LFC Requester:	Eric Chenier

AGENCY BILL ANALYSIS - 2025 REGULAR SESSION

WITHIN 24 HOURS OF BILL POSTING, UPLOAD ANALYSIS TO
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(Analysis must be uploaded as a PDF)

SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Date Prepared: *1/16/25* *Check all that apply:*
Bill Number: *SB2* Original _ Correction __
Amendment __ Substitute _X

Sponsor: Sen. Shendo, Sen Munoz
Short Title: Public Health and Safety Appropriations

Agency Name and Code Number: HCA-630
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SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY25	**FY26**		
~~$73,000.0~~ (HCA only) $115,200.0	~~$73,000.0~~ (HCA only) $115,200.0	Recurring	State General funds

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY25	**FY26**	**FY27**		
$0	$0	**$0**	Recurring	State General funds

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
BHSD	$287.1	$1,148.4	$1,148.4	$2,583.9	Recurring	BHSD GF

MAD	$0.0	$2,723.6	$2,723.6	$5,447.2	Recurring	MAD GF
MAD	$0.0	$2,723.6	$2,723.6	$5,447.2	Recurring	MAD FF

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to:
Duplicates/Relates to Appropriation in the General Appropriation Act

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis: This bill creates $140.0 million in general fund appropriations for public health and safety initiatives for the following departments (HCA appropriations highlighted in blue):

- Section 1: an appropriation of $1.7 million to the Administrative Office of the Courts for regional planning, statewide mapping, and to certain courts and associated programs and services.
- Section 2: an appropriation of $7.0 million to the Administrative Office of the Courts, for judicial district grants, to implement the regional plan and case management.
- Section 3: an appropriation of $10.0 million to the Health Care Authority to implement the regional plan that includes outpatient treatment.
- Section 4: an appropriation of $43.0 million to the Health Care Authority for transitional acute care facilities.
- Section 5: an appropriation of $7.5 million to the Health Care Authority for the implementation of the regional plan, for crisis response facilities.
- Section 6: an appropriation of $1.3 million to the Corrections Department to implement the regional plan for support for discharged persons.
- Section 7: an appropriation of $5.0 million to the Department of Public Safety to implement the regional plan for crisis response and recovery and an appropriation of
- Section 8: an appropriation of $11.5 million to the Health Care Authority for the implementation of the regional plan, for the crisis response and recovery teams.
- Section 9: an appropriation of $1.0 million to the Health Care Authority for education and outreach.
- Section 10: an appropriation of $2.0 million to the Department of Public Safety to implement the regional plan for crisis intervention and response.
- Section 11: an appropriation of $1.0 million to the University of New Mexico for health outreach to homeless persons.
- Section 12: an appropriation of $1.0 million to the Department of Health for outreach to homeless persons.
- Section 13: an appropriation of $48.0 million to the Department of Finance and Administration to implement the regional plan and expansion of certain housing services.
- Section 14: an appropriation of $3.0 million to the Health Care Authority for 988 911 Coordination
- Section 15: an appropriation of $9.0 million to the Health Care Authority for Behavioral Health Patient Navigation
- Section 16: an appropriation of $1.0 million to the Legislative Finance Committee for Behavioral Health Audits and Evaluation
- Section 17 an appropriation of $9.0 million to the Department of Health for Suicide Prevention
- Section 18: an appropriation of $6.0 million to the Public Education Department for

Suicide prevention Youth Behavioral Health.

- Section 19: an appropriation of $1.8 million to the UNM Board of Regents for Project Echo
- Section 20: an appropriation of $200.0 thousand to the Health Care Authority for initiate the planning, coordination and behavioral health standards in accordance with the Behavioral Health Reform and Investment Act.
- Section 21-23: An appropriation of $30.0 million to the Health Care Authority for Certified Peer Support over three fiscal years
- The effective date of the provisions of Sections 1 through 10, 14 through 16 and 20 through 23 of this act is contingent upon Senate Bill 3 or similar legislation of the first session of the fifty-seventh legislature becoming law.
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Amendments 2/12/25 as pertaining to HCA

Page 1 Adds language declaring an emergency in the title.
Section 1 clarifies fiscal expenditure years to be 2025-2029 and amends to revert remaining balance to the behavioral health trust fund rather than general fund and throughout bill.

Section 4 Amends header from Acute Care to Behavioral Health Facilities.

Section 5 adds language to include behavioral health care providers able to receive crisis response funds for 24-hour emergency facilities.

Section 7B Amends language appropriating $2.5 million to HCA for the purchase of equipment and vehicles.

Section 8 adds language allowing appropriations to be utilized to support existing co-response models to transition to federally recognized mobile crisis team models to obtain Medicaid reimbursement and to be used for federally recognized mobile crisis team models to obtain Medicaid reimbursement.

Section 8 amends language stating “Not more than five million five hundred thousand dollars ($5,500,000) may be used by state agencies for regional mobile crisis and recovery response, intervention and outreach teams”

Section 10 Amends language appropriating $2.0 million form DPS to HCA, and HCA to collaborate with DPS on crisis intervention and response.

Section 14 Adds language appropriating $3.0 million to HCA for 988-911 coordination.

Section 15 Adds language appropriating $9.0 million to the HCA to expand patient navigation to behavioral health service through no-wrong door approach, YES-NM customer portal, closed loop referral.

Section 21-23 Adds language appropriating $10.0 million for FY26, FY227, and FY8 for certified peer support services.

Section 23 amends language for clarity stating which sections are contingent on SB1 and 3 becoming law.

Section 25 add the Emergency language.

FISCAL IMPLICATIONS

As written, it is difficult to determine the fiscal impact to HCA and the exact staffing level to implement the bill. After considering the operating and fiscal impacts of three proposed behavioral health-focused bills (SB 1- Behavioral Health Trust Fund, SB 2- Public Health and Safety Initiatives, and SB 3- Behavioral Health Reform and Investment Act) the HCA Behavioral Health Division estimates it would need a minimum estimate of twenty-two (22) FTE, resulting in $2,690,500 total SGF annually for salaries and benefits.

Specifically, as it relates to SB 2 implementation, HCA estimates a minimum of ten (10) FTE, resulting in $1,148,400 SGF annually for salary and benefits as illustrated in the table above. These 10 FTE would include 6 social community service coordinators, one financial analyst, one economist supervisor and two data analysts to implement the activities outlined in the bill. Additional, existing, BHSD staff would engage in training and outreach on available housing resources; support the dissemination of the behavioral health investment request for applications as this would expand the behavioral health investment zones to 16 additional providers, outreach and education for tribal communities and collaboration about specialized behavioral health services, expansion of crisis services, contracting and allocation of the funds and reconciliation of appropriation accordingly.

Detailed discovery sessions would be required to estimate IT costs associated with creating a service delivery continuum and an application process for regional grants specified in the bill.

The bill does not optimize, leverage, or reinforce coordination with the Medicaid program as the primary payor of behavioral health services for New Mexicans, foregoing millions in federal matching funds and risking greater service fragmentation. The proposed framework does not fully consider the crucial opportunity of Medicaid in drawing down $3.40 for each General Fund dollar spent. To do this, services must be evidence-based, documented, and correctly billed by an enrolled provider. The HCA suggests language in the bill to clarify whether this would be an expectation of the funded regional plans.

The listed agencies may not be able to efficiently maximize federal monies available through CMS or the state general fund dollars for indigent care assigned to BHSD leading to delays in funding or implementation of programs due to administrative issues. To realize federal Medicaid dollars with another agency, that agency works with Medicaid each time there is a change to service coverage, details, rates and beyond in addition to the fiscal transfers needed; this can create a burden on two agencies (or more) versus with the HCA that covers this today.

New Mexico Medicaid is the largest payor of behavioral health services wherein the balance of coverage is through the indigent pool (including individuals that do not qualify for Medicaid) overseen by BHSD using the provider network. Creating different pools of funding sources may lead to additional burdens on providers and duplication of programs and funding streams. This would increase the administrative work on providers that will impact their ability to treat additional New Mexicans.

The Medical Assistance Division (MAD) estimates required general fund for 13 FTE and contract costs. Since the bills will likely result in expanded Medicaid reimbursable services, FTE will be needed as program managers for implementation and oversight of expanded services, MCO

monitoring and oversight, and increased data and KPI analysis and reporting. This bill will require significant initial and ongoing coordination of the administrative office of the courts related to the Medicaid Managed Care Services Agreement, Managed Care Medicaid Provider Network and scope of Medicaid Services. This bill will also require MAD to process and coordinate requests for the Managed Care provider network related to the sequential intercept mapping of this bill. The total FTE cost is $1,447,200 with a general fund cost of $723,600.

HCA contractors would need to verify whether regional models of Medicaid-reimbursable services conflict with current actuarial methodologies, and/or propose methodologies to ensure grant recipients reinforce the program as the primary payor of BH services. MAD estimates increasing the scope of contractual services would cost $4,000,000, as these costs are matched at 50% the cost to the GF would be $2,000,000.

SIGNIFICANT ISSUES

Section 8: Appropriates $11.5 million to the HCA but also limits $5.50 million to be used by state agencies. The language is unclear on the limitation of the $5,500.0 million. Clarity is warranted.

Section 14 or anywhere else in the bill does not have an appropriation for 988 contact center costs. The current contract budget is $9.6 million of which $5.9 million is supported by a one-time appropriation. Recurring stable funding is needed for continued operation of the states only 988 crisis response contact center.

As written, this bill would fragment the behavioral health system with funding and oversight accountability allocated to multiple agencies.

The bill appears to completely restructure the state's behavioral health delivery system, transferring control and funding to the courts and local governments with few guardrails. As New Mexico's Single State Authority (SSA), the Health Care Authority Behavioral Health Services Division (HCA BHSD) oversees the adult behavioral health system including programming, funding for patient services and rulemaking. A state's single-state behavioral health authority plays a crucial role in the mental health and substance use treatment landscape, wielding significant influence and responsibility within the state and are designated to give behavioral health providers a single source of guidance and expertise.

Recognized by the federal government, these authorities are designated to oversee and coordinate behavioral health services within a state. This recognition allows them to access federal funding, grants, and technical assistance crucial for supporting mental health and substance use programs within their state. SSAs are responsible for a variety of critical functions designed to promote behavioral health access and quality for residents. For example:

- SSAs develop and implement policies that guide behavioral health services across the state, ensuring alignment with federal guidelines and state-specific needs.
- SSAs coordinate the delivery of mental health and substance use services, ensuring accessibility, quality, and integration across various providers and settings.
- SSAs manage state and federal funds allocated for behavioral health services, ensuring efficient use and compliance with financial regulations.
- SSAs monitor and improve the quality of behavioral health services through data analysis, performance evaluation, and implementing evidence-based practices.
- SSAs oversee crisis intervention and emergency mental health services, ensuring readiness and effective response during emergencies.

- SSAs collaborate closely with other state agencies, healthcare providers, community organizations, and advocacy groups to create a comprehensive behavioral health system that meets the diverse needs of the population.
- SSAs advocate for individuals with mental illness and substance use disorders, representing the state's interests in national discussions on behavioral health policy and funding.

The Behavioral Health Services Division (BHSD) has subject matter expertise to provide guidance and accountability for the network. BHSD together with the Medical Assistance Division (MAD) within the HCA team ensure that managed care organizations and providers are accountable to New Mexicans whereas other agencies listed in the bill have neither this infrastructure (e.g. provider network, care coordination) nor federal authority.

As written, this bill would further dilute the accountability of services provided by clinicians and timeliness of payments by managed care organizations. It could be that the bill is intended to increase access to behavioral health care across New Mexico as well as address the transportation requirements for mobile crisis teams and crisis response services statewide. Additionally, many of the provisions listed in this bill would require significant changes to NMAC, the overall structure of service delivery, and billing procedures. Another potential fragmentation is the progress made on integrated health wherein there is now further distance from primary care to behavioral health.

Additional clarity regarding the following provisions are advised:

- Section 1: The proposed legislation assigns a non-judicial function to the Administrative Office of the Courts.
- Section 1: Appropriation to the Administrative Office of the Court (AOC) for judicial grants. As the SSA, HCA BHSD should have input into the distribution of these funds to ensure that the office of the courts aligns with all categories of specialized behavioral health services, NMAC 8.321.2.
- Section 1: Tasking AOC to create another set of behavioral health regions may be a duplication of efforts. NMAC 7.21.3 established the Behavioral Health Collaborative and regional local collaboratives which may do similar tasks as outlined in this bill. Further NMAC 7.21.2 establishes the standards of delivering behavioral health services.
- Section 3: As written, the section emphasizes outpatient treatment. This should include non-acute residential treatment, which would include step-down services.
- ~~Section 4, Line 17: Language "municipality with state institution of higher education" requires that the transitional acute care facilities be in municipalities that with a state institute of higher education would limit the areas where these facilities could be located. This is not a current requirement of these facilities.~~ Acute Care facilities was amended to behavioral health facilities.
- ~~Section 5: As written, this section may create a more fragmented crisis system. Expanding Certified Behavioral Health Clinics (CCBHCs) in established regions may be more effective as CCBHCs are required to have crisis response services in place 24/7. CCBHC establishment and expansion is already in progress within the HCA~~. Amended language to include behavioral health care facilities which would expand CCBHC.
- Section 6: Unknown impact to Medicaid 1115 Re-entry Waiver. The project parameters of Section 6 would make disbursement of the funds in FY 25 difficult.
- Section 7: Funding outlined in this section may be more suitable for the HCA as BHSD has established Crisis Intervention Services, NMAC 8.321.2.19, outlining criteria,

guidance and certification of crisis services. HCA can consult with the Department of Public Safety (DPS) to establish co-response model criteria. HCA can work with said entities to purchase equipment and vehicles.

- Section 10: Funding outlined in this section may be more suitable for the HCA as the HCA has authority for crisis intervention and response.
- Section 11, 12, 13: These sections could include language to collaborate with HCA on the implementation of services to align with BHSD's mobile crisis response, medication-assisted treatment, health outreach to homeless persons, and supportive housing services.

PERFORMANCE IMPLICATIONS

It is unclear who would have primary oversight and accountability for the state's behavioral health system under the proposed framework. Though the HCA would officially remain the designated Single State Authority, it appears the HCA may take on a newly diluted role under the proposed framework, with authority for the state's behavioral health system largely shifting out of the agency and moving to the courts and local governments.

The HCA supports the involvement and engagement of the courts, state agencies, and local governments in behavioral health planning and strategic execution. However, without clarification of the respective roles, responsibilities, functions, authorities, and points of accountability of the entities involved it is unclear how the bill will improve patient outcomes.

This bill will have several performance implications for the SSBHA and Medicaid Managed Care Organizations (MCOs), and Medicaid Fee-for-Service. These implications will center around the monitoring and reporting of key performance indicators (KPIs) to ensure the funds are used effectively and that services are delivered efficiently and equitably across the state. Specifically, there are significant reporting requirements on access to care, quality outcomes and more to both state and federal partners currently required, including but not limited to:

- Utilization of services
- Access to services
- Treatment outcomes
- Provider performance
- Integration of behavioral health and physical health services
- Behavioral health spending
- Network adequacy
- Member satisfaction

State and federal partners outline and require significant reporting on access to care, quality outcomes, etc. This bill, as written, may dilute or impact the data and will increase monitoring and evaluation. While positive to have increased monitoring and evaluation, if too many items are measured simultaneously, the ultimate burden is felt by the provider. Like quality oversight, the provider, having several state agencies to answer to and contract with can create undue administrative burden and confusion. Increased confusion and administrative burden on providers can lead to a decrease in performance and/or capacity reducing the availability of appointments for New Mexicans.

ADMINISTRATIVE IMPLICATIONS

BHSD would need significant staff time and effort to disseminate these funds by June 30, 2026, and this may not be achievable in this timeframe. Additionally, leveraging federal Medicaid matching funds takes months of negotiation with the US Centers for Medicare and Medicaid

Services, and it may not be possible to leverage all possible federal dollars by June 30, 2026.

The administrative implications of this proposal on the HCA span financial management, policy development, service coordination, compliance, and reporting functions. Much of these functions are those the HCA BHSD and MAD currently perform for other initiatives (e.g. fund administration, budgeting and allocation, monitoring and utilization, stakeholder engagement, regulatory compliance), but the HCA will need additional staffing capacity to expand and/or coordinate these efforts.

There are some states that have regional models for behavioral health through county-organized health systems and regional Medicaid managed care organizations, which New Mexico does not currently utilize. It appears that the bills may be trying to replicate these other state models, rather than building on the foundation that exists in New Mexico today. The HCA does not believe that the AOC and local governments currently have the organizational capacity, staffing, infrastructure, and expertise to execute programs and regional plans in the way that the legislative package envisions. To be successful, there would need to be substantial investment in local governments, the establishment of a clear structure with well-defined accountability and stated expectations for expending funds, coordinating programming, collecting data, and reporting outcomes at the local/regional level. While a few local governments in urban parts of the state stand out as having robust community health systems, this is not uniformly true across New Mexico today.

The establishment of such a regionalized service delivery system will significantly alter the statewide current contracting and structure. Specifically, to best coordinate and oversee delivery of services across a new regional framework and to build a complete service delivery continuum will require a clear organizational structure for managing regional service providers, implementing regional planning processes, and ensuring that services are consistent across different geographic areas.

HCA would need to expand staffing support an application process to award regional specific grants, applications process and allocation of funds, oversee the funds and expenditures, and gather and report data on the impacts to the potential increase in behavioral health services and supports.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

Relationship to:

SB 3- Behavioral Health Reform and Investment Act
SB 1- Behavioral Health Trust Fund

TECHNICAL ISSUES

Define transitional acute care facilities.
Define outpatient treatment.
Define crisis response facilities.
Define Crisis response and recovery teams.
Define how the regions would be composed.
Define Equipment (Section 7).
Define Housing (Section 13)

OTHER SUBSTANTIVE ISSUES

The HCA is the largest payor of behavioral health care in NM. HCA Medicaid is the payor of behavioral health services for the Medicaid eligible population, and HCA BHSD is the payor of behavioral health services for the uninsured individuals and those ineligible for Medicaid.

Together, these two HCA Divisions finance more than 90% of behavioral health care expenses in NM in FY25. This better integrated financing structure was made possible by the passage of the 2014 Federal Patient Protection and Affordable Care Act.

Medicaid pays for the Medication Assisted Treatment for the Medicaid eligible population. The proposed legislation is unclear if any additional appropriation is given to non-Medicaid, uninsured population to BHSD.

According to a 2023 analysis, people with mental illness are more likely to be a victim of violent crime than the perpetrator. Additionally, not all individuals needing access to behavioral health services perpetrate violence. The most important and independent risk factor for criminality and violence among individuals with mental illness is a long-term substance use disorder. In patients with major psychiatric illness, comorbid substance use disorder, there is a four-fold increase in the risk of committing a crime or violence. Studies have shown that the rise in violent crime committed by individuals with mental illness, may entirely be accounted for with a history of alcohol and/or drug use.

ALTERNATIVES
None

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
Status Quo

AMENDMENTS
None