New Mexico Behavioral Health Assessment and Feasibility Study

Final Report, Prepared by Manatt Health for the New Mexico Health Care Authority

January 2026

Executive Summary

Purpose of the Study

During its 2025 legislative session, the New Mexico Legislature directed the Health Care Authority (HCA) to study the "merits, feasibility, costs, and likely enrollment in a proposed new Medicaid waiver for individuals with serious mental illness (SMI) or substance use disorder (SUD) who experience regular confinement in county jails or intensive overuse of hospital emergency rooms or other emergency or crisis services versus continuing with the current service array for people with SMI." The Medical Assistance Division (MAD) of the New Mexico HCA (herein referred to as New Mexico Medicaid) contracted with Manatt Health and its subcontractors—Milliman and Kauffman and Associates Incorporated (KAI)—for this analysis. At New Mexico Medicaid's direction, the study also includes an inventory of services covered by Medicaid and with federal block grants and state funds for people who are uninsured or underinsured ("state-funded services"), a broader review of gaps and opportunities to improve services for people with complex behavioral health issues and/or brain injury in New Mexico, and a comprehensive set of actionable recommendations.

New Mexico's Behavioral Health System: Strengths and Opportunities for Progress

Over the past several years, New Mexico has made significant investments in behavioral health. The state now spends approximately $1 billion annually1 on behavioral health services, serving 295,0002 individuals each year. Medicaid serves as the backbone of the state's behavioral health system, accounting for the vast majority—88 percent—of these expenditures.

Scope of Services Covered

Through Medicaid, New Mexico covers a broad continuum of mental health and SUD services aligned with national best practices. This includes assertive community treatment (ACT), high-fidelity wraparound (HFW) for children and youth, a full continuum of American Society of Addiction Medicine (ASAM)-aligned SUD services, evidence-based

psychotherapies, peer and family supports, and an increasingly robust crisis services array. Many of these services also are covered as state-funded services for New Mexicans who are uninsured or underinsured. Through initiatives such as Linkages and the Set Aside/Special Needs Housing Program (SAHP), New Mexico has established permanent supportive housing (PSH) programs that combine rental assistance with supportive services.

1 New Mexico Legislative Finance Committee. "Medicaid and Behavioral Health Overview." 27 June 2025, https://www.nmlegis.gov/handouts/LHHS%20062525%20Item%2015%20Behavioral%20Health%20Medicaid.pdf

Assumes the SFY 2025 Medicaid budget includes (in thousands) Medicaid Behavioral Health, Managed Care ($520,106); Medicaid Behavioral Health, Managed Care Expansion Population ($311,568) and Medicaid Behavioral Health, FFS ($67,763). Assumes the SFY 2025 state-funded budget includes (in thousands) BHSD Community Mental Health Services ($35,877.7), BHSD Substance Use Services ($45,106.4), the opioid transfer fund ($7,339) and CYFD funding ($33,619.3). CYFD funding amount provided by CYFD on January 12, 2025.

2 New Mexico Legislative Finance Committee. "PERFORMANCE REPORT CARD Behavioral Health Collaborative Second Quarter, Fiscal Year 2024." 2024, https://www.nmlegis.gov/Entity/LFC/Documents/Agency_Report_Cards/6.%20BHSD%20FY24%20Q2%20Report%20Card%20FINAL.pdf

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Recent Reforms, Including Senate Bill (SB) 3

Recent initiatives further strengthen this foundation. Medicaid provider rate increases to 150 percent of Medicare rates have materially improved recruitment and retention, with measurable growth in the behavioral health workforce. Certified Community Behavioral Health Clinics (CCBHCs) are expanding access to integrated care, while mobile crisis services and justice-involved re-entry initiatives (JUST Health Plus)—when more fully implemented—could help address long-standing pressure points. The state is instituting a series of reforms to improve care for people transitioning out of hospitals and residential facilities, prompted in part by the 2024 approval of a major Medicaid 1115 demonstration (also referred to as an 1115 waiver) that, among other things, allows New Mexico to use federal Medicaid matching funds to cover the cost of short-term stays in larger residential treatment centers for people with mental health issues and/or SUDs. Finally, in 2025, New Mexico adopted SB 3, the Behavioral Health Reform and Investment Act (BHRIA), an ambitious effort to reform the state's behavioral health system through a multi-year

regional planning process accompanied by substantial new funding. The state ultimately aims to leverage Medicaid dollars to sustain regional investments made as a result of SB 3.

Remaining Gaps and Opportunities

At the same time, New Mexico's behavioral health system faces sizeable gaps. Although coverage of services is relatively strong on paper, there are significant access issues, particularly in rural and frontier areas where services such as ACT and crisis care are limited due to a shortage of providers. Some high-need individuals do not qualify for certain home- and community-based services (HCBS) that could support their ability to live successfully in the community, and there are significant challenges in finding appropriate step-down options for those transitioning from inpatient or residential treatment. While Linkages and SAHP are model programs, the availability of PSH falls short of demand, and navigational supports systems are often fragmented. People with brain injury are not always identified and may not receive adequate services or support. Some intensive Medicaid-funded services are not accessible to uninsured or underinsured individuals (e.g., intensive outpatient for mental health for adults or partial hospitalization services for mental health for youth and adults).

Recommendations

To build on its existing strengths and address gaps in the current system, the analysis recommends six major strategies. The report recommends sequencing and phasing in the proposed changes, reflecting it would not be feasible to implement all of the recommendations simultaneously. New Mexico already has a significant number of initiatives and resource-intensive changes underway as a result of SB 3, new fiscal and administrative challenges posed by HR 1 (119th Congress), and other federal Executive Branch actions. As a top short-term priority, the report recommends focusing on increasing access to already-covered behavioral health services—such as ACT—and expanding PSH and transitional housing (Strategy #1 and Strategy #2) without the need for new federal authority. Under any scenario, it will be important to align implementation of new strategies with the work already underway in New Mexico.

In addition, the analysis recognizes that shifting federal priorities make it an uncertain and complex time to attempt to secure a major new Medicaid waiver. Even seeking to amend the state's existing Turquoise Care 1115 demonstration could have unintended consequences. As a result, the report does not make any recommendations that would necessitate changes to New Mexico's current 1115 demonstration prior to the next required federal renewal at the end of 2029. To address gaps HCBS for people at high risk of incarceration, homelessness or frequent hospitalization, the report suggests that instead,

New Mexico consider pursuing a 1915(i) State Plan Amendment (SPA) if the gaps remain after a few years of SB 3 implementation.

Strategy #1: Increasing Access to Already-Covered Behavioral Health and Brain Injury Services

New Mexico's behavioral health system offers a wide range of services, but many residents—especially those in rural and frontier areas—still struggle to access the care they need. The state's ACT teams, crisis services, and outreach efforts are vital, but their reach and effectiveness are limited by workforce shortages, geography, and lack of awareness. This strategy aims to close those gaps by expanding the availability and expertise of ACT teams, strengthening crisis response, and ensuring that eligible individuals know about and can access the Community Benefit program. Some of the work expanding the capacity of providers to offer already-covered services such as ACT and crisis services could be integrated into SB 3 initiatives, assuming it is consistent with one or more regional entity's priorities. Maintaining Medicaid payment rates is also crucial to attracting and retaining providers, which directly impacts service availability.

Key Recommendations:

• Expand the number and reach of ACT teams, especially in underserved areas, ideally as part of regional priorities under SB 3 (No new federal authority needed)

• Support ACT teams in developing expertise for SUD and justice system involvement (No new federal authority needed)

• Strengthen statewide crisis services, including mobile crisis teams (No new federal authority needed)

• Conduct outreach to explain that individuals with behavioral health needs or brain injury who have co-occurring physical health disabilities may qualify for the Community Benefit program (No new federal authority needed)

• Retain current Medicaid payment rates to support provider participation (No new federal authority needed)

Strategy #2: Leveraging Existing Initiatives to Expand Permanent Supportive Housing (PSH) and Transitional Housing

Stable housing is foundational to recovery and community integration for people with behavioral health and brain injury needs. New Mexico has made progress with PSH programs, but the supply still falls short of demand. Currently, the state serves 920 people

through Linkages and SAHP[1] but estimates suggest that an additional 3,000 to 4,000 people within New Mexico could benefit from such programs. This strategy focuses on maximizing the impact of existing Medicaid-funded housing supports, expanding transitional housing options, and streamlining referral pathways to make it easier for individuals to access housing. Accelerating the implementation of medical respite services – which cover up to six months of room and board and supportive services for people who are homeless and who are too ill to recover from sickness or injury on the street or in a shelter but do not require hospital level care —would support people transitioning from hospitals.

Key Recommendations:

• Expand PSH to reduce unmet need (No new federal authority needed)

• Increase utilization of Medicaid-funded pre-tenancy and tenancy services (No new federal authority required to increase utilization of already-authorized service units; if more service units are required, could be addressed during next renewal of Turquoise Care 1115 demonstration in late 2029) • Grow transitional and interim housing programs (Use of federal grant dollars requires approval of overseeing federal agency, but no new Medicaid approval)

• Standardize referral and entry processes for supportive housing (No new federal authority needed)

• Expand implementation of medical respite benefit (No new federal authority needed)

Strategy #3: Streamlining and Strengthening Navigational Supports

Navigating New Mexico's behavioral health system can be confusing. To address this challenge, many stakeholders cited a need for a new case management benefit for people with SMI, severe emotional disturbance (SED), and SUD, like what is available to individuals enrolled in the state's Developmental Disabilities or "DD" waiver. At the same time, there are many existing services and programs already potentially available to individuals with SMI, SED, and SUD that provide navigational support. Health Homes and

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3 The Special Needs / Set Aside Housing Program (SAHP) was created jointly in 2009 by two state level institutional partners – the New Mexico Mortgage Finance Authority (MFA) and Behavioral Health Services Division (BHSD) of the New Mexico Human Services Department (HSD). The intent of the SAHP is to provide priority access to housing for income qualified persons with certain disabilities and persons who are homeless. The SAHP is a special program offered within the New Mexico Low Income Housing Tax Credit Program (LIHTC) and is administered by the New Mexico Mortgage Finance Administration (MFA). https://housingnm.org/uploads/documents/New_Mexico_Special_Needs_Program_Operations_Manual_%28LIHTC%29.pdf

CCBHCs, which the state is expanding, provide varying levels of intensity of case management and care coordination. Managed care organizations (MCOs) are required to provide care coordination to all enrollees. Services such as Comprehensive Community Support Services (CCSS), ACT and HFW include elements of navigational support. However, many individuals and providers are unaware of the available options, leading to gaps in care and people "falling through the cracks." For people engaged in one or more options, support is often fragmented or overlapping.

This strategy seeks to establish a clear framework for routing individuals to the most appropriate type of navigational support, encourage MCOs to delegate more care coordination to community providers, and develop specialized support for people living with brain injury. The goal is to create a more seamless, person-centered system that matches services to individual needs.

Key Recommendations:

• Establish a framework for routing individuals to the right case management program, care coordination or high-intensity service that includes navigational support (No new federal authority needed)

• Require MCOs to delegate care coordination for complex cases to Health Homes, CCBHCs, and Opioid Treatment Programs (OTPs) (No new federal authority needed)

• Develop more specialized and intensive care coordination for people with brain injury (No new federal authority needed)

Strategy #4: Expanding Community-Based Services for People with Complex Behavioral Health Conditions and/or Brain Injury, including a Potential 1915(i) SPA

While New Mexico's Community Benefit program provides important HCBS, eligibility requirements mean that individuals at high risk of incarceration, homelessness or frequent hospitalizations do not qualify for these services unless they also have co-occurring physical health issues that necessitate a nursing facility level of care (NFLOC). Even within the Community Benefit program, there are some discrete gaps in the covered services that are particularly important for people with SMI, SUD, and brain injury (e.g., services focused on addressing instrumental activities of daily living (IADL). This strategy recommends that New Mexico consider pursuing a 1915(i) SPA to fill these gaps, offering targeted HCBS – such as community transition services, personal care, and life skills coaching – to people who need extra support to live independently. Given the significant changes coming to New Mexico as a result of SB 3, the report recommends that New Mexico consider gaining experience with SB 3 before pursuing a new 1915(i) SPA. After a few years of SB 3 implementation, the state can assess whether discrete gaps remain in the state's service

continuum, as well as whether a 1915(i) SPA can help offer sustainable Medicaid financing for some of the regional SB 3 initiatives. Finally, aligning state-funded benefits with Medicaid to the extent financially feasible would ensure that all residents have access to essential services, regardless of insurance status.

Key Recommendations:

• Consider a new 1915(i) SPA to address gaps in HCBS for at-risk populations if still needed after the state gains experience with SB 3 regional planning efforts (Would require federal authority for a new 1915(i) SPA)

• Align state-funded benefit packages with the current Medicaid State Plan, especially for intensive outpatient and partial hospitalization services (No new federal authority needed)

Strategy #5: Adopting Tailored Strategies for Populations of Focus

Certain groups—such as people living with brain injury, children and youth, individuals requiring nursing facility (NF) placement, and those with SUD—face unique challenges. This strategy calls for targeted interventions to address their specific needs, including specialized care coordination, expanded residential treatment options, and improved access to recovery services. By focusing on these populations, New Mexico can ensure that reforms are tailored to the specific challenges faced by each population.

Key Recommendations:

• For people with brain injury: Increase funding for the Brain Injury Services Fund (BISF) Program, establish specialized care coordination, and expand community-based supports (Would require a new 1915(i) SPA to expand community-based supports; no other new federal authority needed)

• For children and youth: Expand the reach of HFW and other evidence-based practices, create in-state residential treatment for young people who identify as female, ensure that residential treatment facilities are trained to serve special populations, and adapt the mobile crisis model for rural areas (No new federal authority needed)

• For individuals requiring NF placement: Address denials based on behavioral health issues, incentivize facilities to accept people with complex behavioral health issues, pilot small nursing facilities for this population, and provide staff training on working with people with complex behavioral health needs (No new federal authority needed)

• For individuals with SUD: Scale effective treatment models for pregnant/postpartum women, facilitate Medicaid funding for treatment provided in recovery housing, expand access to medication-assisted treatment (MAT), and consider focused initiatives aimed at

stimulant and alcohol use disorders (AUDs) (Expanded access to MAT would require Substance Use and Mental Health Services Agency (SAMHSA)/Drug Enforcement Administration(DEA) approval but no new Medicaid approval. (no other new federal Medicaid authority needed with exception of seeking Medicaid funding for contingency management, which could be addressed during next renewal of Turquoise Care 1115 demonstration in late 2029)

Strategy #6: Strengthening the Foundational Elements of New Mexico's Behavioral Health System Such as the Behavioral Health Workforce

A strong behavioral health system depends on a robust workforce, effective navigation tools, and reliable transportation. New Mexico faces provider shortages, especially in rural areas, and complex licensing and enrollment procedures. Consumers and providers alike struggle to find information about available services. This strategy recommends continued investment in workforce development, creation of centralized online hubs and navigation tools, and improvements to transportation. These foundational elements are critical to ensuring that services are sustainable and accessible to all who qualify for them.

Key Recommendations:

• Continue efforts to address workforce shortages and fund loan repayment programs (No new federal authority needed)

• Incentivize retention and career growth for Certified Peer Support Workers (CPSW) (No new federal authority needed)

• Participate in healthcare licensing compacts for additional provider types, including psychologists, advanced practice registered nurses (APRNs), social workers, and counselors (No new federal authority needed)

• Develop centralized online hubs and navigation tools for behavioral health and brain injury resources (No new federal authority needed)

• Improve consumer-facing resources on non-emergency medical transportation, expand non-medical transportation coverage, and explore a pilot of a new Medicaid non-law enforcement transportation service (Expanding non-medical transportation would require a new 1915(i) SPA – see Strategy #4)

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From a fiscal perspective, estimates in the full report suggest that a 1915(i) SPA, depending on final design, could serve approximately 7,185 individuals with SMI, SUD or brain injury statewide once fully phased in, with an estimated annual gross cost of $33.7 million,

depending on take-up and utilization of services. Federal Medicaid matching funds would cover roughly 71% of these costs, leaving a state share of approximately $9.7 million annually. This cost estimate assumes service delivery would begin in 2030.

While a 1915(i) SPA is readily approvable by the federal government, including under the current Administration, it still requires significant state administrative resources and oversight. For example, the state would need to develop new services that are not offered today, determine rates for new services, and hire new staff to oversee the SPA. In addition, the state would need to work with MCOs to ensure that there are sufficient providers equipped to respond to an increase in the number of people who qualify for HCBS, as well as to provide the new services that would be made available under the potential 1915(i) SPA. Ultimately, it is New Mexico's decision-makers who will need to determine whether seeking approval for a 1915(i) SPA is appropriate and affordable, taking into account the estimated cost, state administrative burden, the capacity of the state's workforce, and competing priorities.

Conclusion

As New Mexico considers how to help people with SMI or SUD who experience regular confinement in county jails or intensive overuse of hospital emergency rooms or other emergency or crisis services, the central challenge facing the state is not the absence of federal authority, but how best to strengthen and align New Mexico's many notable behavioral health and re-entry initiatives. New Mexico already has established a relatively robust, evidence-based continuum of behavioral health services; secured approval of an ambitious Medicaid 1115 demonstration that provides it with resources and opportunities not available to most other states; and it has launched a major new regional planning initiative. Regardless of whether it eventually pursues new services through a 1915(i) SPA, New Mexico can make significant progress in the short-term by focusing on implementation of existing initiatives, expanding access to already-covered services, conducting more outreach and education, and closely coordinating its statewide work with regional planning under SB 3.