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

		ORIGINAL DATE	02/11/15		
SPONSOR	Harper/Papen	**LAST UPDATED**	03/17/15	**HB**	222/aHJC/aSPAC
SHORT TITLE	Mental Health Community Engagement Teams			**SB**	
				ANALYST	Boerner

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY15	FY16	FY17	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		40.0	40.0	80.0*	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

*The 5 year pilot is estimated to cost $200 thousand; see detailed analysis in Fiscal Impact section below.

SOURCES OF INFORMATION

LFC Files

Responses Received From
Department of Health (DOH)
Human Services Department (HSD)

SUMMARY

Synopsis of Senate Public Affairs Committee Amendment:

- SPAC amendment #1 struck most HJC amendments; those remaining specify a definition for certified peer support worker and clarify the compliance of the CETs with federal and state health information privacy laws.
- SPAC amendments #2 and #3 change language on page 1 to indicate HSD would be responsible for approval of community engagement teams as opposed to establishing and overseeing them as stated in previous versions of the bill.
- SPAC amendments #4 and #5 add "community support worker" to the definition of case manager as a person with specific skills, training and knowledge in mental health who manages and coordinates mental health resources and services and retains the definition of "certified peer worker" identical to the HJC amendment.
- SPAC amendment #13 strikes Section 6 related to division responsibilities in its entirety (which previously described oversight and reporting duties), and replaces it with a new section describing rules for application and approval procedures for entities wishing to operate as CET pilot projects. The amendment also provides for the development of CET evaluation metrics (in consultation with an advisory committee with a broad membership including courts and law enforcement, educational institutions, broad county representation, and others as HSD deems important).

    - Amendment #13 requires HSD to begin accepting application for CETs by April 1, 2016 and states HSD has 30 days to complete applicant reviews and make decisions.
    - Amendment #13 also outlines requirements for annual reporting to the interim Legislative Health and Human Services Committee and Legislative Finance Committee.
    - Finally, amendment #13 requires HSD to make CET contact information available to the state crisis and access lines and a directory of resources to facilitate access to mental health resources.
- Finally amendment #14 strikes Section 8 entirely which included some requirements for telehealth and replaced it with language indicating CET pilot projects may be funded with state or local government appropriations, gifts, grants or donations and that a CET must identify committed sources of funding sufficient to support operating costs for the remaining fiscal year (if applicable) and for the next fiscal year.

<u>Synopsis of House Judiciary Committee Amendment</u>:

- HJC replaces the term "peer" in the bill with "certified peer worker," and defines this individual as a person who: (1) is eighteen years of age or older; (2) has a high school diploma or high school equivalency credential; (3) is self-identified as a current or former consumer of mental health or substance abuse services; (4) has at least two years of mental health or substance abuse recovery; and (5) is certified by the state as a peer worker."

- HJC amends the definition of "unlikely to live safely in the community" to state that based on a determination by a CET, there is a substantial probability that, without treatment or support services, a person *with a mental disorder or illness* will *experience* mental distress and experience deterioration of the ability to function independently…" The definition is further amended to state the pattern of behavior indicated as evidence of this condition may be observed in the preceding 90 days rather than 30 days as in the original bill.

- HJC amends section 7 regarding confidentiality to state a CET may not use or disclose protected health information of persons it serves except as provided by Section 43-1-19 NMSA 1978 (Disclosure of Information) and in accordance with state and federal health care privacy laws."
- Finally, HJC changes date by which HSD must:
    - establish the CET pilot project from January 1, 2016 to September 1, 2015;
    - confer with appropriate parties for development of the pilot from June 30, 2016 to January 1, 2016; and
    - commence the pilot project from July 1, 2016 to January 1, 2016.

<u>Synopsis of Original Bill:</u>

House Bill 222, the Community Engagement Act, provides for the establishment of community engagement teams (CET) to engage and link persons with serious mental disorders or illness, who are unlikely to live safely in the community, with voluntary treatment and services. The availability of CETs is expected to reduce the rate of involvement with law enforcement, reduce involuntary hospitalization, and lessen mental deterioration for such individuals.

CETs can be public, private, or public-private partnerships. CETs must have at least one member who is a licensed mental health professional but can include peers, case managers, community support workers or core service workers. CETs will not be treatment providers but rather

function as a link to treatment or services by: 1) determining whether a person is unlikely to live safely; and if not, 2) encourage voluntary consent to assessment for treatment or support services; and 3) assist with helping the individual access appropriate treatment or services.

HB 222 charges the HSD's Behavioral Health Services Division (BHSD) with the following responsibilities:

- Authorization of the formation of CETs
- Oversight of CETs
- Providing annual reports to LFC, Legislative Health and Human Services Committee, and other appropriate interim committees that study courts and corrections
- Making available a directory of CETs to public and online
- Promulgation of rules as necessary

Finally, BHSD:

- Shall establish a five-year CET pilot project by January 1, 2016 and commence the pilot project by July 1, 2016.
- May contract with CET entities that can be funded in whole or in part from sources other than state.
- Shall incorporate telehealth, including a 24-hour hotline for CET member to consult with a mental health professional and the use of distance technology and teleconferencing.
- Shall convene a performance improvement committee and adopt performance metrics.

FISCAL IMPACTS

HSD provided the updated fiscal impacts regarding SPAC amendments:

HB 222aa would make no appropriation to pay for the operation of CETs that it authorizes, nor would it make an appropriation for BHSD oversight and evaluation of the formation and operation of the teams. Ultimate formation of teams would depend on funding from local governments or another public or private source as yet undetermined. HSD's earlier analyses of the bill in its earlier forms specified an anticipated cost to establish CETs and evaluate them; those estimates no longer apply, since the amended bill no longer calls upon HSD to establish CETs.

BHSD estimates the cost to HSD for BHSD's approval, data analysis, and reporting role in the five-year pilot required by the bill would be $200 thousand spread over 6 years. This would include funding to pay the cost and travel expenses of a 0.5 FTE BHSD staff position to oversee preparation of rules, processing applications, collection of metrics, and required reports, at $40 thousand per year.

HSD cost estimate for original bill which previously called for HSD to *establish* CETs:
BHSD estimates the five-year pilot as described in HB222 and associated evaluation would cost $7.6 million over 5 years. This would include funding for community engagement team operations at several pilot sites across the state for five years, the required 24-hour hotline with clinician support, BHSD oversight, and the required evaluation and reporting.

	FY2016 (Planning)	FY2017	FY2018	FY2019	FY2020	FY2021
CETs – Five sites across the state at $225,000 per site		$1,125,000	$1,125,000	$1,125,000	$1,125,000	$1,125,000
24 Hour Hotline with Clinician		200,000	200,000	200,000	200,000	200,000
BHSD staff position, (1FTE pay band 70)	$65,000	65,000	65,000	65,000	65,000	65,000
Evaluation and Reporting	35,000	110,000	110,000	110,000	110,000	110,000
Total	**100,000**	**1,500,000**	**1,500,000**	**1,500,000**	**1,500,000**	**1,500,000**

SIGNIFICANT ISSUES

HB 222 would make BHSD responsible for administering the CET program. This has important benefits. HSD's Centennial Care has new care coordination services and Medicaid expansion will address many recipients' need for help in linking to services. The CET's work with existing Centennial Care and BHSD care coordination efforts will be critical to ensure consumers receive comprehensive services and coordination is provided effectively.

BHSD is the state mental health authority and with the Medical Assistance Division oversees all public community-based behavioral health services in the state. Most services CETs would link individuals to are administered in the public networks. The BHSD statewide network of Core Service Agencies (CSAs) provide comprehensive BH services designed to meet the needs of individuals with serious mental illness and substance use disorders. Existing CSA efforts to outreach and engage individuals in treatment could be strengthened if specific appropriations were made available for that purpose. HSD would have a direct role in administering the program to ensure the CET's work is not duplicative of Centennial Care's care coordination services or the CSAs services and targets those most in need.

In 2014, BHSD established and circulated recommended standards for establishing CETs which could be incorporated into the CET pilot project as described in this bill. The standards include guidance regarding proposed outcomes with clear metrics for pilot evaluation, specified criteria to identify the population for inclusion and exclusion for the pilot, and defined parameters for effective operations, such as specified and engagement roles for CET members.

OTHER SIGNIFICANT ISSUES

DOH notes that Community engagement teams, or "collaborative care," has been shown to meet standards set by the U.S. Department of Health and Human Services' Community Preventive Services Task Force (thecommunityguide.org) to be effective in achieving clinically meaningful improvements in depression outcomes and public health benefits in a wide range of populations, settings, and organizations; and to provide good economic value in terms of reduced healthcare utilization and enhanced productivity through randomly-controlled trials (Thota et al., "Collaborative care to improve the management of depressive disorders: a community guide systematic review and meta-analysis," 2012; Jacob et al., "Economics of collaborative care for management of depressive disorders: a community guide systematic review," 2012).
In addition, randomly-controlled trials have demonstrated the effectiveness of collaborative care

to improve the outcomes of patients with bipolar disorder and anxiety disorders (Woltmann et al., "Comparative Effectiveness of Collaborative Chronic Care Models for Mental Health Conditions Across Primary, Specialty, and Behavioral Health Care Settings: Systematic Review and Meta-Analysis," 2012). In New Mexico in 2013, 12.2 percent of respondents to the Behavior Risk Factor Surveillance System screened positive for frequent mental distress. In the same year, there were 10,956 hospitalizations for mental disorders. The evidence referenced above indicates that these numbers would be decreased by the implementation of community engagement teams in New Mexico**.**

HSD provided an extensive summary regarding potential issues related to specific provisions of the bill:

- **Section 2C:** statutory language establishes the purposes of the CET program to include "lessen the duration and severity of mental illness of persons with serious mental illness who are unlikely to live safely in the community through early detection and targeted intervention." HSD notes there is no research or information that CETs are effective in "lessening the duration and severity of mental illness;" however, this appears to contradict the evidence cited above by DOH.
- **Section 4E:** makes clear that CETs are not intended to be a treatment provider but are instead intended to function as a link to services. While the work of CETs may lessen the duration of the immediate crisis, it is unlikely they will lessen the severity of serious mental illness. Early detection and early intervention are services provided by community behavioral health providers that are funded and overseen by Medicaid and BHSD. Statutory intent statements that the CET Program will "lessen the duration and severity of mental illness" could be misleading and the reference to severity could be deleted from the bill. Again, this may contradict the evidence cited above by DOH.
- **Section 3J:** the bill adds the definition of "unlikely to live safely in the community." To better focus the work of the CETs, the definition should be modified to specify that this mental distress or deterioration should be "due to serious mental illness." The definition as written could include people without serious mental illness and those without current mental distress or deterioration. Many individuals experience severe mental distress and deterioration due to other factors such as family violence, substance abuse and poverty. Also, individuals who experience mental distress or deterioration may eventually recover completely.
- **Section 3H:** the bill defines qualified mental health professional; however, the list of professionals includes some professionals that are not necessarily behavioral health professionals and leaves out others who are qualified to practice behavioral health services. BHSD recommends the definition require that a qualified mental health professional be licensed for independent practice of behavioral health services by the respective boards. However, despite HSD's comments, the bill's definition clearly states a person, "who by training and experience is qualified to work with persons with a mental disorder or illness."
- **Section 4D:** the bill adds a requirement that each CET include "at least one peer who lives with a mental illness." This provision is unclear and would be strengthened by requiring the "peer" be a certified peer support specialist (SPSS). A CPSS must be in recovery and complete special training. BHSD currently certifies peer support specialists to provide services under the Medicaid program. The certification ensures the individual has had an appropriate term of recovery, has appropriate training and supervision and passes a background check.

- Under existing law, mental health evaluations are voluntary except in very narrow circumstances. In contrast, HB 222 would authorize a team of BH professional to seek out individuals and evaluate their mental health and likelihood of survival in the community. The CET is to make "reasonable efforts" to engage the individual voluntarily in treatment. The bill does not clarify the standard to trigger a CET evaluation and who would authorize it.
  - There are a variety of operational and privacy concerns about which HB 222 is silent but could be clarified in rules governing the program. It does not clarify what authority the team would have to approach individuals in unannounced visits to their home, community or workplace. It does not clarify whether the individual has the right to refuse CET services and does not address how CET services would be provided in tribal jurisdictions.
  - The literature on engagement of people with mental illness, including the Institute of Medicine's report on quality in mental health treatment, describes effective engagement as turning on the relationship between a person with a mental illness and either a treating clinician or a peer. HB 222 is silent on the relationship between a CET team and any existing service provider or agent named in an advance directive or the terms of such directives.
- **In Section 8, BHSD has several concerns:**
  - Subsections H. and I. would require BHSD to appoint a performance improvement committee to develop policies and procedures for the evaluation of the Community Engagement Team Pilot Project. HSD has two concerns with the composition and the duties of the advisory committee: 1) the committee composition is insufficiently composed of members with professional or personal experience with crisis services or behavioral health, and 2) the duties of the committee include activities that are inappropriate for an advisory committee and instead are the responsibility of executive agencies.
  - In subsection H., the requirements for the performance improvement committee facilitator are very narrow and appear to single out one entity as eligible. Broadening the requirements for this position would give BHSD flexibility to choose the most appropriate facilitator.
  - In subsection I., BHSD suggests adding in the committee's required members representation of a community based behavioral health provider, a certified peer support specialist (explained above), and (not or) a family member of an individual with serious mental illness.

RELATIONSHIP

SB 53 is related to HB 222; however, SB 53 provides for assisted outpatient treatment which is defined as categories of outpatient treatment ordered by a district court (services provided by CETs as described in HB 222 are not court-ordered). As provided in SB 53, a court must order case management or assertive community treatment services where assertive community treatment services is a new term defined in SB 53 as a team treatment approach designed to provide comprehensive community-based psychiatric treatment, rehabilitation and support to a person with a serious and persistent mental illness.

TECHNICAL ISSUES

HSD notes that in Section 7, the words "health care" should precede "provider" for purposes of

confidentiality requirements.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Core service agencies funded by BHSD will continue to support the recovery of people with serious mental illness who live in communities across New Mexico. Individuals would continue to receive behavioral health services voluntarily unless they meet the standard for court-ordered treatment.

CEB/je/bb/aml/je/bb/je/bb/je