Government Results and Opportunity Hearing Brief

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

The Legislature appropriated $5 million, which was matched with Medicaid revenue, to the Health Care Authority (HCA) in the 2024 session from the government results and opportunity (GRO) fund for pilot projects for screening brief intervention and referral to treatment (SBIRT) and for certified community behavioral health clinics (CCBHC). Both projects are federally approved approaches to improving behavioral health outcomes. Since fiscal year 2024, the state has appropriated $89.5 million for behavioral health rate increases and in 2025 appropriated $565 million in nonrecurring funding for behavioral health services statewide. However, there is little data indicating New Mexico's health and behavioral health outcomes are improving, or that access is better today than it was when the state began making these investments.

AGENCY: Health Care Authority

DATE: September 22, 2026

PURPOSE OF HEARING: Review of 2024 GRO pilot projects

WITNESS: Nick Boukas, Director, BHSD

PREPARED BY: Eric Chenier

EXPECTED OUTCOME: Informational

Amount: $5 million annually for 3 years	**Purpose: For a pilot to expand evidence-based behavioral health services, including screening brief intervention and referral to treatment and certified community behavioral health clinics, to sustainably bill medicaid once fully operational.**

Certified Community Behavioral Health Clinics

CCBHCs are behavioral health clinics providing a comprehensive array of behavioral health and substance use services according to standardized federal criteria for access, staffing, care coordination, crisis response, service delivery, quality reporting, and organizational capacity. CCBHCs are safety-net behavioral health providers and receive enhanced Medicaid reimbursement rates to support the comprehensive scope of services offered. The state launched its first five clinics in January 2025 and launched an additional five in 2026. One CCBHC was decertified for one of its service locations in Santa Fe County. Two additional clinics are expected to be certified in January 2027. New Mexico is one of 18 states participating in the federal Medicaid CCBHC demonstration program which includes an evaluation of the clinics.

Appropriation Progress At-A-Glance	
Evaluation Plan Submitted	Yes
Percent Expended	
Year 1	95%
Year 2	100%
Outcomes Tracked and Reported	None

HCA cited several studies from other states that serve as an existing evidence-base for the effectiveness of CCBHCs, such as studies that the U.S. Department of Health and Human Services conducted which found substantial changes in clinic staffing and service capacity and expanded crisis care, psychiatric rehabilitation, medication-assisted treatment, and primary care screening and monitoring. Cited studies also concluded that Pennsylvania experienced a 13 percent reduction in emergency department visits for CCBHC clients and an 11 percent reduction in Oklahoma, but no impact in Missouri on emergency department visits. Additionally, most of the impact among these states was among beneficiaries who were already engaged in care as opposed to those who newly entered services, with the evaluation unable to speak to whether CCBHCs brought new people into

CCBHC — Data Reported by HCA

2025 (preliminary)	
Total individuals served	26,517
Time from initial contact to receipt of services	Approximately 1.5 days
Time to receive crisis support	Approximately 30 minutes
Quality Measures Listed but Not Reported	
Depression remission at six months	Not reported
Preventive care and screening	Not reported
Alcohol use screening for depression and follow-up plan	Not reported
Screening for social drivers of health	Not reported
Patient experience of care survey	Not reported
Youth and family experience of care survey	Not reported
Adherence to antipsychotic medications for individuals with schizophrenia	Not reported
Initiation and engagement of alcohol and other drug dependence treatment	Not reported
Plan all-cause readmissions rate	Not reported
Follow-up after ED visit or hospitalization for mental illness	Not reported
Follow-up after ED visit for alcohol and other drug dependence	Not reported
Follow-up care for children prescribed ADHD medication	Not reported
Antidepressant medication management	Not reported
Use of pharmacotherapy for opioid use disorder	Not reported
Hemoglobin A1C control for patients with diabetes	Not reported

services.

HCA's stated goals of the CCBHC initiative are to expand access, provide integrated services, strengthen care coordination, improve quality and outcomes, and build workforce capacity. However, HCA did not include targets, baselines, or thresholds to measure whether the initiative impacted these goals. HCA reported that the evaluation conducted was "primarily designed to monitor program implementation, service delivery, utilization, quality, and outcomes among participating providers and populations rather than to determine causal impact through experimental study design." Therefore, HCA did not identify or establish a control group and cannot establish a causal impact with the data that was collected. There is no information as to whether individuals receiving services through CCBHCs were any better off than if there were no CCBHC initiative. Additionally, HCA's report states that "establishing an appropriate comparison group would require additional evaluation planning, and significant funding". However, the federal evaluation solved this issue by comparing beneficiaries at CCBHCs to beneficiaries at non-certified clinics in the same state. Given the timeline of the state's rollout of CCBHCs, HCA likely has the claims data available to conduct a study with a control population.

Without this kind of study, it is impossible to evaluate whether New Mexico's CCBHC initiative is working as intended with the appropriation that HCA received for the initiative. Given the mixed national results reported above, and the purpose of GRO funding, evaluating this program with a control group as statutorily required would have allowed the Legislature to determine whether CCBHCs are right for New Mexico and whether to continue their funding.

Questions for Consideration:

- Your report lists 15 things you're supposed to measure, and none of them have a number next to them. When will we see those numbers?
- Some counties have these clinics and some don't yet. You have the Medicaid claims for both. Why can't you compare them and tell us whether the clinics are making a difference?
- State dollars from this appropriation brought in about four federal dollars for every one we put in. What happens to these clinics after FY27 when this money runs out? Was the money used for startup costs and are these services billable now?
- These clinics are already getting money from this appropriation, from the federal government, and from what we passed last year. What did our $15 million buy that wouldn't have happened anyway? What specifically was this funding spent on?

Screening Brief Intervention and Referral to Treatment

SBIRT is used to identify, reduce, and prevent risky substance use, abuse, and dependence in primary care clinics, emergency departments, mental health centers, and other healthcare settings. HCA provides SBIRT through training and technical assistance and allows providers to bill Medicaid for this service. Additionally, following the 2025 session, the state enacted legislation amending the

SBIRT — Data Reported by HCA

Comprehensive Addiction and Recovery Act statutes, for infants born exposed to substances, that requires HCA to provide SBIRT training to hospital staff, birthing center staff, and prenatal care providers. All hospitals, birthing centers, and prenatal care providers are also required to use SBIRT at all prenatal or perinatal medical visits and following live births.

Several organizations, including the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Preventive Services Task Force have evaluated the efficacy of SBIRT, including New Mexico's implementation of the program between 2003 and 2008 with SAMHSA grant funding. However, the SAMHSA studies did not include control or comparison groups and did not establish causal effects, but did find improvements in overall client health and reductions in substance use. The Preventive Services Task Force graded the efficacy of SBIRT and gives it a grade of B for adults with unhealthy alcohol use or unhealthy drug use with its efficacy for adults with drug use conditioned on treatment access. Insufficient evidence exists for SBIRT's efficacy in adolescents.

However, while sufficient evidence exists for SBIRT's efficacy in specific populations for certain substances, HCA did not evaluate whether the appropriation it received from the GRO fund for SBIRT changed identification and treatment initiation in New Mexico. The authority listed goals for SBIRT including expanded training access, increased adoption, and increased provider knowledge and confidence, but the authority did not establish targets for the number of providers trained, the number of sites implementing SBIRT, or screening rates. Additionally, HCA's own 2026 GRO report stated that "they have not established a formal comparison or control group" for SBIRT implementation. Without a control group it is impossible to assess a causal impact on expected outcomes as required by statute. All the performance measures reported by HCA are outputs and the authority failed to report outcomes for the appropriation. The authority's reported results come from the study from 2003 through 2008 rather from the program as it was funded between FY25 and FY27. Additionally, without a control group there is no indication of whether the program is being implemented to fidelity and working as intended.

Providers Trained	
Providers trained, FY24	31
Providers trained, FY25	128
Providers trained, FY26	318
Medicaid Utilization	
Unduplicated Medicaid SBIRT claims, FY24	7,999
Unduplicated Medicaid SBIRT claims, FY25	13,537
Unduplicated Medicaid SBIRT claims, FY26	26,152
Measures Committed but Not Reported	
Provider agencies and sites trained	Not reported
Technical assistance delivered, in hours	Not reported
Number of health sites implementing SBIRT	Not reported
Screening rate as a share of eligible encounters	Not reported
Positive screen rate	Not reported
Share of positive screens receiving a brief intervention	Not reported
Share of positive screens referred to treatment	Not reported
Treatment initiation following referral	Not reported

Questions for Consideration:

- Screenings tripled over two years. But we also passed a law requiring hospitals and prenatal providers to do them. How much of that increase is the training we paid for, and how much is the new law?
- You've told us how many screenings happened. How many should have happened? What share of patients are getting screened, not just the raw count. Does SBIRT, which is done nationally, have a standard set of measures?
- We paid to train a few hundred providers. How many clinics and hospitals are actually doing this now?
- The last part of this program is referral to treatment. Of the people who screen positive, how many get referred, and is there anywhere for them to go? Did they engage in treatment?

September 22nd, 2026

Behavioral Health Reform and Investment Act Update

Prepared By LFC Staff

The Behavioral Health Reform and Investment Act (BHRIA) established a regionally driven framework to improve behavioral health services in New Mexico by creating a Behavioral Health Executive Committee and requiring regional plans based on identified service gaps and needs. The legislation assigns key implementation roles to the Health Care Authority (HCA) and the Administrative Office of the Courts (AOC), including planning, mapping service gaps, and adherence to clinical standards. Reporting to the Legislature includes quarterly updates to LFC and ties funding to approved regional plans that prioritize underserved communities and measurable outcomes. Common themes discovered within LFC's regional plan evaluations can guide development of a statewide behavioral health plan that directs resources to activities that will deliver high quality, evidence-based outcomes.

Priority Theme	Regions Identifying Theme	Regional Count	% of Regions
Youth, Family, School-Based & Caregiver Supports	1, 3, 4, 5, 6, 7, 8, 9, 10, 12	10	77%
Access, Treatment Capacity, Recovery & Continuum of Care	1, 2, 5, 6, 7, 9, 10, 11, 12, 13	10	77%
Housing, Transportation & Basic Needs	5, 6, 7, 8, 9, 11, 12, 13	8	62%
Workforce Development, Recruitment & Provider Support	1, 2, 4, 6, 7, 8, 9, 13	8	62%
Crisis Response, Stabilization & Mobile Crisis Services	4, 6, 9, 10, 12, 13	6	46%
Justice, Diversion, Specialty Courts & Reentry	3, 4, 5, 10, 11, 12	6	46%
Prevention, Wellness, Community & Cultural Supports	1, 5, 7, 9, 10, 11	6	46%
Care Coordination, Navigation & System Integration	3, 8, 11, 13	4	31%

Regional Plan Priorities

Sequential intercept (SIM) mapping is a framework used to help communities improve coordination across law enforcement, courts, and behavioral health services. Four dominant themes emerged across New Mexico's 13 behavioral health regions:

1. Expand access to behavioral health treatment and recovery services (10 regions)
2. Strengthen youth, family, school, and caregiver supports (10 regions)
3. Address housing, transportation, and other social determinants of health (8 regions)
4. Build and retain the behavioral health workforce (8 regions)

These 4 priority areas represent the majority of regional planning activity and common investment opportunities across the BHRIA framework. Beginning July 1, 2027 the BHRIA directs HCA to complete a statewide gap analysis of behavioral health services every two fiscal years. Analysis of gaps and overarching themes of the regional plans should be used to prioritize

activities and craft the development of a statewide behavioral health policy that recognizes common needs across the state while providing regions the resources needed to deliver targeted behavioral health services.

Funding for Nations, Tribes and Pueblos

On September 2nd, 2026, the BHEC approved a revised funding formula incorporating Nations, Pueblos, and Tribes (NPTs) while maintaining the total tribal set-aside of approximately $10.4 million. NPT funds are now based on an equal base allocation plus a population-based needs adjustment.

- NPTs may participate by joining a regional plan, submitting a Tribal Plan addendum for direct funding, doing both, or opting out and participating later.

BHRIA Regional Allocations Approved 09/02/2026

	Formula Allocation Less Native American Allocation	Native American Allocation	Total Allocation
Region 1	$8,073,455	$2,412,329	$8,718,174
Region 2	$12,790,016	$643,885	$13,796,540
Region 3	$8,085,082		$8,085,082
Region 4	$6,722,225		$6,722,225
Region 5	$9,444,484		$9,535,776
Region 6	$7,907,605		$7,907,605
Region 7	$7,603,390		$8,311,791
Region 8	$6,291,494	$585,320	$6,744,900
Region 9	$6,606,437		$6,606,437
Region 10	$5,944,987		$5,944,987
Region 11	$3,610,281	$4,228,976	$8,929,580
Region 12	$6,753,426	$344,378	$7,208,121
Region 13	$9,721,393	$2,230,838	$11,488,782
Total	**$99,554,274**	**$10,445,726**	**$110,000,000**

- Tribal Plans can be submitted directly to the HCA and will undergo review by LFC and BHEC approval before funds are awarded. Following approval, HCA will contract directly with and fund participating tribes.

Regional Plans and Evaluations

- At the time of this brief, 11 of 13 BHRIA regional plans have been approved by the executive committee, with Regions 4 and 12 pending.
- LFC developed uniform evaluation guidelines for behavioral health services to review whether regional plans meet those standards and assess the adequacy, feasibility, and effectiveness of implementation of the BHRIA.
- Evaluations assess whether programs demonstrate measurable progress, causal pathways, and evidence-based assumptions, allowing for systematic identification of gaps and continuous improvement in behavioral health investments.
- Regional plans are living documents. The BHRIA and the LFC's evaluation process take this into consideration and plans may evolve over time as milestones are accomplished and a comprehensive, statewide behavioral health policy is developed.
- Approved plans, evaluations and other materials are available to the public through the UNM Behavioral Health Technical Assistance Center (BHTAC).

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Budget Preview: Behavioral Health Services and Child Support Enforcement

Nick Boukas, Director, Behavioral Health Services
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Behavioral Health Services

- For FY28, the Behavioral Health Services Program request of $77.5 million from general fund revenue is $7.2 million, or a 10.3 percent increase from the FY27 operating budget. The requested increase from the general fund is primarily to replace opioid settlement fund revenue for Linkages, a housing program for people with serious mental illnesses, and for supportive housing. Because of the revenue replacement, the total requested increase is $69.6 thousand.
- In 2025, the Legislature eliminated the Behavioral Health Collaborative and replaced it with a new Behavioral Health Executive Committee, led by the Health Care Authority, charged with reviewing and approving regional plans, establishing funding strategies and structures, monitoring and tracking deliverables and expenditures, and establishing management strategies (HCA). The law also requires the Administrative Office of the Courts to complete sequential intercept mapping, a process that helps regions improve regional understanding of needs and gaps at the nexus of behavioral health and crime. LFC has been evaluating the regional plans for the last several months. The General Appropriation Act of 2025 included significant amounts to carry out the provisions of the law—with over $565 million appropriated for behavioral health in nonrecurring funding.
- A recent behavioral health needs assessment that the authority completed with Manatt, using a $1 million appropriation, noted multiple areas for improvement within the state's behavioral health system. For example, the report found that assertive community treatment teams, an evidence-based service for people with serious mental illness, are under-deployed and are largely concentrated in urban areas, leaving many rural areas without access. Additionally, mobile crisis and youth crisis stabilization implementation is incomplete with seven mobile crisis teams operating around the state and zero providers offering mobile response and stabilization services, a youth crisis and stabilization benefit, nearly two years after the federal government approved these services. The assessment also found that crisis triage center capacity is concentrated in urban areas, permanent supportive housing does not meet the estimated need, and there are 44 patients living in

hospitals as their primary residence because nursing facilities will not accept them due to behavioral health concerns.

- A behavioral health evaluation brief from April 2026, noted fewer Medicaid enrollees are using more behavioral health services at a higher cost. Between 2023 and 2025 behavioral health managed care spending increased by 47 percent while utilization increased by 22 percent. The service lines with the greatest increase in spending include applied behavioral analysis (for people with autism), substance use disorder, and community-based services. However, per-member per-month rates paid to the Medicaid managed care organizations increased from about $75 in 2023 to $140 in 2026. This is partly due to the increased rates paid by managed care organizations to providers but is also due to increased utilization. The state is paying more and there is no indication the increased investment is leading to better outcomes.

Child Support Enforcement

- For FY28, the Child Support Enforcement Program request of $15.3 million from general fund revenue is a $122.2 thousand, or 0.8 percent increase from the prior year, primarily for employee liability insurance premiums. From federal revenue, the program requested a $237.3 thousand, or a 0.7 percent increase. The increases would bring the program's total budget to $49.1 million in FY28. The program receives a 66 percent federal matching rate plus federal incentive revenue based on how well the program performs.
- The Health Care Authority also requested $31.2 million, including $10.4 million from the general fund for the continued modernization of the child support enforcement IT system modernization. However, the authority received a $14.3 million appropriation for the modernization project in 2022 and has only spent $941.5 thousand. The project was started in 2013, has gone through multiple revisions and is now expecting completion in 2029, 16 years after the project start date. The project's performance received red ratings on budget, schedule, and risk every year and that status did not change in FY26. The total project cost if HCA receives additional funding would total $74.6 million.
- In FY26, child support collections totaled $118 million, about $2 million less than target and about $1 million less than last year. Average monthly support collected per child rose to $146 an increase above FY25 of $137 per child. The division credited its employment referral program, through which about 40 percent of referred parents found work and 73 percent began paying support afterward, as a driver of more consistent payments.