LFC Requester:	Eric Chenier

AGENCY BILL ANALYSIS - 2025 REGULAR SESSION

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SECTION I: GENERAL INFORMATION

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

Date Prepared: *2/6/25* *Check all that apply:*
Bill Number: *SB3* Original __ Correction __
Amendment _x Substitute __

Sponsor: Sen. Stewart
Short Title: BH Reform and Investment Act

Agency Name and Code Number: HCA-630
Person Writing Anita Mesa
Phone: 505.709.5665 **Email** Anitam.mesa@hca.nm.g

SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY25	**FY26**		
$0	$0	NA	NA

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY25	**FY26**	**FY27**		
$0	$0	$0	NA	NA

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Staff Cost	$191.2	$764.9	$764.9	$1,721.0	Recurring	SGF
DDI State Funds	-	$437.0	-	$437.0	Nonrecurring	SGF
DDI Federal Funds	-	$3,933.0	-	$3,933.0	Nonrecurring	FF
DDI Total Computable	-	$4,370.0	-	$4,370.0		
M & O State Funds	-	-	$1,382.4	$1,382.4	Recurring	SGF
M & O Fed Funds	-	-	$4,147.1	$4,147.1	Recurring	FF
M & O Total Computable	-	-	$5,529.5	$5,529.5		
Total	$191.2	$5,134.9	$6,294.4	$11,620.5		
MAD	$0.0	$2,723.6	$2,723.6	$5,447.2	R	MAD GF
MAD	$0.0	$2,723.6	$2,723.6	$5,447.2	R	MAD FF

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to: SB229132-630 and SB228612-630
Duplicates/Relates to Appropriation in the General Appropriation Act

SECTION III: NARRATIVE

BILL SUMMARY

Senate Bill 3 (SB3) would establish the Behavioral Health Reform and Investment Act, requiring the Administrative Office of the Courts (AOC) to designate behavioral health regions, coordinate regional meetings, complete sequential intercept resource mapping, and coordinate the development of regional plans in coordination with the Health Care Authority (HCA) for the expansion of behavioral health services.

It additionally contains a Declaration of Emergency to accelerate the implementation of the bill. The bill references the Office of the Superintendent of Insurance (OSI) to provide "generally recognized standards for behavioral health" to be included in regional plans for fidelity purposes while funding grants to communities proposing services as outlined in said plans.

It further directs HCA to establish a credentialing and enrollment process for behavioral health providers utilized by all Managed Care Organizations (MCO). There is also a provision to provide grants to cover of indigent and uninsured persons.

Amendments:
Section 2C adds language to include: "behavioral health stakeholders" means…behavioral health advocates, higher education institutions within behavioral health regions and nongovernmental entities.

Section 2H adds language to include: "sequential intercept resource mapping" means…..and gaps.

Section 3A adds language to include: The administrative office of the courts shall…If behavioral health stakeholders request to participate in the development of a regional plan, the administrative office of the courts shall include those stakeholders in the development of the planning process…

Section 3B1 adds language: A regional plan shall… and identification of gaps in behavioral health service needs… access for behavioral health services in the region… include an appendix with a list of all behavioral service providers in the behavioral health region.

Amendments 2/12/25

Section 2C Expands definition of "behavioral health stakeholders" to include all of the following: administrative office of the courts, the public defender department, the district attorney's office in the behavioral health region, behavioral health service recipients, behavioral health service providers, behavioral health care advocates, the health care authority, the department of health, the children, youth and families department, the university of New Mexico health sciences center, higher education institutions within behavioral health regions, Indian nations, tribes and pueblos, local and regional governments and other appropriate state or local agencies or nongovernmental entities, including school districts, local and regional law enforcement agencies, local jails or detention centers, behavioral health associations and local behavioral health collaboratives.

Section 2 adds a definition for "disproportionately impacted community" means a community or population of people for which multiple burdens, including mental, substance misuse and physical stressors, inequity, poverty, limited behavioral health services and high unemployment, may act to persistently and negatively affect the health and well-being of the community or population.

Section2F adds public health officials; and (8) certified peer support workers.

Section 3 Adds Composition of Behavioral Health Executive Committee and duties.

Section 4A Regional Plan—Sequential Intercept Mapping –Reporting Requirements adds language placing HCA responsible to ensure that the regional plan does not jeopardize the Medicaid program and void if necessary.

Section 4B adds responsibilities to the behavioral health stakeholder's role such as meeting participation, expertise, regional plan development, report submission, data sharing.

Section 4C adds language directing AOC and HCA to utilize data to identify gaps in the sequential intercept mapping to ensure behavioral health coverage prior to finalizing plans, states grant funding awards are contingent upon final regional plans.

Section 4 D clarifies language as to what the regional plan shall entail.

Section 4F adds responsibility to the HCA, in consultation with the LFC and the LHHS to determine baseline data collection points to be collected and reported in all reports.

Section 4G adds responsibility to the Behavioral Health Executive Committee, no later than June 30, 2027 and by every June 30 thereafter, shall designate a government entity within each behavioral health region to provide a written report to the legislature and the judicial and executive branches of government. G further clarifies and adds criteria for the report.

Section 4H adds responsibility to the AOC to provide the appropriate interim legislative committees and the HCA a monthly update on the status of sequential intercept mapping and regional planning and date submission cadence.

Section 4I adds responsibility to higher education institutions within behavioral health regions to coordinate with the HCA, the workforce solutions department and other behavioral health stakeholders to create a behavioral health workforce pipeline for the behavioral health services identified within regional plans and includes criteria for the workforce pipeline.

Section 4J adds language stating "New Mexico's single state authority, the behavioral health services division of the health care authority shall continue to oversee the adult behavioral health system, including programming and rulemaking. Nothing in the Behavioral Health Reform and Investment Act shall be interpreted to imply anything to the contrary. The health care authority remains the primary designated federal entity for the state medicaid program".

Section 5A adds responsibility to HCA, in consultation with other state agencies that have behavioral health programs, to provide AOC recognized standards for behavioral health services for the adoption and implementation in regional plans and any behavioral health service access priorities or gaps in the regions.....to ensure behavioral healthcare services are delivered....HCA shall confirm ....regional plan meets behavioral health standards.....

Section 5B adds responsibility to HCA and LFC to provide evaluation guidelines....HCA in consultation with LFC shall confirm whether behavioral health service in each regional plan meets evaluation guidelines.

Section 6A amends language for clarity and changes letters to numbers.

Section 6B adds language stating "a behavioral health region may request to repurpose any unexpended balance of a grant subject to the Behavioral Health Reform and Investment Act to another identified funding priority within that region, and the health care authority shall approve that request" then adds criteria for the approval.

Section 7 Adds language stating "No later than December 31, 2025, the health care authority, in consultation with the legislative finance committee and the legislative health and human services committee, shall establish a working group of health care licensing boards to streamline the process to verify behavioral health licensing and improve the overall behavioral health licensing process. The working group shall provide the legislature with statutory recommendations if needed".

Was Section 7 Prohibition on Caps, is removed.

Section 8 New Section outlines Behavioral Health Service Limitations and HCA responsibilities such as, rule promulgation on the benefits and structure related to behavioral health services.

Section 9 New section 988 and 911 coordination and HCA responsibilities as the 988 managing agency.

Section 10 New section Behavioral Health Audit and Evaluation Requirements and HCA responsibilities such as monitoring, auditing contracts, quality, financial and programmatic compliance, gap analysis cadence, data requests, plan review, evaluation review.

Section 11 Repeal Section 24A-3-1NMSA 1978 which is the establishment of the Behavioral Health Collaborative.

FISCAL IMPLICATIONS

As written, it is difficult to determine the fiscal impact to HCA and the exact staffing level to implement the bill. After considering the operating and fiscal impacts of three proposed behavioral health-focused bills (SB229254-630, SB229132-630, and SB228612-630) the HCA Behavioral Health Division estimates it would need a minimum estimate of twenty-two (22) FTE, resulting in $2,690,500 total SGF annually for salaries and benefits.

Specifically, as it relates to SB3 implementation, HCA estimates a minimum of six (6) FTE, resulting in $764,900 SGF annually for salary and benefits as illustrated in the table above.

HCA plans to implement a centralized credentialing system for all provider types including behavioral health. However, this funding is not currently allocated to the HCA Medical Assistance Division. The design, development, and implementation (DDI) of the system would require $4,370,036 for the first 12 months. Maintenance and operation (M&O) for subsequent years will require an additional estimated cost of $5,529,506. Illustrated in the table above, is the estimated additional operating budget impact for the Medicaid cost allocation model: 90% federal funds ($3,933,000), and 10% state funds ($437,000) for DDI; 75% federal funds ($4,147,100), and 25% state funds ($1,382,400) for M&O.

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

The Medical Assistance Division (MAD) estimates required general fund for 13 FTE and contract costs. Since the bills will likely result in expanded Medicaid reimbursable services, FTE will be needed as program managers for implementation and oversight of expanded services, MCO monitoring and oversight, and increased data and KPI analysis and reporting. This bill will require significant initial and ongoing coordination of the administrative office of the courts related to the Medicaid Managed Care Services Agreement, Managed Care Medicaid Provider Network and scope of Medicaid Services. This bill will also require MAD to process and coordinate requests for the Managed Care provider network related to the sequential intercept mapping of this bill. The total FTE cost is $1,447,200 with a general fund cost of $723,600.

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

SIGNIFICANT ISSUES

Amendments 2/12/25
Section 2C HCA recommendation to include “individuals receiving behavioral health services”

Section 2F(8) HCA recommendation to specify adult, youth and family peer support workers.

Section 4A and throughout HCA recommendation to specify 0-6 when referencing sequential intercept mapping. (e.g. sequential intercept mapping 0-6)

Section 4D HCA two recommendations: 1) to include that the plan shall require that each has a designation of a capable entity responsible and accountable for executing the regional plan; 2) Should a region fail to reach consensus, HCA using data informed decisions, will allocate funds in alignment with bill’s intentions.

Section 5A It is unclear what is defined as behavioral health standards. Clarification is needed.

Section 6 requiring the health care authority shall establish a universal behavioral health service provider credentialing and enrolling process for all managed care organizations to reduce the administrative burden on behavioral health providers is duplicative existing Medicaid Managed Care Services Agreement section 4.8.16.5 that requires the same.

Section 7 Oversight of licensing is a multi-agency responsibility. Regulation & Licensing oversees individual clinical specialty licensing, Children Youth and Families oversees Licensing and certification of provider facilities and/or services for children and adolescents and HCA oversees licensing for adult behavioral health facilities. It may be difficult to implement uniform or streamlined licensing processes as the requirements vary by agency, administrative code, facility type, clinical specialty and profession.

Section 7 which requires that a Managed Care Organization not limit the number of new behavioral health patients that a behavioral health service provider serves if the provider has the capacity to provide services has the potential to create confusion related to the authority to determine if the provider has capacity. A Managed Care Organization is responsible for the administrative and oversight of their respective providers.

Section 8 It is unclear as to what is defined as behavioral health limitations. Clarification is needed.

Section 10 and throughout there is no reference to Department of Health collaboration on data sharing. NM Department of Health is the primary source of epidemiological and other health related data. It is crucial to have access to data from the Department of Health.

The bill appears to completely restructure the state’s behavioral health delivery system, transferring control and funding to the courts and local governments with few guardrails. As New Mexico’s Single State Authority (SSA), the Health Care Authority Behavioral Health Services Division (HCA BHSD) oversees the adult behavioral health system including programming, funding for patient services and rulemaking. A state's single-state behavioral health authority plays

a crucial role in the mental health and substance use treatment landscape, wielding significant influence and responsibility within the state and are designated to give behavioral health providers a single source of guidance and expertise.

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

- SSAs develop and implement policies that guide behavioral health services across the state, ensuring alignment with federal guidelines and state-specific needs.
- SSAs coordinate the delivery of mental health and substance use services, ensuring accessibility, quality, and integration across various providers and settings.
- SSAs manage state and federal funds allocated for behavioral health services, ensuring efficient use and compliance with financial regulations.
- SSAs monitor and improve the quality of behavioral health services through data analysis, performance evaluation, and implementing evidence-based practices.
- SSAs oversee crisis intervention and emergency mental health services, ensuring readiness and effective response during emergencies.
- SSAs collaborate closely with other state agencies, healthcare providers, community organizations, and advocacy groups to create a comprehensive behavioral health system that meets the diverse needs of the population.
- SSAs advocate for individuals with mental illness and substance use disorders, representing the state's interests in national discussions on behavioral health policy and funding.

The bill reassigns the role of the HCA as the state's behavioral health expert and main point of accountability to other entities and agencies. Specifically, the bill, as written in Section 3.A-D, would authorize the AOC to assume decision making authority over behavioral health services that reach beyond the intent of sequential intercept resource mapping. In so doing, it would impact HCA's ability to serve as the SSA for behavioral health services and ensure a broad continuum of care for New Mexicans. This can also create confusion for providers receiving direction and guidance from different state agencies. There would have to be significant coordination to avoid conflicting guidance and maintenance of state and federal requirements.

The language as currently written in Section 6 requiring a universal behavioral health credentialing process is duplicative of the existing Medicaid Managed Care Service Agreement that requires the transition and implementation of centralized credentialing.

> *4.8.16 Standards for Credentialing and Recredentialing*
> *4.8.16.1 HCA intends to implement centralized credentialing and recredentialing applicable to all MCOs during the term of this Agreement. The CONTRACTOR shall assist HCA with the transition and implementation of centralized credentialing and recredentialing and comply with all HCA requirements related thereto*.

The language, as currently written in Section 7, directs a Managed Care Organization shall not limit the number of new behavioral health patients that a behavioral health service provider, is potentially restrictive. While there are no limitations in the Medicaid Managed Care Services Agreement for the number of members a behavioral health service provider may serve, Managed

Care Organizations may have quality of care concerns, primarily, the continuity of care provided to the members. (Continuity of care ensures individuals can be seen ongoing in alignment with their clinical needs). The impact of this can be that clinics may not be able to see unlimited numbers beyond their capacity and impacting their ability to see individuals ongoing. MAD recommends language that ensures continuity of care for the members (i.e., no limitations of the members a provider may see provided members are able to see the behavioral health provider on a regular cadence based on clinical guidelines).

PERFORMANCE IMPLICATIONS

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

It is unclear as to what branch of government would hold final authority for compliance and technical assistance specific to evidence-based practices, program fidelity, federal and state reporting, evaluations and quality service reviews. As written, the bill assigns various components to different agencies which may not have subject matter expertise in behavioral health and dilutes efforts for further collaboration amongst state partners. In creating a decentralized system, some regions may not be equipped to stand up resources in a timely manner and would require a significant investment for infrastructure including personnel, regulatory controls and resource development.

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

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

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

State and federal partners outline and require significant reporting on access to care, quality outcomes, etc. This bill, as written, may dilute or impact the data and will increase monitoring and evaluation. While positive to have increased monitoring and evaluation, if too many items are measured simultaneously, the ultimate burden is felt by the provider. Like quality oversight, the

provider, having several state agencies to answer to and contract with can create undue administrative burden and confusion. Increased confusion and administrative burden on providers can lead to a decrease in performance and/or capacity reducing the availability of appointments for New Mexicans.

ADMINISTRATIVE IMPLICATIONS
BHSD would need to collaborate with AOC to develop priorities, policy, procedures, performance measures, and data collection for the expansion of behavioral health services specific to the established regional areas. The administrative implications of this proposal on the HCA potentially span financial management, policy development, service coordination, compliance, and reporting functions. Much of these functions are those the HCA BHSD and MAD currently perform for other initiatives (e.g. fund administration, budgeting and allocation, monitoring and utilization, stakeholder engagement, regulatory compliance), but the HCA will need additional staffing capacity to expand and/or coordinate these efforts with the AOC.

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

Finally, the bill lacks a defined approach for residential substance use disorder services, something that the HCA has been focused on for several years. Clarification on whether the regional plans would include the build-out of residential treatment, or whether the HCA retains this responsibility is advised.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

Relationship to SB229132-630 and SB228612-630

TECHNICAL ISSUES
None

OTHER SUBSTANTIVE ISSUES
The HCA strongly supports funding the AOC and judiciary to fill gaps, support forensic evaluations and treatment courts, and improve behavioral health service navigation for people who are involved in the justice system; and for executing the Sequential Intercept Model (SIM). The HCA also strongly supports financing behavioral health infrastructure – including making capital investments – across New Mexico, as appropriate.

The HCA is the largest payor of behavioral health care in NM. HCA Medicaid is the payor of behavioral health services for the Medicaid eligible population, and HCA BHSD is the payor of behavioral health services for the uninsured individuals and those ineligible for Medicaid. Together, these two HCA Divisions finance more than 90% of behavioral health care expenses in

NM in FY25. This better integrated financing structure was made possible by the passage of the 2014 Federal Patient Protection and Affordable Care Act.

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

As proposed this discussion bill conflicts with the New Mexico State Constitution at Article III, Separation of Powers. The clear mandate and limitation of the Courts, in any role or sub-agency thereof, is adjudication of matters of law and the role envisioned here is encroachment on the management of information and money rightfully under the executive branch.

ALTERNATIVES
None

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

AMENDMENTS

The amendments to SB3 do not directly impact the Health Care Authority.

2/12/25 Amendments: HCA impacts and recommendations are noted in Significant Issues.