH workforce studies compiled by UNM and other sources show evidence of a lack of BH providers of all crucial types (acute/intensive inpatient; intensive outpatient; family counseling and social services) throughout the state, with an over availability of some types in specific areas in rare cases;
b) NM has no centralized acute triage and/or detoxification center for the provision of intensive inpatient services, forcing patients to seek services out of state;
c) The State of NM has no real plan in place to enforce MCO continuum of care requirements codified in statute and included in contracts;
d) Insufficient evaluation/standardization of empirical data of non-evidence based programs further complicates delivery of a continuum of care.

4. Care Coordination

The "Achilles Heel" of BH services in NM is insufficient care coordination. Because of a lack of or insufficiently trained and supported care coordinators, coordination of BH services is difficult, at best and impossible, at worst.

a) Again, workforce is an issue;
b) MCOs are not held accountable to properly train and support care coordinators, and some are denied access to EHRs and participation in the HDE;
c) Transportation is a major issue, especially in rural areas;
d) Medicaid reimbursement rates are insufficient, and are not tied to cost of living or cost or service provision indicators, as they are in other states;
e) MCOs are not being held accountable for enforcement of training requirements in contracts;
f) Insufficient MCO training on medical billing practices, especially as they relate to Medicaid is complicating coordination of care and in some cases leading to a denial of care;
g) MCOs are not being held accountable for appointment wait time and availability of services provisions in managed care contracts;
h) Monopolization of care has lead to insufficient salaries and difficult working conditions.

SOLUTIONS: