

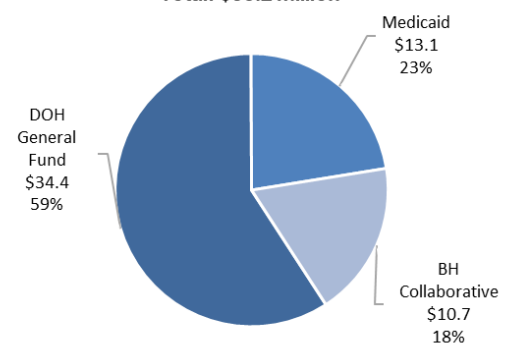
## Cost, Use and Effectiveness of Inpatient Behavioral Health Services for Adults

### AT A GLANCE

Hospital inpatient and residential behavioral health services for adults are at the top of the behavioral health care continuum. For some people these services offer the critical highest level of care and are the safety net between them and personal disaster. For others, inpatient or residential treatment is less effective, often something they seek only because they are unable to access more appropriate services from an outpatient program or provider in their community, or because they have been court-ordered into treatment. Despite varying effectiveness and persistent challenges to measuring outcomes, inpatient and residential services are the most expensive behavioral health services, with high per person costs. Because so few of these services for adults are covered by Medicaid, most of the costs are paid for with state general fund dollars.

Of the total \$58 million spent on these services in 2017, over \$34 million came from the general fund budgets of the Department of Health's behavioral health facilities. The New Mexico Behavioral Health Institute (NMBHI), the New Mexico Rehabilitation Center (NMRC) and Turquoise Lodge Hospital reported combined FY17 operating costs of \$39.8 million, and total reimbursements from Medicaid and other insurance of about \$5.4 million, leaving the remaining \$34.4 million to be covered by general fund. Medicaid paid \$13.1 million in psychiatric hospitalization costs in 2017; most of the utilization came from the Medicaid expansion population. The last major payor for this set of services is the Behavioral Health Collaborative, which reimbursed \$10.7 million of hospital and RTC costs in 2017.

**Chart 1: 2017 Inpatient and Residential Behavioral Health Spending**  
Total: \$58.2 million



The relatively small number of New Mexicans accessing hospital inpatient psychiatric and residential treatment services should not disguise the importance of the subject. Most people with mental illness will never need inpatient treatment. But access to inpatient treatment is critical for some. Individuals with chronic acute psychiatric illness are a particularly vulnerable population whose illness often poses barriers to employment and stable housing. Failure to provide the services needed by this population can have consequences that reverberate throughout New Mexico's social, economic, justice and educational systems.

Historically federal laws and regulations have placed strict limitations on Medicaid's coverage of inpatient behavioral health services for adults. More recently, as a result of the establishment of mental health parity laws and in response to the opioid epidemic sweeping the nation, Congress and the Centers for Medicare and Medicaid Services (CMS) have begun to consider relaxing those limits. New Mexico's Centennial Care 2.0 (CC 2.0) waiver renewal is still pending CMS approval, but holds great promise for expanded coverage of behavioral health services – particularly for treatment of substance use disorders – all along the continuum of care. For adult inpatient behavioral health, CC 2.0 will bring Medicaid coverage of accredited adult residential treatment centers and an extension of coverage for services received in psychiatric hospitals. Other CC 2.0 changes should make the outpatient levels of care just below hospitalization, including partial hospitalization and intensive outpatient programs, more robust, allowing more New Mexicans to find the care they need without having to resort to hospitalization.

**Health Notes** are briefs intended to improve understanding of healthcare finance, policy, and performance in New Mexico.



## Hospital Inpatient Mental Health

In New Mexico, hospital inpatient psychiatric and mental health services are provided by the Department of Health's three mental health facilities, the state's four private psychiatric hospitals, and the psychiatric units of 12 general and acute care hospitals.

An IMD is a hospital, nursing home, or other residential treatment facility with the primary purpose of treating individuals with mental diseases, though it may also offer medical and nursing care. New Mexico's four private psychiatric hospitals and three DOH behavioral health facilities are IMDs.

The New Mexico Rehabilitation Center and Turquoise Lodge Hospital provide hospital-based behavioral health services. They are classified—and reimbursed—by Medicaid as IMDs. This report focuses on their inpatient detox and substance use disorder treatment programs, although both also provide some physical and mental health care. Because of these factors, they are included in the hospital discussion of this brief.

There are similarities between hospital-based inpatient mental health services and the services provided by residential treatment centers, and there are also important differences. In New Mexico, hospital mental health inpatient services are provided by the Department of Health's (DOH's) three mental health facilities, the state's four private psychiatric hospitals, and the psychiatric units of 12 general and acute care hospitals. All of these hospitals provide acute psychiatric care, but most of the general hospitals only offer substance abuse disorder (SUD) detox and/or rehabilitation services when they are co-occurring with a psychiatric condition.

Medicaid has historically covered very few inpatient mental health services for adults, primarily limited to acute or emergency situations where hospitalization is medically necessary. The limitations have extended to the setting of care as well, prohibiting services delivered in an institution of mental disease, or an IMD. An IMD is a hospital, nursing home, or other residential treatment facility with the primary purpose of treating individuals with mental diseases, though it may also offer medical and nursing care. Initial Medicaid legislation excluded all IMD services for all populations except adults over 65 years old; subsequent changes allowed coverage for inpatient psychiatric treatment for children under 21, and for services received in IMDs with fewer than 17 beds. New Mexico's four private psychiatric hospitals and three DOH behavioral health facilities are IMDs.

Driven by the national opioid addiction crisis, the Center for Medicare and Medicaid Services (CMS) has recently taken steps to make IMDs more accessible, but only to individuals with substance use disorders. CMS has adopted the principle that substance abuse disorders (SUDs) are primary, chronic diseases that require long-term treatment and carry the inherent risk of relapse. To address the pressing national need for SUD services, which is particularly pronounced among Medicaid recipients, the agency has opened two routes states can follow to add IMD coverage to their Medicaid programs.

The first route allows states to include IMD services in their Section 1115 waivers through SUD service delivery transformation projects. To receive CMS approval, the projects must be designed around the American Society of Addiction Medicine (ASAM) levels of care for adult SUD detox and ensure access to a wide array of evidence-based SUD services. Known as the ASAM pyramid, services build up from the lowest level, outpatient detoxification, through intensive outpatient and partial hospitalization programs, into four levels of residential treatment involving increasing degrees of medical management, and culminating in short-term inpatient stays in hospital and IMD settings.

In 2016, CMS provided additional IMD options for states when it issued new rules for Medicaid managed care. States have always had the option to offer some services "in lieu of" other services available under their state plans, as long as the new services are cost effective and medically appropriate. The new managed care rule extended that category to include up to 15 days per month of psychiatric or SUD inpatient or crisis residential services received in an IMD.

New Mexico's Human Services Department has taken action on both these fronts. Under the 2016 rule change, HSD sent a letter of direction to the Medicaid man-

aged care organizations (MCOs) directing them to pay for inpatient medical detoxification services, for no more than 15 days, at Turquoise Lodge Hospital and other Department of Health IMDs. The department also included coverage for both mental health and SUD provided by IMDs in its CC 2.0 waiver renewal, where it proposed to extend the 15 day limit to 30 days and offer the same coverage to the fee for service population. The CC 2.0 application is still under CMS review, and HSD has reported that working out the details of IMD coverage is one of the areas under discussion. The key question for CC 2.0 is CMS's preference for allowing waivers to cover only IMD SUD services. CMS has already denied requests from several other states to cover mental health services in IMD settings, and appears likely to deny HSD's request as well.

A key question for CC 2.0 is CMS's preference for allowing waivers to cover only IMD SUD services. HSD initially proposed coverage for both mental health and SUD, but CMS has denied similar requests from other states.

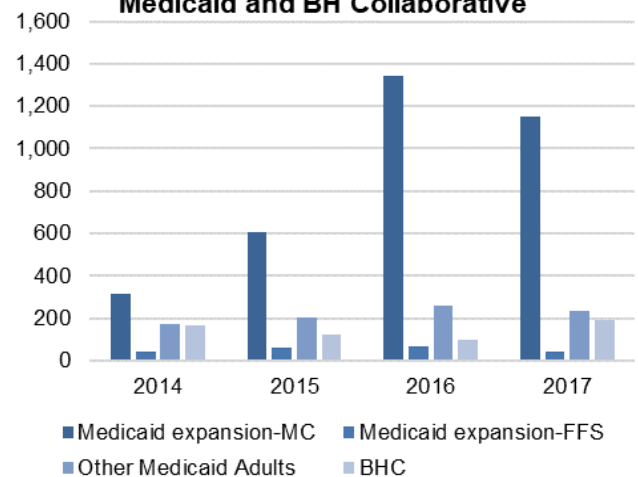
HSD's CC 2.0 implementation plan (currently undergoing a rewrite after the department received CMS comments) lays out the department's plan for its SUD demonstration project and identifies current state coverage and future plans for each ASAM level, including medically supervised withdrawal management, short-term inpatient or residential treatment, intensive outpatient program (IOP) treatment, medication-assisted treatment (MAT), care coordination, and aftercare supports for long-term recovery such as transportation, employment, housing, and community and peer support services. The focus on evidence-based treatments such as IOP and MAT are an important advance for SUD treatment in the state. Numerous LFC reports have recommended the state invest more in IOP, one of the few demonstrably effective treatment protocols for individuals with substance use disorders. Medication assisted treatment (MAT) uses counseling in combination with medications such as methadone, buprenorphine, or suboxone, and is widely considered to be the standard of care for sustained SUD recovery.

### Hospital inpatient costs and utilization

Hospital inpatient psychiatric treatment is, ideally, the apex of a full continuum of care, utilized only by individuals in acute crisis or who have persistently severe chronic mental health conditions. The stronger and more complete the continuum is, the more likely many – if not most – individuals in need of services are to be able to access those services at an earlier stage and avoid hospitalization. In New Mexico, rising utilization and costs for publicly-funded hospital inpatient psychiatric services are driven on one hand by Medicaid expansion and improved access to services, and on the other by the persistence of well-known gaps in the state's behavioral health system. In addition, the largest portion by far of the increase in Medicaid spending in this category is for the expansion population; without Medicaid expansion, the general fund spending by the DOH facilities would be higher, and much of costs elsewhere would be borne by the hospitals as uncompensated care with at least some portion reimbursed through the Medicaid safety net care pool.

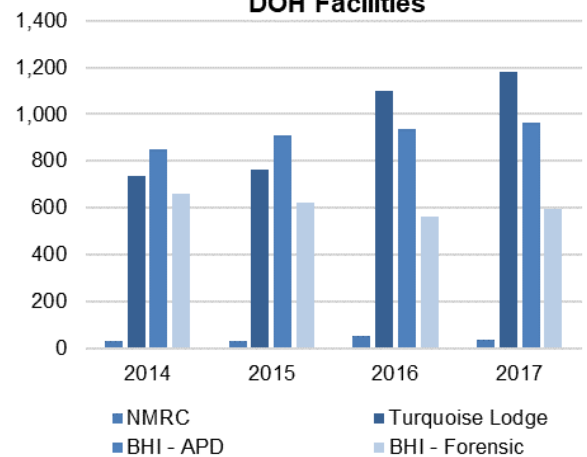
That said, and despite a 48 percent increase between 2014 and 2017, the number of adults using these services remains relatively

**Chart 2: Hospital Inpatient Clients - Medicaid and BH Collaborative**



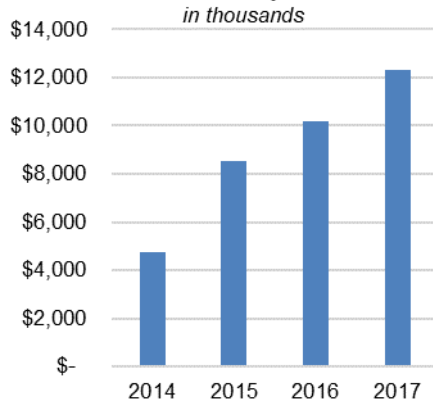
Source: HSD and BHC encounter and claims data

**Chart 3: Hospital Inpatient Clients - DOH Facilities**



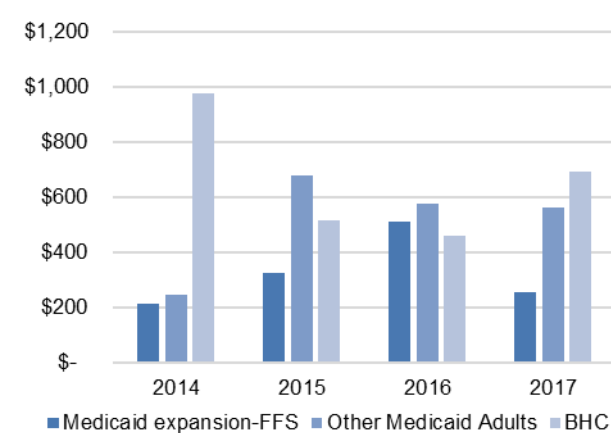
Source: DOH facilities

**Chart 4: Hospital Inpatient Costs - Managed Care Medicaid Expansion**



Source: HSD encounter data

**Chart 5: Hospital Inpatient Costs - Other Medicaid and BH Collaborative**



Source: HSD and BHSD claims data

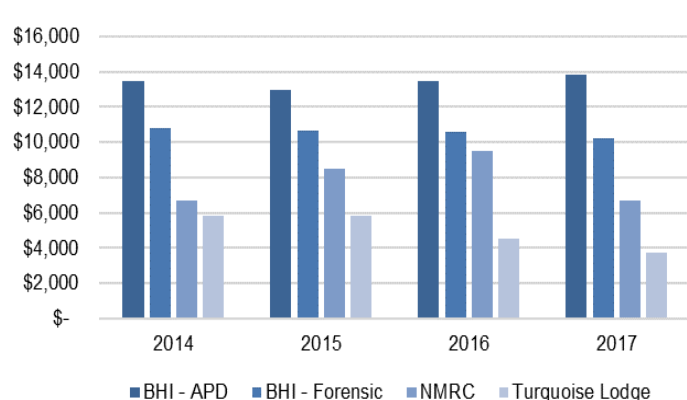
Hospital inpatient spending for managed care Medicaid expansion increased by 159 percent from 2014 to 2017. The growth largely follows rising enrollment, and the fact that costs have risen more slowly than utilization indicates that HSD is achieving efficiencies in managing this part of the program.

small, approximately 4,000 in 2017. For all Medicaid categories combined, about 530 people used mental health hospital inpatient services in 2014, rising by 263 percent to just over 1,400 in 2017. BHC covered 165 clients in 2014, a number that decreased each subsequent year until rising to 191 in 2017. Costs and utilization for each of the DOH facilities are discussed in greater detail later in this report; in brief, all but the forensic unit at NMBHI have seen double-digit increases in the number of clients using services. The total number of people accessing services through Medicaid, the collaborative and the DOH facilities is difficult to calculate because there is a degree of duplication, as people may move on and off Medicaid – and therefore on and off BHC eligibility – or receive services at a hospital prior to being transported to BHI.

For all the years covered by this study the diagnoses for people using inpatient psychiatric hospitalization services were primarily bipolar disorder, psychosis, schizophrenia, and depression and other mood disorders.

Between FY14 and FY17 costs for the individual DOH facilities either declined or held relatively flat; cumulative costs were about \$36.7 million in FY14, dropping 6 percent to \$34.5 million by FY17. Chart 6 represents these general fund costs to the state by deducting total reimbursements received by the hospitals from Medicaid, Medicare and other sources from the facilities' total operating costs. Hospital inpatient spending for managed care Medicaid expansion, by far the largest portion of the Medicaid spend, increased by 159 percent from 2014 to 2017, from \$4.7 million to \$12.3 million. The growth largely follows rising enrollment, and the fact that costs have risen more slowly than utilization indicates that HSD is achieving efficiencies in managing this part of the program. In 2017, spending for the other Medicaid adults and BHC together totaled about \$1.5 million, as increased costs for Medicaid adults was offset by decreasing BHC spending.

**Chart 6: Hospital Inpatient Costs After Reimbursements - DOH Facilities**



Source: DOH facilities



## Survey of available hospital-based inpatient resources

According to the 2018 State of Mental Health in America, nearly 20 percent of New Mexican adults have a mental illness, higher than the national average of 18 percent. New Mexico also ranks higher than the national averages for adults with unmet mental health needs, lack of mental health treatment, and serious thoughts of suicide. It isn't possible to know from these statistics how many New Mexicans will have conditions acute enough to need hospitalization, but the fundamental need to maintain adequate bed capacity for individuals who experience a psychiatric crisis should be clear. On the other hand, how many beds are enough is uncertain: the Treatment Advocacy Center (TAC) notes that the most commonly cited benchmark for an adequate supply of *state operated* psychiatric beds – including any 24 hour beds, in hospitals and residential treatment facilities – is between 40 to 60 beds per 100,000 people, but also notes that there is scant evidence to validate the target. The TAC estimate focuses on state operated beds because many patients ill enough to need inpatient services lack the financial resources or job stability to have health insurance. In New Mexico, state run hospitals may still be an important part of the network of care for behavioral health, but since passage of the Affordable Care Act and Medicaid expansion, they are no longer the only option for people who cannot afford private insurance.

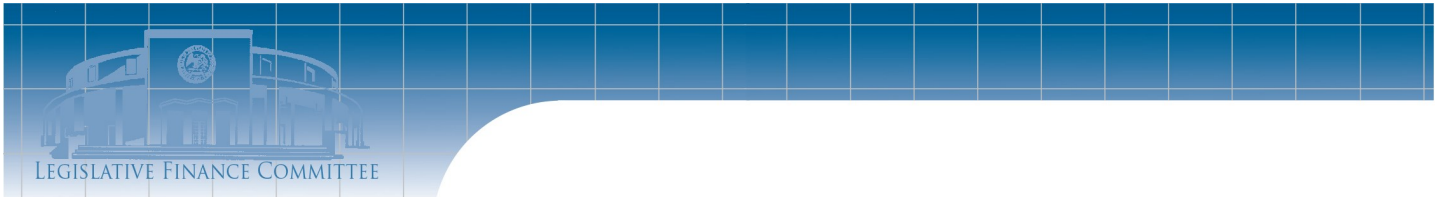
Statewide, New Mexico currently has 40 operational hospital psychiatric and mental health beds per 100,000 people, roughly 34 per 100,000 in the northern portion of the state and 47 per 100,000 in the south. Combined with residential treatment beds (discussed in more detail below), the statewide number improves to just over 61 inpatient beds per 100,000 people. Hospitals distinguish between licensed beds and operational beds based on hospital priorities, and staffing and financial resources, so operational beds is a more accurate measure of true availability than licensed beds. Available beds, of course, are not the only – or even the best – measure of access, they are just one standard way of assessing resources. Access may still be limited by a number of factors: patients must meet the medical necessity criteria for inpatient care, the hospital may not accept the patient's insurance or Medicaid, beds are not distributed equally around the state, and even operational beds can fluctuate depending on immediate staffing and on current patients. One hospital reported to LFC staff that it was currently holding half its beds empty due to the high acuity among the existing patients.

Hospital licensing data reports only licensed beds, and the New Mexico Hospital Association assisted LFC staff with gathering information about operational and adult/pediatric beds by distributing a survey to its members. Only 13 hospitals responded to the survey, and additional information was drawn from publicly available sources.

Of the 51 general and specialty hospitals in the state, 14 have designated psychiatric or mental health beds and five are psychiatric hospitals; together, they have a combined 840 operational psychiatric beds, or about 17 percent of total operational hospital beds. About 150 of the operational psychiatric beds are dedicated specifically for children or adolescents, and the actual number of beds available for psychiatric patients is likely somewhat higher, since many hospitals provide acute psychiatric care without necessarily designating beds as such. Nursing homes also provide inpatient psychiatric services, although they are out of the scope of this brief. Ten of the hospitals are located in the northern portion of the state, seven in Albuquerque alone, representing 64 percent of all operational psychiatric

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beds. The other nine hospitals are in the southern half of the state and have about 36 percent of psych beds; when the 84 forensic unit beds at NMBHI are removed from the calculation, that portion increases to 40 percent. (See Appendix A for a map of hospitals with psychiatric and mental health beds.)

**Table 1: New Mexico Hospital Psychiatric and Mental Health Beds, 2018**

Hospital	Location	Licensed Beds	Operational Beds	Licensed Psych and MH Beds	Operational Psych and MH Beds
Artesia General Hospital	Artesia	49	34	15	15
Central Desert Behavioral Health Center	Albuquerque	26	26	26	26
Christus St. Vincent Regional Medical Center	Santa Fe	200	192	11	11
Eastern New Mexico Medical Center	Roswell	162	162	25	25
Gerald Champion Regional Medical Center	Alamogordo	100	100	38	24
Gila Regional Medical Center	Silver City	68	42	10	10
Haven Behavioral Hospital of Albuquerque	Albuquerque	48	34	48	34
Lea Regional Medical Center	Hobbs	186	179	20	20
Lovelace Medical Center	Albuquerque	263	263	44	21
Memorial Medical Center	Las Cruces	199	199	0	12
Mesilla Valley Hospital	Las Cruces	88	88	88	88
New Mexico Behavioral Health Institute	Las Vegas	213	180	213	180
New Mexico Rehabilitation Center	Roswell	43	34	28	24
Peak Behavioral Health Services	Santa Teresa	119	88	88	88
Presbyterian Kaseman Hospital	Albuquerque	85	56	46	45
San Juan Regional Medical Center	Farmington	194	184	13	13
Turquoise Lodge Hospital	Albuquerque	40	32	40	32
University of New Mexico Hospital	Albuquerque	527	527	91	82
VA Medical Center Hospital	Albuquerque	310	310	90	90
<b>Subtotal</b>		<b>2,920</b>	<b>2,730</b>	<b>934</b>	<b>840</b>
Total beds from non-psychiatric hospitals		2,239	2,165	0	0
<b>Total</b>		<b>5,159</b>	<b>4,895</b>	<b>934</b>	<b>840</b>

\* NMBHI beds are adult psychiatric and forensic divisions  
Source: NMHA; DOH; NMBHC website, VA website

## State-Operated Behavioral Health Hospitals

The Department of Health provides hospital-based inpatient and residential behavioral health services at three facilities: the New Mexico Behavioral Health Institute (NMBHI), the New Mexico Rehabilitation Center (NMRC), and Turquoise Lodge Hospital. Between them, they have 236 beds and account for 28 percent of the operational inpatient mental health beds in the state. As noted above, the DOH facilities reported total reimbursements from Medicaid, Medicare and other insurance of about \$5.4 million for FY17, leaving about 86 percent of their combined operating costs of \$39.8 million to be paid for out of the department's general fund budget. Some of the gap is due to Medicaid coverage limitations, but some also appears to be due to the variable capacity – and determination – of the facilities to bill Medicaid appropriately. Each facility is discussed in more detail below.

**The New Mexico Behavioral Health Institute (NMBHI) is the largest psychiatric inpatient hospital in the state; in 2017 average costs per non-forensic client stay at the facility were over \$20 thousand.** Located in Las Vegas, NMBHI has 213 licensed adult psychiatric beds; 180 are currently operational. The adult psychiatric division (APD), with 96 operational beds, provides acute and extended care services for individuals who arrive voluntarily as well as for those who are court-ordered; the population is primarily composed of people who have been found to present a likelihood of harm to themselves or others and are sent to NMBHI for 7 day emergency mental health evaluations or 30 day civil court commitments. Many of these individuals are transferred from other hospitals, since NMBHI, as a public facility, is required to accept them. Clients often have a co-occurring substance use disorder, but APD is not licensed to provide medical detox services. NMBHI reports that due to time to transport, many individuals arrive at the hospital already having undergone detox, one way or another.

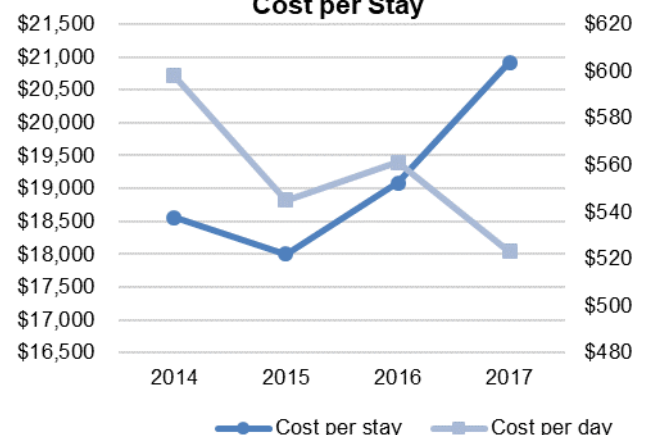
Since 2014, the adult psychiatric division (APD) has increased its Medicaid reimbursements by 101 percent, from \$880 thousand in 2014 to about \$1.8 million in 2017. Total reimbursements, which include commercial insurance, private pay and Medicare, increased by 36 percent. Driven by the boost in Medicaid funding, the facility's non-recoverable costs – paid for by general fund – have increased only 3 percent, despite increases in both numbers of patients and costs per stay. From 2014 through 2017, APD saw a 13 percent increase in average daily census and a 14 percent increase in average number of patients per year. The division has lowered average cost per patient per day by 13 percent, but the average cost per stay increased by 13 percent (see Chart 7).

According to NMBHI, one contributing cost driver is the generally increasing acuity of many substance use disorder patients, more of whom have substance-induced psychosis and are addicted to more than one substance. Notably, LFC staff heard concerns about increasing acuity from virtually every hospital and RTC contacted for this brief. Another contributing cost driver is increasing lengths of stay at the facility. Accomplishing a safe discharge is often a challenge and can

The DOH hospitals reported total reimbursements from Medicaid and other insurance that covered only about 14 percent of operating costs in FY17, leaving \$34.4 million to be paid for out of the department's general fund budget.

Some of the gap is due to Medicaid coverage limitations, but some also appears to be due to the variable capacity – and determination – of the facilities to bill Medicaid appropriately.

**Chart 7: NMBHI APD Cost per Day and Cost per Stay**



Source: NMBHI

### Emergency Holds and Civil Commitments

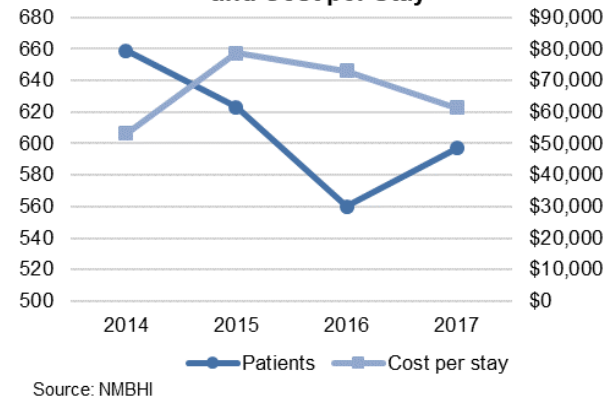
The New Mexico Mental Health and Developmental Disabilities Code (NMSA section 43-1-1 – 43-1-25) authorizes both seven day emergency evaluations and 30 day civil commitments for people found to present the likelihood of harm to themselves or others. However, those are maximum time limits, and the actual time an individual is held will vary depending on the needs of the individual and the judgment of treating providers.

lead to an individual remaining at APD longer than expected. NMBHI reports that a notable portion of the APD population have chronic severe mental health issues, may have a history of violence toward health care workers, and often become unstable again very shortly after discharge. These clients can be difficult to place and may end up spending months or even years in the extended care units at APD. Some elderly clients may not have a guardian and cannot be safely discharged until one is appointed for them by the Office of Guardianship, currently experiencing a significant back-log of cases. Other clients may be difficult to discharge safely because there are inadequate step-down outpatient services in their home community.

On the other hand, some clients may be evaluated and released within just hours of arriving. Most APD clients have first spent at least some amount of time at another hospital, awaiting a court decision on their case, transportation availability, or bed availability at APD. APD reports that many times clients have stabilized before they get to NMBHI, so that they no longer meet admission criteria. If the client is on a 7 day emergency evaluation, they may stay just long enough for APD staff to complete an evaluation; if the client arrives as the result of a court commitment they must be admitted but may then be discharged relatively quickly if APD staff determine they no longer pose a risk to themselves or others.

The NMBHI forensic treatment unit houses individuals who have been charged with a felony level crime but determined not competent to stand trial and too dangerous to be released; the average cost per stay for these clients was over \$60

**Chart 8: NMBHI Forensic Unit Clients and Cost per Stay**



thousand in 2017. No services in the forensic unit are eligible for reimbursement by Medicaid or any commercial source, so all costs for this population are paid by the state general fund. Forensic clients are court-ordered to NMBHI for an initial 90 day period of competency restoration, but depending on the individual's progress and the nature of their crime, some ultimately stay for as long as they would have been sentenced for their alleged crime. An individual may also remain at NMBHI after they are determined competent if the judge in the case determines she or he needs more care while waiting for trial than can be provided by the county jail.

Despite a 9 percent drop in both average daily census and average number of patients per year, the forensic unit has experienced an increase of 5 percent in average cost per client per day and a 15 percent rise in average cost per stay between 2014 and 2017 (see Chart 8). Rising costs are due in part to some of the same

forces driving up medical costs for prisons around the country: the long-term portion of the population is aging and facing more chronic and acute health conditions. Forensic unit clients who need off-site medical attention must be accompanied by staff at all times, adding to the cost of their care. Another characteristic the forensic unit population shares with the state's prison population: high rates of hepatitis C, for which NMBHI does not provide treatment.

**Turquoise Lodge Hospital, founded in 1952, is the state's oldest publicly funded inpatient detox and rehabilitation hospital; in FY17, the average client cost per stay was \$3,612 for the detox program and \$6,864 for the rehabilitation program.** Located in Albuquerque, Turquoise Lodge has 40 licensed beds; 32 are currently operational, split evenly between the

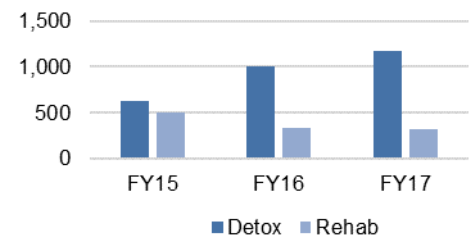


seven day detox program and the 18 to 21 day social rehabilitation program. The facility has an on-site medical team that includes internal medicine and psychiatry, and has the resources to care for clients with more challenging physical health conditions or mental health dual diagnoses than most other similar programs can admit. However, while detox and rehab at Turquoise Lodge are medically managed in the sense that clients receive careful medical attention and a variety of medications to make the process of detox more tolerable, the rehab portion of the program does not provide medication assisted treatment (MAT) for withdrawal management and uses suboxone only for pregnant women.

Through the end of FY15, Turquoise Lodge offered a single program that combined detox and rehabilitation over a 30 day time period. Realizing that many clients only wanted the detox portion of the program and preferred to complete their rehabilitation in an outpatient setting, the facility administration divided services into two distinct programs at the start of FY16. The administration reports the 60 percent increase in clients it has seen since 2014 is largely the result of this change, as the number of people receiving detox services has increased by 88 percent while the number of clients in the rehab program has decreased by 36 percent. Turquoise Lodge does not currently track clients once they leave the facility, and outpatient rehab outcomes for patients who leave after detox are unknown.

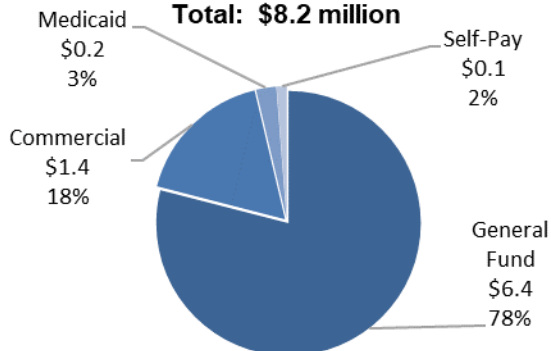
Since 2014, Turquoise Lodge has increased its Medicaid reimbursements by almost 900 percent, from just over \$200 thousand in 2014 to about \$2.3 million in 2017. During the same time, the facility's non-recoverable costs – paid for by general fund – have dropped by nearly 50 percent, from \$6.4 million in 2014 to \$3.3 million in 2017. Under the current Medicaid program, medically-necessary and supervised detox is a billable Medicaid service; social rehabilitation, whether inpatient or outpatient, has not historically fit the classic medical model of Medicaid and therefore has not been a covered service (although that may change under Centennial Care 2.0). The hospital's shifting proportion of detox to rehab has allowed it to be reimbursed for a much larger portion of the services it delivers.

**Chart 9: Turquoise Lodge Detox and Rehab Admissions**

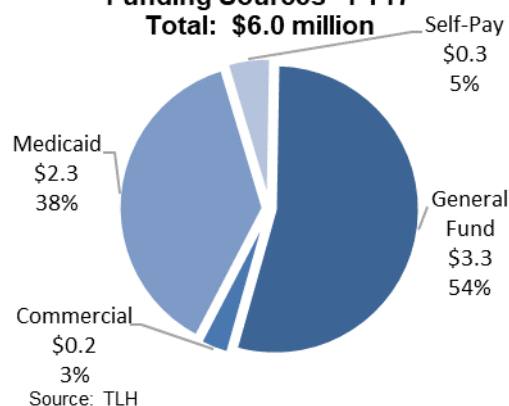


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**Chart 10: Turquoise Lodge Funding Sources - FY14**  
Total: \$8.2 million



**Chart 11: Turquoise Lodge Funding Sources - FY17**  
Total: \$6.0 million



Turquoise Lodge Hospital and the NMRC provide two different ASAM levels of care.

Social rehabilitation programs are ASAM level 3.5, clinically managed high intensity residential services with 24 hour support from trained providers.

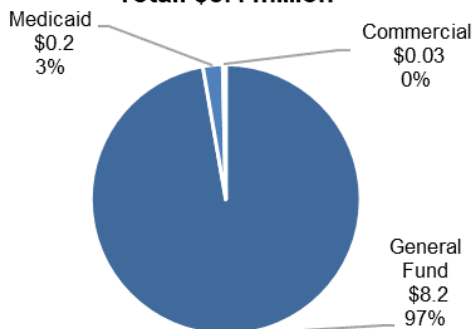
Medical detox programs are ASAM level 3.7, medically managed intensive inpatient services with 24 hour nursing, daily physician care, and counseling.

The restructure has also reportedly allowed greater efficiency in staff and facility utilization and better access to services. The annual cost to operate the facility has declined by 15 percent, from \$7.6 million in 2014 to \$6.7 million in 2017, while access has improved. Under the old model the facility frequently had a wait time of up to 10 weeks; hospital administrators report initial assessments are now completed within one to three days and the wait time for admission is between three and 10 days. Turquoise Lodge has recently been certified for intensive outpatient program (IOP) services, and now offers three key stages of the substance abuse treatment continuum: inpatient detox and rehabilitation, and then IOP.

**The New Mexico Rehabilitation Center (NMRC) is DOH's other hospital-based inpatient detox and rehabilitation facility; in FY17, the average cost per client per stay in the detox program was just over \$5,000.** Located in Roswell, NMRC has 43 licensed beds, 15 of which are licensed for medical rehabilitation and 28 of which are licensed for the chemical dependency unit (CDU). Only 24 beds CDU are currently operational; eight for the detox program and 16 for the social rehabilitation program. As at Turquoise Lodge, the detox and rehabilitation programs at NMRC are medically managed but do not include medically assisted treatment (MAT) for withdrawal. NMRC was not able to provide most of the requested data for FY14, and gaps in services in the detox and rehabilitation programs do not permit accurate trending. The facility did provide full FY18 data, however.

**Chart 12: NMRC Funding Sources 2015**

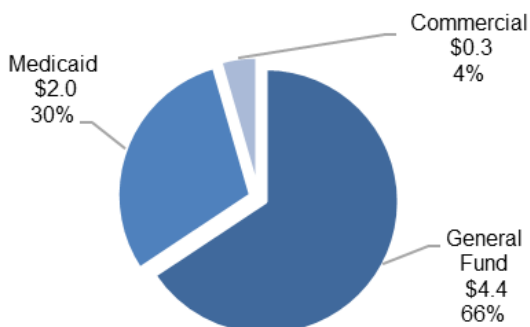
**Total: \$8.4 million**



NMRC has faced chronic staffing shortages since it opened in 2011, which have impacted the facility's ability to deliver services consistently. Originally, the only behavioral health service offered was a 28 day inpatient social rehabilitation. NMRC added the seven day inpatient medically managed detox program in late 2015, and in early 2016 gained certification for its intensive outpatient program (IOP), so that the facility could provide three key elements of the continuum of care for substance use disorders. However, the detox program has experienced numerous stops and starts primarily due to shortages of direct care staff; the average daily census was less than two patients for the first three quarters of operation, and then the unit was non-operational for the first two quarters of FY17. The residential rehabilitation program shut down entirely in December of 2016.

**Chart 13: NMRC Funding Sources 2018**

**Total: \$6.7 million**



In 2017 the facility began to stabilize under a new administration and with the addition of four staff members who transitioned over from DOH's now-closed Yucca Lodge program. NMRC first focused on stabilizing and enhancing the detox and intensive outpatient programs, and restarted the rehabilitation program in July 2018. The NMRC's total number of patients per year increased by 23 percent from 2015 to 2018, from 369 to 453.

Despite the multiple disruptions in services, NMRC increased its Medicaid reimbursements by 700 percent between FY15 and FY18, from just over \$240 thousand in FY15 to almost \$2 million in FY18. During the same time frame, NMRC's operating budget was reduced from \$8.5 million to \$6.7 million, leading to a 47 percent drop in general fund spending on the program, from \$8.2 million in FY15 to \$4.4 million in FY18.

Source: NMRC

**The closure of Yucca Lodge in March of 2017 resulted in a net loss of residential substance abuse treatment services for the state.**

Yucca Lodge, located on the campus of the Fort Bayard Medical Center (FBMC), was the third DOH inpatient treatment facility. FBMC is a 200 bed medical rehabilitation and long term care facility, with 40 beds set aside for a veterans unit; according to DOH, the Yucca Lodge chemical dependency unit, licensed for 14 beds, was not a good fit for the facility. The department has put forth a number of reasons for closing Yucca, including low reimbursements, plans to expand the veterans unit, and more efficient use of state resources through consolidation of substance abuse treatment services into a single southern facility, the NMRC in Roswell. However, Yucca has been closed for about 18 months and there has not yet been a corresponding expansion of services at NMRC, nor have the Yucca beds been repurposed for the veterans unit at FBMC.

Yucca Lodge offered a four week clinically managed intensive residential social detox program and served between 150 and 160 clients per year from FY14 through mid-FY17. LFC staff was not able to obtain the same level of detailed information for Yucca Lodge as for the other DOH programs, but review of the available data indicates the program admitted between 30 and 45 people each quarter with an average occupancy rate of 77 percent.

**Each of the DOH facilities primarily serves patients from its own region of the state; NMRC and Turquoise Lodge in particular may be most clearly understood as regional rather than statewide providers.**

In FY17, NMBHI provided adult psychiatric services to patients from 23 counties, although approximately 55 percent came from the northeast region. Patients were sent to the forensic unit from 28 counties, drawn more evenly from around the state. On the other hand, 72 percent of clients at Turquoise Lodge in 2017 came from the northwest region of the state, 57 percent from Bernalillo County alone. NMRC operated sporadically in FY17 and served patients from a total of only 12 counties, with 78 percent coming from the southeastern counties, 42 percent from Chavez County alone. (Appendix C has all facility admissions by county for 2017.)

Yucca Lodge was only open for half of FY17; for FY16, the program served almost exclusively the western half of the state, drawing 60 percent of patients from the southwest region and 37 percent from the northwest. The success of DOH's consolidation of services from Yucca to NMRC is difficult to assess, but this historical demographic pattern would seem to work against the idea that individuals in need of treatment will journey to the other side of the state for services. In FY17, about 16 percent of patients at NMRC were from western counties. Turquoise Lodge might be closer for many people, but approximately the same percent of its patients came from western counties (other than Bernalillo) both before and after Yucca Lodge was closed, 24 percent in FY16 and 23 percent in FY17.

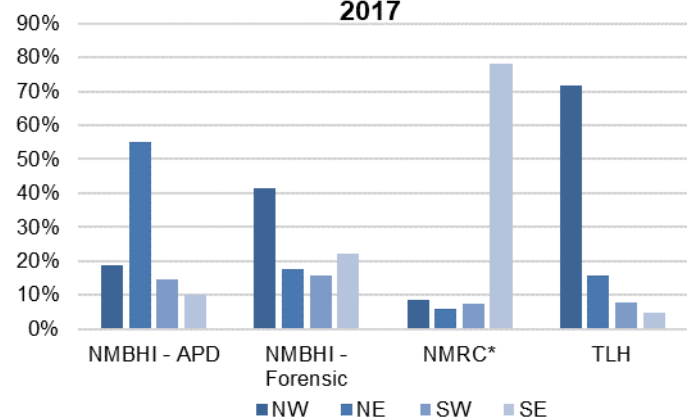
Since the 2017 closure of Yucca Lodge, there has not been a corresponding expansion of services at NMRC, nor have the Yucca beds been repurposed for the veterans unit at FBMC.

In 2017, all but the NMBHI forensic unit saw primarily patients from their own region of the state:

- NMBHI APD = 55 percent
- NMRC = 78 percent
- Turquoise Lodge = 72 percent

The success of DOH's consolidation of services from Yucca to NMRC is difficult to assess. There is not yet any indication that individuals in need of treatment are making the journey to the other side of the state for services.

**Chart 14: DOH Facility Admissions by Region, 2017**



Note: NMRC is detox only

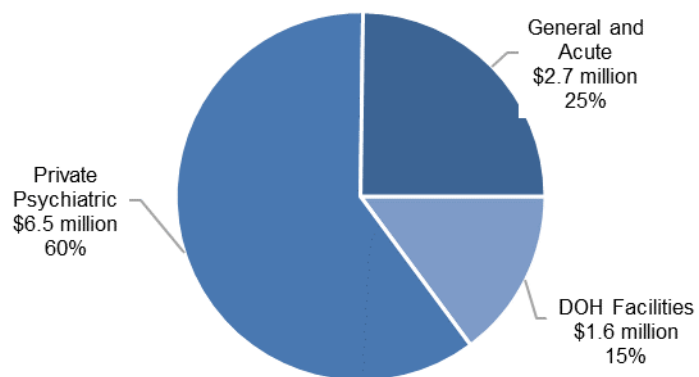
## New Mexico's Private Psychiatric Hospitals

From 2014 and 2017, between 40 percent and 50 percent of all Medicaid reimbursements for hospital inpatient psychiatric services went to three private psychiatric hospitals, Haven Behavioral, Mesilla Valley and Peak Behavioral Health. According to HSD data, in 2017, Haven received just over \$1 million in Medicaid reimbursements. Mesilla Valley Hospital and Peak Behavioral Health Services are the two largest psychiatric facilities in the state after NMBHI and the VA hospital's psychiatric unit; in 2017, Mesilla received about \$2.5 million in Medicaid reimbursements and Peak received just under \$2.6 million. Mesilla Valley is the only psychiatric hospital to also receive reimbursements from the collaborative.

New Mexico has four private psychiatric hospitals:

- Central Desert Behavioral Health
- Haven Behavioral Hospital
- Mesilla Valley Hospital
- Peak Behavioral Health

**Chart 15: Medicaid Psychiatric Inpatient Reimbursements by Type of Hospital, 2017**  
Total: \$10.8 million



Source: LFC analysis of HSD encounter and claims data

Central Desert Behavioral Health is a 26 bed specialty hospital in Albuquerque that provides psychiatric services to seniors only. Haven Behavioral Hospital, also in Albuquerque, is a 48 bed facility providing acute psychiatric care to adults. Both of these facilities treat co-occurring mental health and substance use disorders, but do not offer separate detox services. Mesilla Valley Hospital in Las Cruces provides acute psychiatric care, medical detox and addiction recovery; the hospital is in the process of switching 16 beds from its adolescent residential treatment center back to inpatient acute, which will bring its total operational beds to 104, about 63 of which are dedicated to adults. Peak Behavioral Health Services, located in Santa Teresa, is a 119 bed facility that provides acute psychiatric services in separate inpatient programs for children, adolescents, adults and seniors. Both Mesilla Valley and Peak also offer step-down services through partial hospitalization and intensive outpatient programs.

Between them, the four private psychiatric hospitals account for 28 percent of all operational inpatient psychiatric beds in the state. The financial stability of these hospitals is important to maintain the strength of the inpatient psychiatric network in the state. Based on comparison of the Medicaid encounter and claims data with cost reports filed by the hospitals with the Centers for Medicare and Medicaid



Services (CMS), Medicaid revenues made up between 10 percent and 15 percent of net patient revenues for Haven, Mesilla Valley and Peak. Medicaid is a smaller payor for the geriatric patients at Central Desert. CMS cost reports show the four hospitals have had different financial experiences over the last four years. Central Desert has seen a steady increase in patient revenues, Haven and Mesilla both saw increased revenue between 2014 and 2015, declines in 2016, and then slight increases in 2017, leaving them all with positive growth trends. Peak, on the other hand, experienced steep declines in patient revenues between 2014 and 2016. Its 2017 cost report is not posted on the CMS web site, and the hospital was without a CEO at the time of this brief and was non-responsive for requests for information.

**The true game-changer for the state's psychiatric hospitals, both private and public, is the imminent decision by CMS about whether New Mexico's Medicaid program will be authorized to expand payment for services delivered at institutions for mental disease (IMD).** Under the current program, IMDs may be reimbursed for medically-necessary psychiatric stabilization for any Medicaid patient, and inpatient withdrawal and detox, for a maximum of 15 days, only for Medicaid managed care patients. Most patients are medically stable and/or detoxed in under a week, which leaves the IMDs without a payor for any services their healthcare professionals believe necessary past that point. The CC 2.0 waiver renewal pending before CMS includes IMD coverage for up to 30 days, but as noted earlier, CMS is likely to approve this extension only for substance use disorder (SUD) treatment.

Some of New Mexico's IMDs provide more SUD treatment than mental health, and those hospitals will benefit from the coming changes, as long as they meet standard of care and other criteria. For example, Turquoise Lodge and NMRC would seem to be well-positioned for CC 2.0. However, neither facility offers MAT, which is a CMS requirement, and both are ASAM level 3.7 detox programs. The CC 2.0 implementation plan developed by BHSD indicates that only ASAM level 4.0 IMDs will be part of the new program.

On the other hand, some IMDs provide relatively smaller amounts of SUD services. Mesilla Valley, for example, reports that about 80 percent of its patients come to the hospital for mental health conditions, and so the hospital does not expect changes to the IMD rules to be of particular benefit. However, improved Medicaid reimbursements for even 20 percent of the patient population should benefit the hospital's economic position.

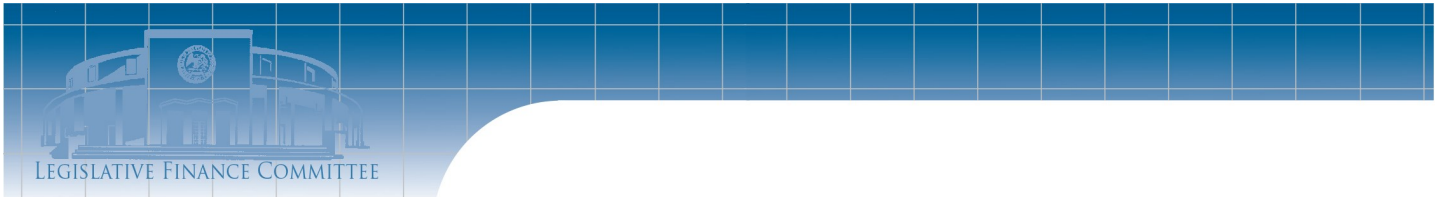
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## General and acute care hospitals

Psychiatric units at general and acute care hospitals are not subject to the IMD exclusion, which applies only to stand-alone psychiatric hospitals. For their adult patients, they are, of course, still limited to billing Medicaid only for the very few adult psychiatric services currently covered by the program. Nonetheless, according to Medicaid encounter and claims data provided by the Human Services Department, New Mexico's general hospitals – with 33 percent of the operational psychiatric beds in the state – do not appear to be billing for or receiving Medicaid reimbursement commensurate with their share of the market. Only six of the state's general hospitals had Medicaid reimbursements of \$100 thousand or more in 2017; the largest of these were Presbyterian Kaseman in Albuquerque with just



New Mexico's general hospitals – with 33 percent of the operational psychiatric beds in the state – do not appear to be receiving, or even billing for, Medicaid reimbursement commensurate with their share of the market.

over \$1 million, and Gerald Champion Regional Medical Center (GCRMC) in Alamogordo, with about \$470 thousand. Not counting the VA Hospital, three hospitals with psychiatric beds did not bill Medicaid for any services. UNM hospital, with the fifth largest number of psych beds in the state, received much less in Medicaid reimbursements than several other general hospitals, slightly under \$400 thousand. UNMH reports receiving significantly higher reimbursements than the Medicaid data shows, but LFC staff were unable to determine the source of the data inconsistency.

One reason there may be less than expected hospital billing for psychiatric services is the diagnostic related grouping, or DRG, billing system used by Medicaid and Medicare. Under this system, a hospital is paid a fixed amount based on the patient's DRG or diagnosis. The hospital cannot bill for both DRG and separate psychiatric services on the same day, and according to HSD DRG rates are higher than behavioral health rates. So if a patient is admitted with co-existing physical health and mental health issues, the hospital is most likely to bill for the physical diagnosis, even while also treating the mental health condition.

In addition, BHSD reports that because of their focus on physical health, some general hospitals do not have staff trained to conduct SUD screenings or in the best practices for SUD withdrawal. BHSD reports it continues to work with general hospitals to encourage them to offer more SUD treatment services, including numerous regional free trainings, but the Medicaid claims and encounter data reviewed for this brief shows no general hospital billing for medical inpatient detox.

## Psychiatric inpatient services in southern New Mexico

NMBHI has built up significant expertise and institutional knowledge about how to work with committed patients over the years, but there are several downsides to having just one hospital to provide these services.

Because NMBHI is the only state-run psychiatric facility in the state, it has traditionally been the primary facility for seven day emergency mental health evaluations and 30 day civil commitments. NMBHI has built up significant expertise and institutional knowledge about how to work with committed patients over the years, but there are several downsides to having just one hospital to provide these services. Transportation to and from Las Vegas can be time consuming and costly, the distance may discourage family members and other natural supports from visiting patients, and coordination of follow-up services between NMBHI and providers from the patients' home community may be difficult. In addition, a person may begin her stay at one hospital and receive treatment there while waiting for a court hearing; if the hearing results in commitment, the shift to NMBHI can involve a disruptive change in providers, medications, and therapy styles.

The 2016 Southern New Mexico Mental Health Hospital Study found that another 19 publicly-funded inpatient psych beds are necessary just to meet civil commitment needs in the south

As a result of these concerns, there have been at least three major studies, the most recent completed in 2016, to consider the issue of publicly-funded inpatient mental health services in the southern part of the state. The 2016 Southern New Mexico Mental Health Hospital study found that the existing hospitals in the area were meeting current inpatient service needs, with the exception of civil commitments. The study found that another 19 publicly-funded inpatient mental health beds are needed just for civil commitment needs in the south, along with eight to 10 additional beds to meet growing needs of the area.

Options discussed include the construction of a new state-run psychiatric hospital, state purchase of an existing psychiatric hospital, or a state-private partnership or

contract with an existing hospital. The 2016 study recommended a two-phase approach: for the short to medium term, partner with an existing facility. For the long term, plan to build a new 30 bed state-owned psychiatric hospital in Doña Ana County, with estimated construction costs of \$15.5 million and annual operating costs of \$6 to \$7 million. No action appears to have been taken on either of these recommendations.

At the current time, the need for civil commitment services in the south is clear, but the need for a new state-run psychiatric hospital is less so.

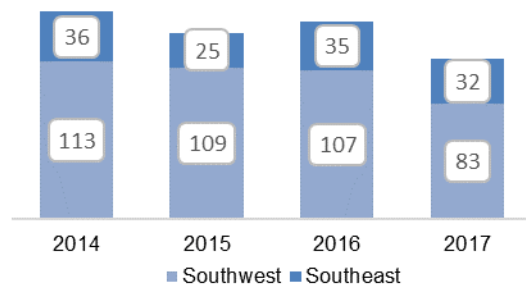
During the 2018 legislative session, House Joint Memorial 2 (HJM2) requested the LFC investigate this issue once again. The memorial did not pass, but LFC staff did consider the issue while researching this brief. At the current time, the need for civil commitment services in the south is clear, but the need for a new state-run psychiatric hospital is less so.

A relatively small number of patients at NMBHI are from southern New Mexico, an even smaller number are from the southwest counties.

**Potential patient base:** A relatively small number of patients at NMBHI are from southern New Mexico. For 2017, the adult psychiatric division (APD) at NMBHI reported a total of 115 patients from the 12 southern counties that have been the focus of previous studies, 23 percent fewer than in 2014.

Two counties account for most of those, Doña Ana County with 59, and Chavez County with 24. For many people in Chavez, Lincoln, Eddy and Lea counties, traveling to Las Cruces would be just as difficult, if not more so, than traveling to Las Vegas, so even a count of 115 may be unrealistically high; the southwestern counties sent 83 people to NMBHI in 2017. Despite all of the potential costs and disruption caused by sending people to Las Vegas, 83 patients per year are not a sufficient base for a new hospital.

**Chart 16: NMBHI APD Patients from 12 Southern Counties**



Source: NMBHI

**Estimated construction costs:** The 2016 study proposed a 30 bed, 37,500 square foot hospital, at \$413 per square foot or \$516 thousand per bed, and a total cost of \$15.5 million. There are several recent hospital construction projects in the state that can serve to establish a possible New Mexico specific range:

- Sierra Vista Hospital initially projected the cost of a new 25 bed general hospital at close to \$30 million, or about \$1.2 million per bed. General and acute care hospitals generally cost more than specialty psychiatric hospitals because they require more extensive medical support systems.
- The 2016 winning bid for the New Mexico Veterans Hospital's new 59 bed memory care unit was \$28 million, or \$474 thousand per bed and \$325.58 per square foot. A good deal of space at the 86,000 square foot facility is designated for community uses; this type of space has lower labor and material costs and results in a lower overall cost per square foot.
- The winning bid for the first RFP for NMBHI's 72 bed Meadows 3 facility was \$24.3 million, or \$337 thousand per bed. At 50,080 square feet, the cost per square foot was \$484.65, and includes 3,400 square feet of infrastructure shared with the other Meadows units.

A new 37,500 square foot public psychiatric hospital would likely cost over \$18 million to design, build, furnish and equip.

Of the three comparable projects, the NMBHI Meadows facility is closest to a psychiatric hospital. Using that project's \$484.65 per square foot, and taking into account recent trade tariffs that have increased the cost of construction materials, a new 37,500 square foot psychiatric hospital would likely cost over \$18 million to design, build, furnish and equip.



Operating costs are estimated to be between \$7.5 million and \$8 million per year, which would increase the state's general fund spending for psychiatric hospital inpatient services to over \$40 million per year.

Available behavioral health funding may be better spent stabilizing and enhancing the full continuum of evidence-based outpatient services than by building a new hospital.

Mesilla Valley Hospital has already made a proposal to Dona Ana County to provide civil commitment services. Hospital administrators believe they have a strong case for cost savings and improved outcomes if patients are allowed to remain in the community.

Estimated operational costs: The 2017 operating budget for APD, with 96 operational beds, was \$16.4 million, which annualizes to over \$170 thousand per bed per year. The \$523 per patient per day cost APD reported to the LFC is based on Medicaid reimbursement rates, and is not likely to equal the true cost of providing services. The 2016 study estimated a more realistic per patient cost of about \$700 per day, and projected an operating cost between \$6 million and \$7 million per year.

Using more current costs at NMBHI, the LFC calculates the actual operating cost to be between \$7.5 and \$8 million per year, which would likely increase the state's current general fund spending for inpatient mental health services to over \$40 million per year. Medicaid reimbursements would cover only a portion of those costs, because even with the easing of the IMD exclusion Medicaid still only pays for medically necessary days – the bulk of a 30 day civil commitment would almost certainly not be covered.

In addition to an insufficient patient base and significant construction and operating costs, fully staffing a new hospital seems certain to place further avoidable strain on the state's already critically short supply of mental health professionals. Lastly, as noted repeatedly throughout this brief, inpatient mental health services can often be avoided with appropriate care at lower levels of the continuum. Available behavioral health funding may be better spent stabilizing and enhancing the full continuum of evidence-based outpatient services — many of which would receive federal Medicaid matching funds for up to 90 percent of cost — than by building a new hospital.

The New Mexico Mental Health and Developmental Disabilities code, (NMSA section 43-1-1 – 43-1-25) defines an evaluation facility as a “community mental health or developmental disability program or a medical facility that has psychiatric or developmental disability services available.” The NMBHI is one such facility, but there are a number of hospitals around the state and particularly in the southern region that meet the broad scope of this definition. Many hospitals already participate, to one extent or another, in 7 day emergency evaluation cases; the state and/or counties could formalize relationships with these facilities, expand one or more of them to include 30 day civil commitments, and provide more complete reimbursement, all for substantially less than the cost of a new facility. New Mexico would not be the only state to use non-state hospitals for civil commitments: a 2014 national survey conducted by the National Association of State Mental Health Program Directors found that about 37 percent of all involuntary non-forensic (civil commitment) patients were in state hospitals, with the remainder divided almost equally between general hospitals with psychiatric units and private psychiatric hospitals.

According to Mesilla Valley Hospital, it has already made just such a proposal to officials with Dona Ana County. The hospital is already a secure facility, with on-site commitment hearings held once a week, and between waiting for a hearing and then waiting for transportation to NMBHI, patients often spend a week or more at the facility before going to Las Vegas. Hospital administrators believe they have a strong case for the benefits of continuity of care, and think patients would have better outcomes if they were allowed to remain in the community. The hospital's current proposal is to bill Medicaid for the days the program will cover, and then bill the county for any necessary additional days. Mesilla Valley,



which is in the process of increasing its operational beds from 88 to 104, offers step-down services through its partial hospital program and it working on starting an adult intensive outpatient program; having these outpatient services available at the same facility would ease discharge planning for civil commitment patients. According to hospital administration, its proposal is in the preliminary stages of consideration by the county.

## Residential Treatment Centers

For individuals with substance use disorders (SUDs), residential treatment centers are the highest level of care short of hospitalization. According to research gathered by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), evidence-based outpatient SUD detoxification and treatment can be very effective for many people, but for others a residential setting may provide stability and community that may be lacking elsewhere and ultimately prove more effective than outpatient treatment alone. Residential treatment may be particularly useful for vulnerable populations like pregnant women or homeless individuals, who benefit most from wrap-around type services.

Residential treatment programs for children are closely regulated and licensed by the Children, Youth and Families Department. No such structure currently exists for adult residential treatment centers (RTC). Historically, neither the Human Services Department's Behavioral Health Services Division (BHSD) nor the Behavioral Health Collaborative have exercised oversight regarding the quality of adult RTC programs, including whether an RTC is using evidence-based therapies or tracking program outcomes.

This situation will change once CC 2.0 is implemented and adult RTCs become eligible for Medicaid reimbursement. BHSD is in the process of drafting rules for the new services now, as well as a policy manual for providers. The department reports that discussions with CMS have established that adult residential treatment centers will only be eligible for reimbursement if they are accredited with one of three national accrediting bodies: the Joint Commission (JC), the Council on Accreditation (COA), or the Commission on Accreditation of Rehabilitation Facilities (CARF). Adult RTCs will also be required to follow the American Society of Addiction Medicine (ASAM) level of care guidelines, and provide evidence-based substance abuse disorder treatments, including medication assisted treatment (MAT).

According to SAMHSA, medication-assisted treatment (MAT) is widely accepted to be the standard of treatment for opioid use disorders, although there is less agreement about how best to treat other substance use disorders. MAT combines psychosocial counseling with FDA-approved medications – methadone, naltrexone or buprenorphine – and has been demonstrated to be safer and more effective than either psychotherapy or medication alone. MAT is most commonly provided in an outpatient setting, but SAMHSA guidelines suggest residential treatment can be the most appropriate choice for some patients. In particular, people who have other substance abuse disorders or polysubstance abuse issues, who lack family or community supports, or who have unstable living situations or are homeless may benefit from residential treatment.

Neither the Human Services Department's Behavioral Health Services Division (BHSD) nor the Behavioral Health Collaborative currently exercise oversight of adult RTC programs.

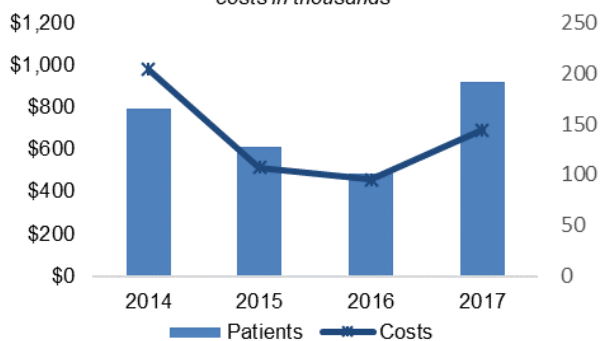
This situation will change once CC 2.0 is implemented and accredited adult RTCs become eligible for Medicaid reimbursement.

In New Mexico, MAT, using any of the three medications, is covered by Medicaid. Access to the service is limited, however, by the state's shortage of providers approved to administer methadone or buprenorphine.

**Because of Medicaid's current coverage limitations, the Behavioral Health Collaborative (BHC) is the primary payor for adult residential treatment for both Medicaid and non-Medicaid clients around the state.** The BHC was created in 2004 to coordinate and streamline the scattered behavioral health services provided by an array of state agencies. Behavioral health was 'carved out' of Medicaid and other programs and into the domain of BHC. Ten years later, in 2014, HSD implemented Centennial Care and reintegrated Medicaid behavioral and physical health. Today, BHC continues as the payor of last resort for medically or clinically necessary services to clients who are not Medicaid eligible or who do not have another form of health insurance, or for services that are not covered by Medicaid or the client's other insurance. Other than the lack of insurance or Medicaid coverage, there are no formal eligibility rules or criteria for which patients can have their behavioral health costs covered by the collaborative; the decision to treat is left up to the judgement of the providers who contract with the collaborative's administrative services organization (ASO). Medicaid expansion extended coverage for most behavioral health services to the roughly 250 thousand New Mexicans now served by that program, which significantly reduced the role of the collaborative. However, as long as adult residential treatment services are excluded from Medicaid coverage, and until mental health parity becomes a reality for both Medicaid and commercial insurers, there will be a need for BHC in the state's array of behavioral health payors.

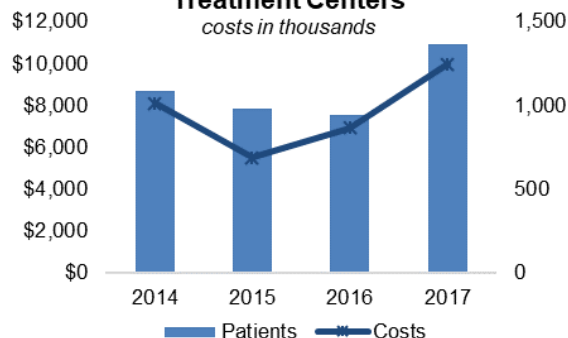
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**Chart 17: BHC Hospital Inpatient costs in thousands**



Source: BHC claims data

**Chart 18: BHC Residential Treatment Centers costs in thousands**



Source: BHC claims data

The collaborative administers much of the state's spending for adult residential treatment, but the bulk of the actual funding comes from federal grants, primarily from the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA grants to New Mexico for adult substance abuse programs have increased by 170 percent since 2014. The agency oversees major federal block grants like the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment (SAPT) Block Grant, as well as numerous competitive discretionary grants that can go to state agencies and directly to providers. According to BHSD, the SAMHSA SAPT grant supports the majority of adult residential treatment costs in the state; since 2014 the SAPT amount has increased very little, from \$9.5 million in FY14 to \$9.6 million in FY17.

The Behavioral Health Collaborative funds far more adult residential treatment services than inpatient hospital psychiatric services. Between 2014 and 2017, the collaborative spent \$30.5 million on residential treatment services, primarily for substance use disorder, for over 4,300 people. In the same time period, the collaborative spent a much smaller amount, \$2.6 million to cover inpatient hospital services for approximately 580 adults. Medicaid expansion should have reduced the collaborative's spend on inpatient hospitalization even further; when asked for an explanation for the persistence of this population, BHSD suggested undocumented immigrants may make up the bulk of the group.

The number of BHC clients accessing inpatient services dropped by nearly 40 percent between 2014 and 2016, before rising a surprising 69 percent in 2017. Spending followed a similar pattern, with a 51

percent increase for 2017. (Charts 17 and 18.) The drivers for this increase are unclear, although the number of individuals under consideration here may be small enough to be sensitive to the drop in Medicaid enrollment that began mid-2017.

Almost all BHC hospital reimbursements have gone to four hospitals: from 2014 and 2017, UNM Hospital received greater than 50 percent of reimbursements each year, while Mesilla Valley Hospital received between 30 percent and 44 percent. Lea Regional Hospital and Gila Regional Medical Center received smaller shares for 2014 through 2016, and none in 2017. As noted above, these are large shares of small amounts: according to BHC data, in 2017, UNMH was reimbursed for under \$500 thousand and Mesilla Valley for less than \$250 thousand.

The 13 percent decline in RTC clients between 2014 and 2016 likely reflects the departure of two of the Arizona providers rather than any true reduction of need for services.

New Mexico, like the rest of the country, is experiencing a serious increase in substance use disorders, and the upswing in utilization and costs for both hospital and residential treatment services clearly reflect that trend. The 13 percent decline, about 140 people, in RTC clients between 2014 and 2016 likely reflects the departure of two of the Arizona providers rather than any true reduction of need for services. In addition, the claims data set for 2014 included payments for a number of nursing facilities. These errors inflated the numbers for 2014 and clearing them out of the system may account for some of the decline in 2015.

### **Survey of available adult residential substance use disorder treatment programs**

According to BHSD and the Behavioral Health Collaborative website, there are at least 16 residential treatment centers (RTCs) currently operating in New Mexico, with a total bed capacity of 452 beds. Some residential treatment centers (RTCs) offer both detoxification, medically or clinically monitored or managed, as well as some form of short or long term therapeutic treatment; others accept only clients who have already undergone the rigors of detoxification elsewhere. The programs listed below are predominantly 12 step based, and most also use evidence-based therapies such as cognitive behavioral therapy, dialectic behavior therapy, and motivational interviewing. Six of the programs include clinically or medically managed detox; the others require patients to be detoxed before they arrive. Seven are 90 day or longer programs, seven are four to six week programs, and two are limited to one week or less of detox. Two serve only men, one serves only women. The 16 RTCs are notably concentrated in the north and west regions of the state (see Appendix B for a map of RTC locations).

Adult residential treatment centers in New Mexico are predominantly 12 step based, and most also use evidence based therapies such as cognitive behavioral therapy, dialectic behavior therapy, and motivational interviewing.

Most importantly for the purposes of assessing publicly-funded services, the 16 active RTCs in New Mexico vary widely in how well they are positioned to be eligible for Medicaid reimbursement under CC 2.0. The detailed provider eligibility regulations and provider manual are still being developed by BHSD, but at a minimum RTCs will need to be Medicaid enrolled providers and accredited. As Table 2 shows, only three RTCs, representing 98 out of 452 beds, are currently enrolled and accredited and prepared to receive CC 2.0 Medicaid reimbursements effective January 1, 2019. The RTCs that are not currently enrolled Medicaid providers may not find current reimbursement levels and limitations to be worth participating in the program, but those providers may not be aware that Medicaid coverage is about to be extended to more of their services.

**Table 2: Adult Residential Treatment Centers in New Mexico, 2018**

Facility	Location	Beds	Accreditation	BHC Contract/Medicaid Provider
Bernalillo County Metro Assessment and Treatment	ABQ	48	None	Contract, not Medicaid enrolled
Casa Feliz - Taos Recovery Inc.	Taos	18	CARF	No contract, not Medicaid enrolled
Four Winds Recovery Center	Farmington	23	None	Contract, Medicaid enrolled
Golden Services, Inc. - Villa de Esperanza	Carlsbad	18	None	Contract, Medicaid enrolled
Hoy Recovery Program	Velarde	44	None	Contract, Medicaid enrolled
Interfaith LEAP, Inc. (ILEAP) - Sangre de Cristo House	Pena Blanca	16	None	Contract, not Medicaid enrolled
Life Healing Center	Santa Fe	39	CARF	No contract, not Medicaid enrolled
Na Nizhoozhi Center Inc (NCI) - A Bridge to Recovery	Gallup	35	None	Contract, not Medicaid enrolled
New Moon Lodge - Eight Northern Indian Pueblos Council	Ohkay Owingeh	14	None	Contract, Medicaid enrolled
Rehoboth McKinley Christian Healthcare - Behavioral Health Services	Gallup	69	None	Contract, not Medicaid enrolled
Santa Fe Recovery Center	Santa Fe	54	CARF	Contract, Medicaid enrolled
Shadow Mountain Ranch	Taos	20	JCAHO	No contract, Medicaid enrolled
Shadow Mountain Recovery Center	Albuquerque	24	JCAHO	No contract, Medicaid enrolled
St. Martin's Hospitality Center - Casa de Phoenix	ABQ	20	None	No contract, not Medicaid enrolled
Turning Point Recovery Center	ABQ	5	None	No contract, not Medicaid enrolled
Viewpoint Rehabilitation Center	Rio Rancho	5	None	No contract, Medicaid enrolled
<b>Total capacity</b>		<b>452</b>		

Source: BHSD, BHC website; LFC research

Without focused attention and assistance from the department there are 354 RTC beds that may very well not be eligible for Medicaid reimbursement at the start of CC 2.0.

Without focused attention and assistance from the department to help them come into line with new eligibility requirements, there are 354 RTC beds that may very well not be eligible for Medicaid reimbursement at the start of CC 2.0. The collaborative may elect to continue to fund services received through these RTCs; however, as much as the services are needed by New Mexicans, it would be a setback to the forward-thinking and evidence-based approach of CC 2.0 to have a dual-track with different standards for RTCs.

## Conclusion

Publicly-funded adult inpatient behavioral health services, whether oriented towards psychiatric treatment or residential substance abuse disorders, are both crucial and costly. Crucial because although most people with mental illness will never need inpatient treatment, for others these services offer the critical highest level of care and are the safety net between them and personal disaster. Costly because despite varying effectiveness and persistent challenges to measuring outcomes, inpatient and residential services are the most expensive behavioral health services, with high per person costs. Because so few of these services for adults are covered by Medicaid, of the total \$58 million spent by public agencies in



2017, over \$34 million came from the general fund budgets of the Department of Health's behavioral health hospitals.

New Mexico currently has 40 operational hospital psychiatric and mental health beds per 100,000 people; combined with residential treatment beds, the statewide number improves to just over 61 inpatient beds per 100,000 people. According to some research, this means the state has sufficient inpatient resources. But, as with all health care in New Mexico, having resources is only half the picture – in our rural state, where those resources are located, how well they are staffed by qualified health care professionals, and whether the individuals who need services can afford them, are the key variables in determining whether they are truly accessible.

Several anticipated changes appear likely to improve not just the picture but the reality of access to adult inpatient psychiatric and mental health care. Centennial Care 2.0 offers the promise of a stronger behavioral health continuum at all levels, with expanded psychiatric hospital care and newly-covered accredited adult residential SUD programs. CC 2.0 will also bring a new set of financial incentives for the state and existing psychiatric hospitals to consider new options for resolving the persistent need for civil commitment options in southern New Mexico.

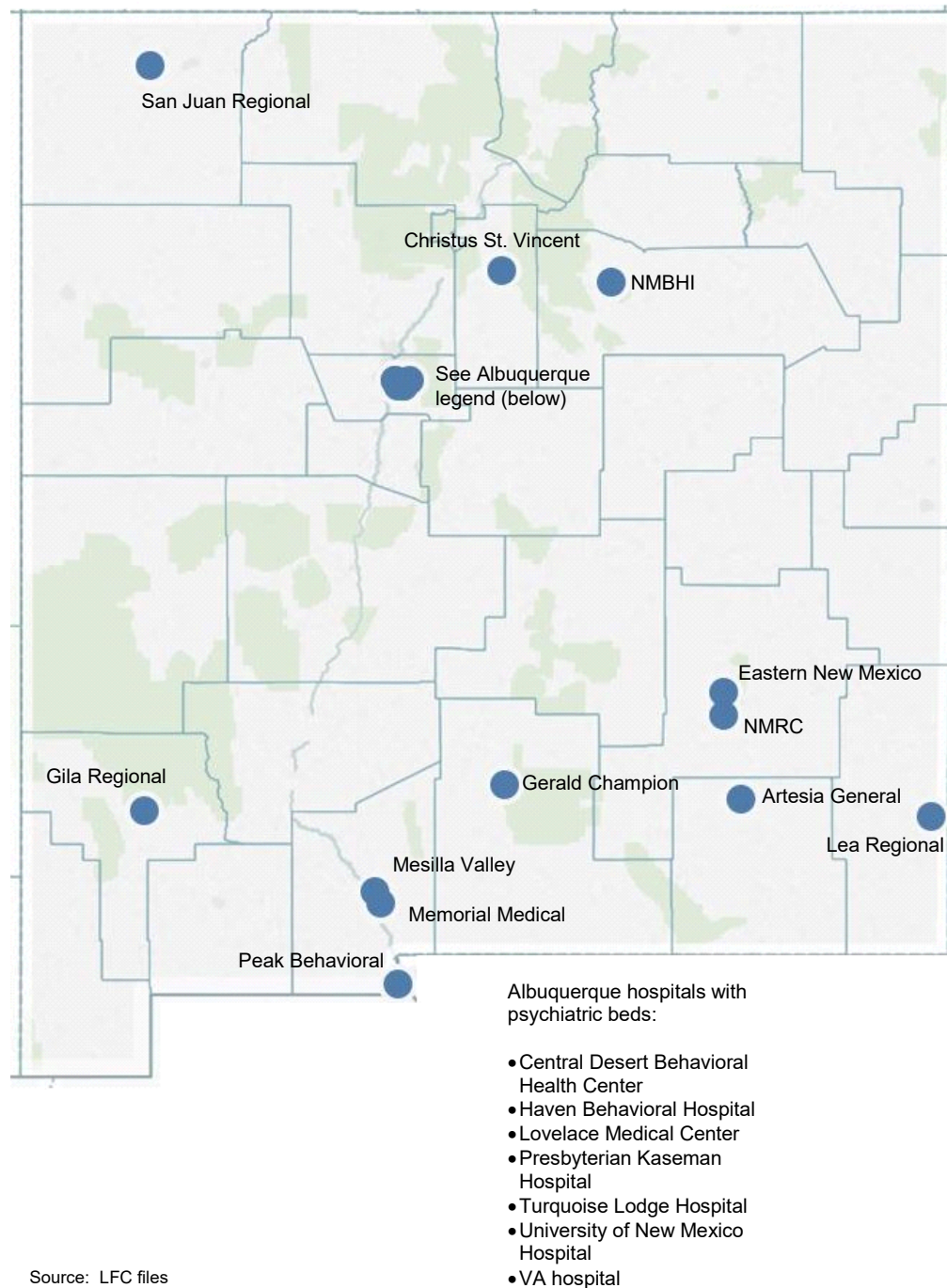
There are a number of hurdles to be overcome before these promises can come to fruition. CMS has not yet approved the CC 2.0 waiver, and indeed, according to HSD, has asked for a complete re-write of the state's implementation plan for the new SUD treatment. CMS has indicated it is not likely to fund the room and board portion of residential treatment, which may leave a significant gap in funding. The department is still in the process of reviewing draft rules to govern the new services and providers, as well as the policy manual to accompany them. BHSD reports it has communicated with the New Mexico Behavioral Health Providers Association about coming CC 2.0 changes, but it has not communicated directly with providers or offered technical assistance regarding accreditation and other eligibility criteria, although it plans to do so at some future date. This leaves would-be providers uncertain of what they will need to do to become qualified to provide services, and Medicaid managed care organizations not yet prepared to credential providers. Even the IMD status of two DOH facilities, Turquoise Lodge and NMRC, appears to be uncertain. In short, CC 2.0 will become effective January 1, 2019, but there may be some lag time before the new services it offers will be available to New Mexico's Medicaid recipients.

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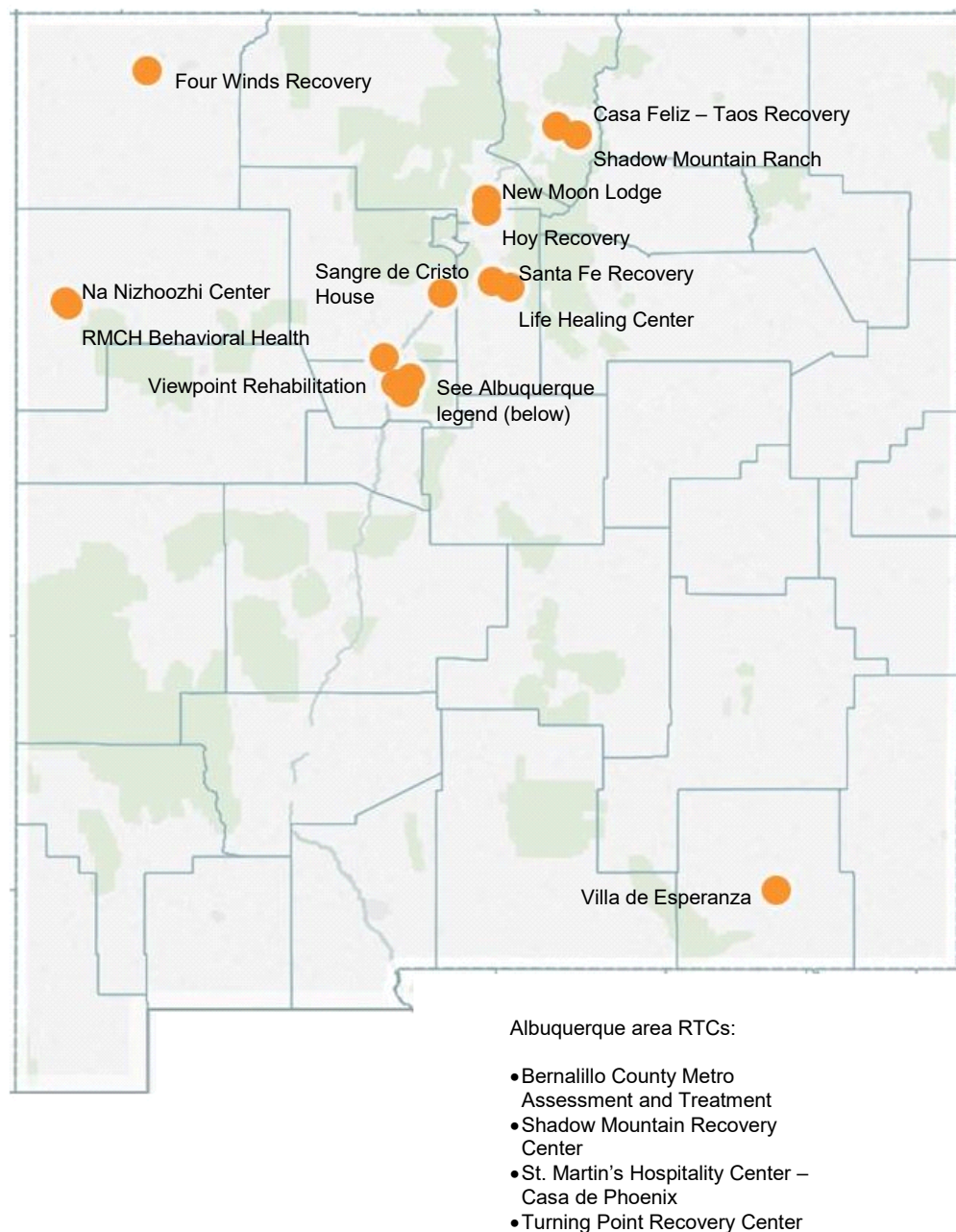
## Appendix A: Map of New Mexico Hospitals with Psychiatric Beds

**Figure 1: New Mexico Hospitals with Psychiatric and Mental Health Beds, 2018**



## Appendix B: Map of New Mexico Adult Residential Treatment Centers

**Figure 2: New Mexico Adult Residential Treatment Centers, 2018**



Source: LFC files

## Appendix C: DOH Facility Admissions by County, 2017

**Table 3: DOH Facility Admissions by County, 2017**

	BHI - APD		BHI - Forensic		NMRC		Turquoise Lodge		Yucca Lodge	
	Clients	Percent of total	Clients	Percent of total	Detox Clients only	Percent of total	Clients	Percent of total	Clients (2016)	Percent of total
Bernalillo	69	12%	35	21%	4	6%	583	57%	6	4%
Catron	0	0%	1	1%	0	0%	2	0%	1	1%
Chaves	24	4%	15	9%	29	42%	4	0%	1	1%
Cibola	2	0%	5	3%	0	0%	8	1%	5	3%
Colfax	19	3%	2	1%	1	1%	5	0%	0	0%
Curry	7	1%	7	4%	8	12%	13	1%	0	0%
De Baca	1	0%	0	0%	0	0%	0	0%	0	0%
Dona Ana	59	10%	6	4%	1	1%	31	3%	31	21%
Eddy	4	1%	7	4%	10	14%	6	1%	0	0%
Grant	6	1%	3	2%	0	0%	9	1%	47	31%
Guadalupe	7	1%	1	1%	0	0%	2	0%	0	0%
Harding	0	0%	0	0%	0	0%	0	0%	0	0%
Hidalgo	2	0%	0	0%	0	0%	0	0%	3	2%
Lea	1	0%	2	1%	3	4%	12	1%	0	0%
Lincoln	3	1%	1	1%	1	1%	6	1%	0	0%
Los Alamos	6	1%	1	1%	0	0%	3	0%	0	0%
Luna	3	1%	1	1%	1	1%	5	0%	2	1%
McKinley	3	1%	3	2%	0	0%	16	2%	31	21%
Mora	14	2%	1	1%	0	0%	4	0%	0	0%
Otero	9	2%	6	4%	3	4%	12	1%	1	1%
Quay	14	2%	3	2%	0	0%	4	0%	0	0%
Rio Arriba	9	2%	1	1%	0	0%	48	5%	0	0%
Roosevelt	2	0%	2	1%	3	4%	5	0%	0	0%
San Juan	18	3%	10	6%	0	0%	16	2%	0	9%
San Miguel	152	27%	18	11%	1	1%	19	2%	0	1%
Sandoval	5	1%	7	4%	0	0%	52	5%	0	0%
Santa Fe	50	9%	5	3%	2	3%	65	6%	0	1%
Sierra	0	0%	1	1%	0	0%	2	0%	0	3%
Socorro	4	1%	8	5%	0	0%	17	2%	0	1%
Taos	55	10%	0	0%	0	0%	15	1%	0	0%
Torrance	2	0%	2	1%	0	0%	8	1%	0	0%
Union	1	0%	0	0%	0	0%	0	0%	0	0%
Valencia	7	1%	7	4%	2	3%	56	5%	0	0%
Out of state/ unknown	27	5%	5	3%	0	0%	0	0%	0	0%

Source: DOH facilities