LFC Requester:	Scott Sanchez

AGENCY BILL ANALYSIS - 2025 REGULAR SESSION

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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: *3/3/25*
Bill Number: *SB54*

Check all that apply:
Original __ Correction __
Amendment __ Substitute _x

Sponsor: Sen. Duhigg
Criminal Justice Changes

Short Title:

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**		
None	None	N/A	N/A

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY25	**FY26**	**FY27**		
None	None	None	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
Total	$0.0	$3382~~2,303.1~~ - $4,303.1	$3382~~2,303.1~~ - $4,303.1	$6764~~4,606.2~~ - $8,606.2	Recurring	SGF

(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: Senate Bill 54 (SB54) relates to public safety, establishes new funds, and proposes a coordinated multi-agency approach to addressing behavioral health issues that impact public safety and corrections statewide to include workforce development, in-service training, system-wide behavioral health standards of care, data collection management and utilization, to target law enforcement resources, crisis intervention, law enforcement deflection, medical treatment, intervention, pre-trial diversion, post-incarceration re-entry programs, and the creation of a statewide plan for community-based crisis intervention.

Senate Bill 54 Substitute relates to public safety; preserves the intent of the original 60-page measure to propose a coordinated multi-agency approach to addressing behavioral health issues that impact public safety and corrections statewide (NMLR Analysis). Two significant changes in the substitute bill occur in Sections 6 and 25. The substitute bill removes key language relating to the New Mexico Sentencing Commission's roles and responsibilities (Section 2), as well as removing the Jail Reentry Fund. Section 15 adds new language relating to "preprosecution diversion programs." and incorporates a new definition for "behavioral health crisis" within the context of providing a temporary provision for the statewide plan for a community-based crisis treatment system and tasks HCA with administering a newly created creating the clinical supervision fund.

FISCAL IMPLICATIONS

In FY2021-FY2025 the Health Care Authority (HCA) supported six Law Enforcement Assisted Diversion (LEAD) programs. Outcomes demonstrated that programs of this scope require significant pre-planning of 1-2 years before implementation depending on specific community readiness. It takes an additional estimated 2-3 years for program outcomes to be appropriately evaluated. The HCA's annual costs for each program ranged from $250,000 - $500,000 per program. The average program cost results in $375,000 per program. Statewide program costs are estimated to be up to $12,375,000 annually. Estimates are informational purposes [only] based on HCA's experience of costs and service delivery; should an appropriation be made for the Law Enforcement Deflection programs.

The HCA has expertise in implementing the type of program proposed in Section 14. ~~28 and 29~~. It would be important for HCA to collaborate with the Department of Public Safety (DPS). HCA would require ~~2~~3.0 FTE program coordinators (pay band 70) and 1 FTE supervisor (pay band 75) for a total cost of $411,000 ~~$303,100~~ in salary and benefits. These 3 BHSD and 1 MAD FTE would collaborate with DPS to train their staff on the crisis continuum of care and ensure that HCA's strategic plan to build up Certified Community Behavioral Health Clinics (CCBHC), Crisis Triage Centers (CTC), and Mobile Crisis Teams (MCT) aligns with the requirements in SB54. These staff would also promulgate state rules around Medication Assisted Treatment, CCBHCs, CTCs and MCTs which could take more than a year.

SIGNIFICANT ISSUES

~~Section 2.D.14 would expand the New Mexico Sentencing Commission (NMSC) role to assume identical functions currently tasked to HCA. The bill, as written, would task NMSC to establish a workforce capable of delivering the array of services listed in this section. HCA estimates that NMSC would require a minimum of 3 FTE: a supervisor, program coordinator and administrative staff to implement required tasks. Costs related to this staffing are unknown as NMSC is not a state agency and may not utilize the same pay band structure. NMSC currently utilizes Crime Reduction Act funds estimated at $4,000,000. The funds provide funding awards to Criminal Justice Coordinating Councils (CJCC) by the judicial district. These awards enable communities to provide services more in line with the mission of NMSC and enable synergy between state agencies, rather than duplication of efforts as proposed in SB54.~~

Section 2.D(14) is removed. The Commission is no longer tasked with coordinating reentry efforts for persons released from prison and detention centers; fostering collaboration and communications among stakeholders working on reentry issues; and establishing minimum standards for reentry, behavioral health continuum of care, housing and basic needs.

Section 6.A does not state an appropriation to the HCA for the "medication-assisted treatment for the incarcerated program fund". It is estimated a minimum of $2,000,000.-$4,000,000. may be needed in the first year of funding, although this estimate is an arbitrary amount to some degree as it is difficult to calculate actuals because the type, frequency and dispensing practices of medication assisted treatments are varied and influenced by county, program protocols, personnel staff requirements, access to services, diversion precautions, withdrawal management services and outreach and education. Cost would likely increase proportionally in subsequent years.

Section 6. B would require HCA to promulgate rules, "...for the operation of medication-assisted treatment programs in correctional facilities...". However, In August 2024, the promulgation of rules was formalized by HCA in NMAC 8.325.12 relative to Medication Assisted Treatment (MAT) and Mediations for Opioid Use Disorder (MOUD) in state correctional facilities. It is unclear if the substitute bill is seeking new rules specific to county detention centers or presumes the existing rules (NMAC 8.325.12) can be amended to meet the substituted bill's expectations. In either scenario, additional time, as much as one year or more, beyond the proposed timelines of the substitute bill would be necessary.

Section 6.D(2) seeks to remove a timeline already established in NMAC 8.325.12. Further, it does not clarify if a replacement date is to be established, or if the proposed language would take effect on July 1, 2025. In either case, the new language proposed in Section 6.D.2-6 conflicts with NMAC 8.325.12.9A-C.

Section 6.D(6) states, "ensure a continuum of behavioral health care between county detention facilities and the correction department, including the continuation of any medication-assisted treatment medications". However, at present there are some county detention centers that do not offer treatment services thus making it difficult to fulfill this proposed mandate.

Section 6.E describes medication-assisted treatment utilization data to be reported to HCA. However, it is unknown if the county detention centers have the capacity to report this data, and what mechanisms would be needed to support the scope of this request.

Section 6.F requires "each county detention facility" to establish and operate a medication-assisted treatment program as described in Section 6.F.1-5. A program of this scope would require rules to ensure appropriate implementation. NMAC 8.325.12 was not written with county detention centers

in mind because the initial legislation that mandated the creation of NMAC 8.325.12 did not clearly define correctional facility to include "county detention centers".

While this substituted bill seeks to correct certain definitions (per proposed Section 6.H.1). County Detention Centers would be unable to provide the operational structure equivalent to those identified in NMAC 8.325.12. For example, any medication assisted treatment program in a county detention center must account for the variable of unpredictable release dates; whereas state correctional facilities have prescribed release dates that can be taken into consideration when developing treatment protocols.

Section 6G makes county detention facilities responsible for reporting barriers and resolutions without providing a timeline for these facilities to assess their capacity to implement a medication-assisted treatment program to identify barriers or necessary resources.

~~Section 7A-17-23 appears duplicative of current funded and potential services for the HCA. SB54 directs medication assisted treatment (MAT) funds to be used for any county delivering MAT services. HCA's Reach, Intervene, Support and Engage (RISE) program currently supports this function within county specific parameters, and the 1115 re-entry waiver will be structured to support MAT services for participating counties.~~

~~Section 7A does not state an appropriation to the HCA from the "medication assisted treatment for the incarcerated program fund".~~

~~Section 7B HCA promulgated rules for MAT/MOUD in state correctional facilities. It's unclear if the legislation is seeking amendment to existing rules or new rules for county correctional facilities. If a set of new rules is the expectation, the due date of December 1, 2025, does not support the time necessary to appropriately bring together the required workgroup and complete the promulgation process.~~

~~Section 15~~ Section 14 describes the creation of a Law Enforcement Deflection Program and states "funded by state and federal grants (Section 14.A)". It is unclear what state agency would receive and administer these funds, or how they would be awarded. HCA currently allocates $1,000,000 SGF to deliver pre-arrest/deflection programs to execute community-based programs that are like those described in section ~~15. B-D~~ Section 14.B-E. A Request for Application (RFA) for these services is slated to be released by HCA for FY2026.

Section 15.A expands eligibility for a pre-prosecution diversion program and grants authority to the district attorney to determine an individual's likelihood to benefit from such a program. This language presents as granting unilateral decision-making to one individual, without consultation by other key court staff, such as pretrial services, hearing officer or a judge.

~~Section 27 refers to the Reach, Intervene, Support and Engage (RISE) program and currently provides reentry services for participating counties, if counties choose to utilize this model. Many RISE programs are unable to use community services due to limited access. Language in SB54 does not detail how access to services would be bridged through the reentry fund. State correctional facilities have robust reentry services for individual returning to local communities.~~

Section 26 provides for Clinical Supervision Fund and the eligibility criteria to access the funds, and makes HCA responsible for administering the fund. However, as NM Regulation and

Licensing Department determines the criteria upon which a person can become a clinical supervisor, they are best positioned to administer the fund.

~~Section 29~~ Section 27 new language is incorporated into the bill to provide that if a peace officer or mental health professional has probable cause to believe that a person is experiencing a behavioral health crisis and the person voluntarily consents to treatment, the peace officer may resolve the intervention by directly transferring the person to: (1) a state-licensed community treatment provider, a hospital, a certified community behavioral clinic, a crisis triage center, an approved treatment facility offering detoxification services for chemical dependency emergencies, an emergency department or other approved treatment provider that specializes in behavioral health responses; or (2) a public or private community service that the person is willing to accept (NMLR Analysis).

Section 27 HCA has a current statewide plan to establish the crisis continuum of care (including the 988 crisis call center that refers people to Certified Behavioral Health Clinics (CBHC), Crisis Triage Centers (CTC), and Mobile Crisis Teams (MCT). It should be noted that these service sites can also receive referrals from other community stakeholders and individuals. HCA oversees the certification and approval for specialized behavioral health services as alternatives to inpatient residential care and provides services to individuals in crisis. HCA would need to update these processes to ensure activities align with the work of other agencies listed in the bill if SB54 is implemented. HCA identified areas of the state that could support multiple CCBHCs due to the number of individuals in that community with mental health and substance use needs. HCA is ensuring that all crisis service providers are collaborating to ensure seamless provision of services. HCA identified existing barriers for rural counties and established goals, objectives and priorities for crisis services across the state. HCA established methods to evaluate service effectiveness which will be reported at the end of calendar year 2025. HCA and the 988-call center have established agreements to ensure that Managed Care members have a referral point for follow up by their MCO, and the 988-call center also deploys mobile crisis teams that are being developed statewide.

HCA has oversight of 8.321.2 NMAC specialized behavioral health services for Medicaid enrolled mobile crisis teams that consist of a behavioral health clinician and certified peer support worker. Medicaid does not pay for co-response models that include law enforcement officers. HCA is partnering with law enforcement to collaborate with mobile crisis teams that are approved by the HCA and can bill Medicaid for the provision of mobile response. HCA issued Final-LOD30-CCBHC-Demonstration-Implementation-002.pdf to the Managed Care Organizations and a provider supplement Supplement-24-22-CCBHC-providersupplement_AH11.11.24_v3.pdf for CCBHCs that will be incorporated into the NMAC in 2025. These LODs and supplements lay out care coordination, data collection and reporting requirements for CCBHCs.

HCA has also issued an Final-LOD-20-Mobile-Crisis-Intervention-Mobile-Response-and-Stabilization-Services.pdf October 4, 2024to the MCOs and provider supplement October 7, 2024 Supplement-24-14-Final-Mobile-Crisis-Provider-Supplement.pdf with guidance on service provision and billing for Mobile Crisis Teams. HCA is the recipient of enhanced federal funding of up to 81%, for CCBHC services under a 4-year demonstration program. CCBHC services include crisis stabilization, mobile crisis services and collaboration and partnership with law enforcement and other key safety, social, health providers within their catchment areas.

PERFORMANCE IMPLICATIONS
SB54, Section ~~7~~ 6 identifies tasks that remain unclear as to whether a new set of rules will be required, or amendment of existing rules. If new rules are required, the due date of December 1, 2025 does not support the time necessary to appropriately bring together the required workgroup and complete the entire promulgation process. If an amendment to the existing rules is expected, the date of December 1, 2025 does not support the promulgation process to include public comment.

SB54 Section ~~29~~ 27 would require significant time and effort for our staff to collaborate with the Department of Public Safety (DPS), the HCA Department of Health Inspection (DHI) that licenses Crisis triage centers, and to update our Crisis Services Strategic plan to ensure that all requirements outlined in SB54 are met by June 30, 2026.

Over the past two years, HCA built its Crisis Services Strategic plan which includes applying for and being accepted into the CCBHC demonstration with 10 other states nationwide to ensure federal funding. This also includes the year it took to create and hire the crisis services team. HCA will need more than a year to ensure that all areas required in Section 29 are accomplished.

HCA would also need additional funding to pay for services to the non-Medicaid population that as some individuals do not qualify for Medicaid (35% of the state's population). HCA would need to build crisis services payment mechanism for the non-Medicaid population through the Administrative Services Organization contract.

HCA would also need to collaborate with 911 staff to ensure that there is a warm handoff for calls between 911 and 988. HCA would also need to collaborate with DPS for their alternative response units and align the training for Mobile Crisis Teams received for HCA approved MCTs and the training that law enforcement alternate response teams to respond to individuals with mental health or substance use crisis.

ADMINISTRATIVE IMPLICATIONS
HCA estimates that the agency designated to implement the Law Enforcement Deflection Program would benefit from HCA expertise, however, these positions would need to be created in order meet the demand of expansion and collaborate with other state agencies. There are time barriers to the creation, recruitment and onboarding of these positions.

HCA program coordination for all required activities in the bill include RFA development, policy and procedure development, technical assistance to awardees, training, data collection, reporting, contracting, site visits, quality service review and all associated operational tasks. Supervision would include collaboration with leadership, quarterly reporting, employee oversight, and support during legislative session.

~~The new Medical Assistance Division (MAD) Medicaid 1115 Waiver for Justice Involved Re-entry services for incarcerated Medicaid members up to 90 days prior to release is companion work to the HCA RISE program. The Justice re-entry program focuses on transition- related strategies to support community reentry and improve care transitions for incarcerated Medicaid members. Medicaid reimbursement for 1115 Waiver services is slated to be implemented July 1, 2025.~~

SB54 Section 2.D(14) states that the NM Sentencing Commission shall create and maintain a data-sharing network to receive, store, analyze and disseminate criminal justice data for and between

participating criminal justice and behavioral health agencies for the purpose of evaluating local and statewide criminal justice systems and programs and supporting, encouraging and accomplishing information sharing among criminal justice agencies and criminal justice coordinating councils. HCA will need detailed requirement-gathering meetings with the Commission to be able to estimate the parameters, format, cost, and timeline of providing data to the Commission.

~~The bill also states that HCA shall promulgate rules for the operation of medication-assisted treatment programs in correctional facilities in consultation with the corrections department, county corrections administrators, and providers who specialize in substance use disorder treatment and have experience working in correctional settings.~~ Each correctional facility shall track and report data on medication-assisted treatment utilization to the health care authority. Detailed planning will be necessary to determine the way that data will be submitted by the correctional facilities to the HCA; IT costs and timeline will not be known until such planning is completed. HCA would also need to promulgate regulations for CCBHCs based on LOD 30 and the provider supplement which can take more than a year.

SB 54 Section ~~29~~ would take time and effort for HCA Crisis Services team to collaborate with DPS, HCA DHI, to update our crisis service strategic plan and align the 911 and 988 call centers to ensure that those calling 911 for mental health and substance use related concerns are transferred to the 988-crisis call center. This would also require HCA staff to collaborate with the MCOs to ensure that their membership has access to care coordination and services available statewide including CCBHCs, CTC, and that 988 can dispatch mobile crisis teams. SB 54 would also require funding for those individuals who do not qualify for Medicaid which is about 35% of the population and then HCA would need to build these funds into the non- Medicaid fee schedule.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
None

TECHNICAL ISSUES
Pages 36-54 involves changes to the Criminal Procedure Act, beginning with the Definitions section (Sec. 31-1-2), which has been changed to remove definitions for a "person in crisis," "behavioral health crisis," "law deflection program," mental health professional," and "validated risk and needs assessment," that were in the original bill. However, each of these terms is reintroduced into the bill in greater detail in new sections of the Criminal Procedure Act. The definition for "Encounter of a Person in Crisis" that was in the original measure is no longer in the substitute version (NMLR Analysis).

At p.54, new to the bill is a lengthy Definitions section from the Mental Health and Developmental Disabilities Code, Sec. 43-1-3, which has been incorporated into the substitute in order to establish a definition for "mental health disorder" by simply changing the term "mental disorder" to "mental health disorder" without changing the existing statutory definition: "mental health disorder means substantial disorder of a person's emotional processes, thought or cognition that grossly impairs judgment, behavior or capacity to recognize reality, but does not mean developmental or intellectual disability." (NMLR Analysis).

At p.60, and new to the bill, is the inclusion of Sec. 43-1-10 with (1) a new title, Emergency Mental Health Evaluation and Care and Interactions with Persons Experiencing a Behavioral Health Crisis; (2) the insertion of the phrase "behavioral health crisis," and (3) authority for a peace officer to detain and transport a person for emergency mental health evaluation and care in the absence of

a legally valid order from the court if the peace officer, based upon the officer's own observation and investigation, has reasonable grounds to believe that the person "is experiencing a behavioral health crisis" and presents a likelihood of serious harm to that person's self or to others and that immediate detention is necessary to prevent such harm (NMLR Analysis).

The same foundational rationale is extended to (1) a physician, psychologist or qualified mental health professional licensed for independent practice who is affiliated with a community mental health center or core service agency; and (2) an evaluation facility for an emergency-based admission when presented with such a person who, as a result of a mental health disorder, presents a likelihood of serious harm to that person's self or to others and that immediate detention is necessary to prevent such harm (NMLR Analysis).

Section 26 A "fully licensed" individual does not fully define who may become an approved clinical supervisor. This role is defined by the NM Regulation and Licensing Department. Please refer to clinical supervision section in nmrecovery.org (https://nmrecovery.org/resources-2#clinical).

~~Section 7.G.2~~ Section 6.H(2) as written does not align with clinical standards or SAMHSA definitions of MAT/MOUD (https://www.naco.org).

Section 7.C adds "licensed clinical social worker or licensed counselor", but Section ~~9.A.20~~ 8.A leaves the title of "a licensed independent social worker;" and does not define "a licensed clinical social worker". These licensures are not interchangeable. A Licensed Clinical Social Worker (LCSW) is the current and applicable designation for delivery of these services. Definition of Licensed Counselor is ambiguous. A Licensed Professional Clinical Counselor is the current designation for these services. Section 9.A.20 and 21 identifies LISW. This designation is not interchangeable to a Licensed Clinical Social Worker (LCSW) which is the more current and applicable designation for delivery of these services. Definition of Licensed Counselor is ambiguous. A Licensed Professional Clinical Counselor is the current designation for these services.

Section 13.M adds a definition of "mental illness" without distinguishing for "serious mental illness" which is specific to schizophrenia, severe bipolar disorder, and major depression and typically warrants specialized treatment plans to those of individuals with a "mental illness".

OTHER SUBSTANTIVE ISSUES

~~Consider whether HCA Jail Reentry Fund (Section 27) dollars might be leveraged to obtain Medicaid FFP for justice related services.~~

ALTERNATIVES

None suggested

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Status quo

AMENDMENTS

New language in Section 6 and 25 significantly impacts the HCA analysis.