LFC Requester:	Rachel Mercer-Garcia

AGENCY BILL ANALYSIS - 2025 REGULAR SESSION

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SECTION I: GENERAL INFORMATION

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

Date Prepared: *3/12/25*

SB42SUBJU

Check all that apply:

Original _ Correction __

Amendment __ Substitute x__

Sponsor: Sen Padilla

Short Title: NEW CARA PROGRAM REQUIREMENTS

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**		
$0.0	$0.0	N/A	N/A

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY25	**FY26**	**FY27**		
$0.0	$0.0	$0.0	N/A	N/A

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
HCA Medicaid Care Coordination	$0.0	$3,881.8	$3,880.4	$7,762.2	Recurring	GF
HCA Medicaid Care Coordination	$0.0	$9,815.5	$9,816.8	$19,632	Recurring	FF
HCA Medicaid SBIRT	$0.0	$36.1	$36.1	$72.2	Recurring	GF
HCA Medicaid SBIRT	$0.0	$91.2	$91.2	$182.4	Recurring	FF
HCA MAD Program Staff	$0.0	$108	$108	$216	Recurring	GF
HCA MAD Program Staff	$0.0	$108	$108	$216	Recurring	FF
FIT Program	$0.0	$878.8	$878.8	$1,757.6	Recurring	GF
FIT Program	$0.0	$2,222.0	$2,222.0	$4,444.4	Recurring	FF
BHSD SBIRT Training	**$0.0**	$8,162.5	$0.0	$8,162.5	Recurring	GF
Medicaid Home Visiting	$0.0	$1,530.4	$1,530.4	$3,060.8	Recurring	GF
Medicaid Home Visiting	**$0.0**	$3,869.6	$3,869.6	$7,739.3	Recurring	FF
HCA total	**$0.0**	**$30,346.9**	**$22,541.5**	**$52,888.4**	**Recurring**	**GF/FF**

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to: Not known
Duplicates/Relates to Appropriation in the General Appropriation Act: Not known

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis:

An act relating to the child safety welfare act; enhancing the State program administered pursuant to the Federal Comprehensive Addiction and Recovery Act of 2016; moving the program from the Children Youth and Families Department (CYFD) to the Department of Health (DOH); amending requirements for the Plan of Safe Care (POC); and providing for rule making.

- Defines Comprehensive Addiction and Recovery Act (CARA) of 2016 that establishes a comprehensive, coordinated and balanced strategy for substance-exposed newborns and those newborn's caregivers, through enhanced grant programs that expand prevention and education efforts while promoting treatment and recovery.
- Defines the plan of safe care as a written plan created by a health care professional intended to ensure the immediate and ongoing safety and well-being of a substance-exposed newborn or to provide perinatal support to a pregnant person with substance use disorder
- Defines substance-exposed newborn as an infant under the age of one who has been prenatally exposed to a controlled substance, including misuse of a prescribed or non-prescribed drug or alcohol, that may affect the infant's health or development
- Defines birthing facility as a hospital, clinic or birthing center where a pregnant person gives birth to a baby with assistance from a health care provider
- Defines a CARA Navigator as a professional employed by the DOH to provide intensive case management to a pregnant person with SUD or a substance-exposed newborn and parents
- Defines a Care Coordinator as a person assigned to a substance exposed newborn and the parents, relatives, guardians or caretakers by the Managed Care Organization (MCO), private insurance or the Health Care Authority (HCA)
- Defines MCO as a person or entity eligible to enter into risk-based capitation agreements with the HCA to provide health care and related services
- Defines the duties of CARA Navigator as it relates to the development and follow-up on existing plans of safe care.
    - Arrange a home visit and complete the family assessment
    - Updates to the plan of safe care
    - Connect newborns and families to services

- ~~Adds the requirements for a family assessment to be prepared by the CARA Navigator during a home visit with the CARA infant's parents, relatives, guardians or caretakers.~~
- Adds the requirement that by July 1, 2026, the DOH, in consultation with the office of the superintendent of insurance, the HCA and CYFD shall develop rules to guide birthing facilities, medical providers, MCOs and private insurers in the care of pregnant persons with SUD
- Speaks to the necessity for ongoing interaction between the CARA Navigator, the MCO Care Coordinator and the CARA Member
- ~~Speaks to processes to manage non-compliance of plan of care. The department will be notified within three business days of non-compliance and shall proceed with an investigation should the following occur:~~
    - ~~Refusal to engage in a family assessment conducted by a CARA Navigator~~

- ~~Disengage with a CARA Navigator when the family assessment indicates failure to engage with services will result in risk of imminent harm~~
- ~~Failure to comply with a plan of safe care.~~

- Adds requirements for the HCA:
  - Ensure at least one care coordinator available at every birthing facility
  - Ensure all substance exposed newborns who have a (plan of safe care) POSC are assigned a Care Coordinator
  - Provide training to birthing facility staff and perinatal health care providers on screening, brief intervention and referral to treatment program SBIRT
  - Develop a training process for a birthing facility or health care provider to participate in the development of the POSC at a perinatal medical visit
  - Require the birthing facility to participate in the discharge planning process including the creation of the POSC prior to discharge and requires the POSC to be sent immediately to DOH
  - Require the POSC be signed by the discharge facility and at least one of the infant's parents, relatives, guardians, custodians, or caretakers
  - Requires a referral in the POSC to an early intervention family infant toddler program (FIT) or home visiting program
  - Ensure contact and demographic information for the infant and parent/guardian are included in the POSC
  - Requires an assessment to determine the infant will have a safe living environment

FISCAL IMPLICATIONS

Note: The bill does not include any new appropriations.

The bill creates a need to add ~~one~~ two FTE's for HCA Quality Assurance Specialists to manage requirements ~~as it relates~~ related to updating rules, training facilities and providers on development of POCs, collaborating with DOH, CYFD, MCO and ECECD to develop training for hospitals and providers on the development and management of the plan of safe care, and the work necessary to implement, monitor compliance, and provide oversight of updated activities involving care coordination provided by the Medicaid Managed Care Organizations, and provider training and implementation of SBIRT assessment, at a cost of ~~one~~ two FTE's is ~~$107.9~~ $216 (dollars in thousands) per year with 50% Federal Match at ~~$53.95~~108 (dollars in thousands).

Note: Ongoing budgetary impact of ~~$107.9~~ $52,888.4 is based on the annual totals of providing the required FIT and SBIRT training and assessments as directed in the bill and Care Coordination Services for an estimated annual number of 900 CARA infants and pregnant persons identified as having SUD. The cost includes training for providers and hospital staff to conduct and bill for SBIRT assessments. In addition, the cost includes CARA infants and parents participating in one of the 5 Medicaid approved Home Visiting Models. The cost of training and administration of SBIRT assessments includes services across 35 hospitals, 3 birthing centers, and 739 QB/GYN and Midwife providers.

The state general fund for FIT services is supported by the Early Childhood Education and Care Department, so an additional appropriation would be required to support the additional FIT services without impact to the HCA budget.

SIGNIFICANT ISSUES

The role of the regulatory agency, specifically the Division of Health Improvement (DHI), as written is inconsistent throughout the bill. Page 15 describes the need to develop rules that guide the facility on best practices. It is unclear whether or not there is intention to have enforcement of those rules as requirements that must be complied with or if the bill is purely asking for best-practice document to be created by the HCA that is not a requirement for compliance. Additionally, these best practices point towards the need for a medical provider to develop which is not the role of the Division of Health Improvement. If the bill intends to enforce these best practices, the guidelines must be written as specific requirements in order to enforce compliance, optional guidelines are not enforceable. Substantial changes to the NMAC 8.370.12 would need to be made. The ability to have oversight of such practices would only occur on a complaint-driven basis, meaning validation of these practices could be completed if a complaint was submitted to the DHI by a constituent.

Requirements outlined on pages 18 and 19 would require a rule change of NMAC 8.370.12 and also need to avoid conflict with the Center for Medicare and Medicaid Services (CMS) 482.43 Condition of participation: Discharge planning. Section c on page 18 outlines the requirement for the HCA to provide training to birthing facility staff and perinatal health care providers on the screening, brief intervention and referral to treatment program and this expertise does not currently exist within the DHI. Again, these requirements in this bill are presented more as best practices and not regulations, which serve a different purpose than enforcement of rule that NMAC 8.370.12 and CMS 482.43 accomplish.

PERFORMANCE IMPLICATIONS

Will increase the amount of required collaboration between CARA Navigators and MCO Care Coordinators and therefore will create need for updates and changes to processes, management and oversight of the Medicaid Managed Care Organizations MCOs by HCA staff.

The additional requirements for FIT and SBIRT assessments could potentially result in assessment fatigue for parents and guardians of CARA infants resulting in disengagement in participation in the programs offered for CARA infants and families.

ADMINISTRATIVE IMPLICATIONS

None noted by HCA.
No IT impact.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

There is a relationship between this bill and HB343 and HB171 and HB205

TECHNICAL ISSUES

The proposed bill creates an opportunity to require increased and mandatory intercommunication between CYFD, DOH and HCA, to allow for a quality review of the processes, initiate process improvement updates if indicated and to mitigate further risk.

OTHER SUBSTANTIVE ISSUES

- The definition for birthing facilities does not define a facility as a licensed birthing facility
- The requirement to conduct SBIRT assessments more than clinically indicated will result in the inability to draw Federal funding resulting in providers not be compensated for assessments completed in excess of what is considered medically necessary

- The references to Care Coordinator and activities that need to be completed by a Care Coordinator within the bill indicates the need for a Care Coordinator to be employed by DOH, HCA and MCO's. Native American individuals with Medicaid have a choice of Fee-For-Service or Managed Care as required; a distinction is that Fee-For-Service does not have care coordination in the model. In any case there may be both a financial and workforce concern in meeting the requirements.

ALTERNATIVES
None**.**

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
The proposed bill creates improvements in defining responsibility and accountability. If not enacted, it means continuation of current processes where lack of definition creates confusion and disorganization when it comes down to accountability and responsibility.

AMENDMENTS
None at this time.