New Mexico Behavioral Health Assessment and Feasibility Study

Final Report, Prepared by Manatt Health for the New Mexico Health Care Authority

January 2026

Acronym List

ABI: Acquired Brain Injury

ABP: Alternative Benefit Plan

ACA: Affordable Care Act

ACT: Assertive Community Treatment

ADL: Activities for Daily Living

APRN: Advanced Practice Registered Nurse

ASAM: American Society of Addiction Medicine

AUD: Alcohol Use Disorder

BHRIA: Behavioral Health Reform and Investment Act

BHSD: New Mexico Behavioral Health Services Division

BISF: Brain Injury Services Fund

CCBHC: Certified Community Behavioral Health Clinics

CCSS: Comprehensive Community Support Services

CFR: Code of Federal Regulations

CMS: Centers for Medicare and Medicaid Services

CNA: Comprehensive Needs Assessment

CPSW: Certified Peer Support Worker

CSW: Community Support Worker

CYFD: New Mexico Children, Youth and Families Department

DBT: Dialectical Behavior Therapy

DCO: Designated Collaborating Organization

DD: Developmental Disabilities

DOH: Department of Health

ECHO: Extension for Community Healthcare Outcomes

EMDR: Eye Movement Desensitization and Reprocessing

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment

FACT: Forensic Assertive Community Treatment

FDA: Food and Drug Administration

FFS: Fee-for-Service

FFT: Functional Family Therapy

FTE: Full-Time Employee

FFY: Federal Fiscal Year

HB: House Bill

HCA: New Mexico Health Care Authority

HCBS: Home- and Community-Based Services

HFW: High-Fidelity Wraparound

HHS: U.S. Department of Health and Human Services

HRA: Health Risk Assessment

HRSN: Health-Related Social Needs

HUD: U.S. Department of Housing and Urban Development

HUD-VASH: U.S. Housing and Urban Development Veteran Affairs' Supportive Housing Program

IADL: Instrumental Activities of Daily Living

ICF: Intermediate Care Facility

IDDT: Integrated Dual Diagnosis Treatment

I/DD: Intellectual and/or Developmental Disability

IID: Individuals with Intellectual Disabilities

IHS: Indian Health Service

IPS: Individual Placement and Support

ILOS: In Lieu of Services

IMD: Institution for Mental Disease

KAI: Kauffman and Associates Incorporated

LFC: Legislative Finance Committee

LIHTC: Low-Income Housing Tax Credit

LOC: Level of Care

LTSS: Long-Term Services and Supports

MAD: Medical Assistance Division

MAT: Medication-Assisted Treatment

MCO: Managed Care Organization

MFA: New Mexico Mortgage Finance Authority

MHBG: Mental Health Block Grant

MOU: Memorandum of Understanding

MRSS: Mobile Response and Stabilization Services

MST: Multi-Systemic Therapy

NEMT: Non-Emergency Medical Transportation

NF: Nursing Facility

NFLOC: Nursing Facility Level of Care

OTP: Opioid Treatment Program

OUD: Opioid Use Disorder

PSH: Permanent Supportive Housing

RHTP: Rural Health Transformation Program

SAHP: Set Aside/Special Needs Housing Program

SAMHSA: Substance Abuse and Mental Health Services Administration

SUPTRS: Substance Use Prevention, Treatment, and Recovery Services

SB: Senate Bill

SED: Severe Emotional Disturbance

SFY: State Fiscal Year

SMI: Serious Mental Illness

SOR: State Opioid Response

SPA: State Plan Amendment

SSDI: Social Security Disability Income

SSI: Supplemental Security Income

SUD: Substance Use Disorder

TBI: Traumatic Brain Injury

TFC: Treatment Foster Care

TF-CBT: Trauma-Focused Cognitive Behavioral Therapy

UNM: University of New Mexico

Executive Summary

Purpose of the Study

During its 2025 legislative session, the New Mexico Legislature directed the Health Care Authority (HCA) to study the "merits, feasibility, costs, and likely enrollment in a proposed new Medicaid waiver for individuals with serious mental illness (SMI) or substance use disorder (SUD) who experience regular confinement in county jails or intensive overuse of hospital emergency rooms or other emergency or crisis services versus continuing with the current service array for people with SMI." The Medical Assistance Division (MAD) of the New Mexico HCA (herein referred to as New Mexico Medicaid) contracted with Manatt Health and its subcontractors—Milliman and Kauffman and Associates Incorporated (KAI)—for this analysis. At New Mexico Medicaid's direction, the study also includes an inventory of services covered by Medicaid and with federal block grants and state funds for people who are uninsured or underinsured ("state-funded services"), a broader review of gaps and opportunities to improve services for people with complex behavioral health issues and/or brain injury in New Mexico, and a comprehensive set of actionable recommendations.

New Mexico's Behavioral Health System: Strengths and Opportunities for Progress

Over the past several years, New Mexico has made significant investments in behavioral health. The state now spends approximately $1 billion annually[1] on behavioral health services, serving 295,000[2] individuals each year. Medicaid serves as the backbone of the state's behavioral health system, accounting for the vast majority—88 percent—of these expenditures.

Scope of Services Covered

Through Medicaid, New Mexico covers a broad continuum of mental health and SUD services aligned with national best practices. This includes assertive community treatment (ACT), high-fidelity wraparound (HFW) for children and youth, a full continuum of American Society of Addiction Medicine (ASAM)-aligned SUD services, evidence-based psychotherapies, peer and family supports, and an increasingly robust crisis services array. Many of these services also are covered as state-funded services for New Mexicans who are uninsured or underinsured. Through initiatives such as Linkages and the Set Aside/Special Needs Housing Program (SAHP), New Mexico has established permanent supportive housing (PSH) programs that combine rental assistance with supportive services.

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[1] New Mexico Legislative Finance Committee. "Medicaid and Behavioral Health Overview." 27 June 2025, https://www.nmlegis.gov/handouts/LHHS%20062525%20Item%2015%20Behavioral%20Health%20Medicaid.pdf Assumes the SFY 2025 Medicaid budget includes (in thousands) Medicaid Behavioral Health, Managed Care ($520,106); Medicaid Behavioral Health, Managed Care Expansion Population ($311,568) and Medicaid Behavioral Health, FFS ($67,763). Assumes the SFY 2025 state-funded budget includes (in thousands) BHSD Community Mental Health Services ($35,877.7), BHSD Substance Use Services ($45,106.4), the opioid transfer fund ($7,339) and CYFD funding ($33,619.3). CYFD funding amount provided by CYFD on January 12, 2025.

[2] New Mexico Legislative Finance Committee. "PERFORMANCE REPORT CARD Behavioral Health Collaborative Second Quarter, Fiscal Year 2024." 2024, https://www.nmlegis.gov/Entity/LFC/Documents/Agency_Report_Cards/6.%20BHSD%20FY24%20Q2%20Report%20Card%20FINAL.pdf

Recent Reforms, Including Senate Bill (SB) 3

Recent initiatives further strengthen this foundation. Medicaid provider rate increases to 150 percent of Medicare rates have materially improved recruitment and retention, with measurable growth in the behavioral health workforce. Certified Community Behavioral Health Clinics (CCBHCs) are expanding access to integrated care, while mobile crisis services and justice-involved re-entry initiatives (JUST Health Plus)—when more fully implemented—could help address long-standing pressure points. The state is instituting a series of reforms to improve care for people transitioning out of hospitals and residential facilities, prompted in part by the 2024 approval of a major Medicaid 1115 demonstration (also referred to as an 1115 waiver) that, among other things, allows New Mexico to use federal Medicaid matching funds to cover the cost of short-term stays in larger residential treatment centers for people with mental health issues and/or SUDs. Finally, in 2025, New Mexico adopted SB 3, the Behavioral Health Reform and Investment Act (BHRIA), an ambitious effort to reform the state's behavioral health system through a multi-year regional planning process accompanied by substantial new funding. The state ultimately aims to leverage Medicaid dollars to sustain regional investments made as a result of SB 3.

Remaining Gaps and Opportunities

At the same time, New Mexico's behavioral health system faces sizeable gaps. Although coverage of services is relatively strong on paper, there are significant access issues, particularly in rural and frontier areas where services such as ACT and crisis care are limited due to a shortage of providers. Some high-need individuals do not qualify for certain home- and community-based services (HCBS) that could support their ability to live successfully in the community, and there are significant challenges in finding appropriate step-down options for those transitioning from inpatient or residential treatment. While Linkages and SAHP are model programs, the availability of PSH falls short of demand, and navigational supports systems are often fragmented. People with brain injury are not always identified and may not receive adequate services or support. Some intensive Medicaid-funded services are not accessible to uninsured or underinsured individuals (e.g., intensive outpatient for mental health for adults or partial hospitalization services for mental health for youth and adults).

Recommendations

To build on its existing strengths and address gaps in the current system, the analysis recommends six major strategies. The report recommends sequencing and phasing in the proposed changes, reflecting it would not be feasible to implement all of the recommendations simultaneously. New Mexico already has a significant number of initiatives and resource-intensive changes underway as a result of SB 3, new fiscal and administrative challenges posed by HR 1 (119th Congress), and other federal Executive Branch actions. As a top short-term priority, the report recommends focusing on increasing access to already-covered behavioral health services—such as ACT—and expanding PSH and transitional housing (Strategy #1 and Strategy #2) without the need for new federal authority. Under any scenario, it will be important to align implementation of new strategies with the work already underway in New Mexico.

In addition, the analysis recognizes that shifting federal priorities make it an uncertain and complex time to attempt to secure a major new Medicaid waiver. Even seeking to amend the state's existing Turquoise Care 1115 demonstration could have unintended consequences. As a result, the report does not make any recommendations that would necessitate changes to New Mexico's current 1115 demonstration prior to the next required federal renewal at the end of 2029. To address gaps HCBS for people at high risk of incarceration, homelessness or frequent hospitalization, the report suggests that instead, New Mexico consider pursuing a 1915(i) State Plan Amendment (SPA) if the gaps remain after a few years of SB 3 implementation.

Strategy #1: Increasing Access to Already-Covered Behavioral Health and Brain Injury Services

New Mexico's behavioral health system offers a wide range of services, but many residents—especially those in rural and frontier areas—still struggle to access the care they need. The state's ACT teams, crisis services, and outreach efforts are vital, but their reach and effectiveness are limited by workforce shortages, geography, and lack of awareness. This strategy aims to close those gaps by expanding the availability and expertise of ACT teams, strengthening crisis response, and ensuring that eligible individuals know about and can access the Community Benefit program. Some of the work expanding the capacity of providers to offer already-covered services such as ACT and crisis services could be integrated into SB 3 initiatives, assuming it is consistent with one or more regional entity's priorities. Maintaining Medicaid payment rates is also crucial to attracting and retaining providers, which directly impacts service availability.

Key Recommendations:

- Expand the number and reach of ACT teams, especially in underserved areas, ideally as part of regional priorities under SB 3 (No new federal authority needed)
- Support ACT teams in developing expertise for SUD and justice system involvement (No new federal authority needed)
- Strengthen statewide crisis services, including mobile crisis teams (No new federal authority needed)
- Conduct outreach to explain that individuals with behavioral health needs or brain injury who have co-occurring physical health disabilities may qualify for the Community Benefit program (No new federal authority needed)
- Retain current Medicaid payment rates to support provider participation (No new federal authority needed)

Strategy #2: Leveraging Existing Initiatives to Expand PSH and Transitional Housing

Stable housing is foundational to recovery and community integration for people with behavioral health and brain injury needs. New Mexico has made progress with PSH programs, but the supply still falls short of demand. Currently, the state serves 920 people through Linkages and SAHP but estimates suggest that an additional 3,000 to 4,000 people within New Mexico could benefit from such programs. This strategy focuses on maximizing the impact of existing Medicaid-funded housing supports, expanding transitional housing options, and streamlining referral pathways to make it easier for individuals to access housing. Accelerating the implementation of medical respite services – which cover up to six months of room and board and supportive services for people who are homeless and who are too ill to recover from sickness or injury on the street or in a shelter but do not require hospital level care —would support people transitioning from hospitals.

Key Recommendations:

- Expand PSH to reduce unmet need (No new federal authority needed)
- Increase utilization of Medicaid-funded pre-tenancy and tenancy services (No new federal authority required to increase utilization of already-authorized service units; if more service

units are required, could be addressed during next renewal of Turquoise Care 1115 demonstration in late 2029)
- Grow transitional and interim housing programs (Use of federal grant dollars requires approval of overseeing federal agency, but no new Medicaid approval)
- Standardize referral and entry processes for supportive housing (No new federal authority needed)
- Expand implementation of medical respite benefit (No new federal authority needed)

Strategy #3: Streamlining and Strengthening Navigational Supports

Navigating New Mexico's behavioral health system can be confusing. To address this challenge, many stakeholders cited a need for a new case management benefit for people with SMI, severe emotional disturbance (SED), and SUD, like what is available to individuals enrolled in the state's Developmental Disabilities or "DD" waiver. At the same time, there are many existing services and programs already potentially available to individuals with SMI, SED, and SUD that provide navigational support. Health Homes and CCBHCs, which the state is expanding, provide varying levels of intensity of case management and care coordination. Managed care organizations (MCOs) are required to provide care coordination to all enrollees. Services such as Comprehensive Community Support Services (CCSS), ACT and HFW include elements of navigational support. However, many individuals and providers are unaware of the available options, leading to gaps in care and people "falling through the cracks." For people engaged in one or more options, support is often fragmented or overlapping.

This strategy seeks to establish a clear framework for routing individuals to the most appropriate type of navigational support, encourage MCOs to delegate more care coordination to community providers, and develop specialized support for people living with brain injury. The goal is to create a more seamless, person-centered system that matches services to individual needs.

Key Recommendations:

- Establish a framework for routing individuals to the right case management program, care coordination or high-intensity service that includes navigational support (No new federal authority needed)
- Require MCOs to delegate care coordination for complex cases to Health Homes, CCBHCs, and Opioid Treatment Programs (OTPs) (No new federal authority needed)
- Develop more specialized and intensive care coordination for people with brain injury (No new federal authority needed)

Strategy #4: Expanding Community-Based Services for People with Complex Behavioral Health Conditions and/or Brain Injury, including a Potential 1915(i) SPA

While New Mexico's Community Benefit program provides important HCBS, eligibility requirements mean that individuals at high risk of incarceration, homelessness or frequent hospitalizations do not qualify for these services unless they also have co-occurring physical health issues that necessitate a nursing facility level of care (NFLOC). Even within the Community Benefit program, there are some discrete gaps in the covered services that are particularly important for people with SMI, SUD, and brain injury (e.g., services focused on addressing instrumental activities of daily living (IADL). This strategy recommends that New Mexico consider pursuing a 1915(i) SPA to fill these gaps, offering targeted HCBS

– such as community transition services, personal care, and life skills coaching – to people who need extra support to live independently. Given the significant changes coming to New Mexico as a result of SB 3, the report recommends that New Mexico consider gaining experience with SB 3 before pursuing a new 1915(i) SPA. After a few years of SB 3 implementation, the state can assess whether discrete gaps remain in the state's service continuum, as well as whether a 1915(i) SPA can help offer sustainable Medicaid financing for some of the regional SB 3 initiatives. Finally, aligning state-funded benefits with Medicaid to the extent financially feasible would ensure that all residents have access to essential services, regardless of insurance status.

Key Recommendations:

- Consider a new 1915(i) SPA to address gaps in HCBS for at-risk populations if still needed after the state gains experience with SB 3 regional planning efforts (Would require federal authority for a new 1915(i) SPA)
- Align state-funded benefit packages with the current Medicaid State Plan, especially for intensive outpatient and partial hospitalization services (No new federal authority needed)

Strategy #5: Adopting Tailored Strategies for Populations of Focus

Certain groups—such as people living with brain injury, children and youth, individuals requiring nursing facility (NF) placement, and those with SUD—face unique challenges. This strategy calls for targeted interventions to address their specific needs, including specialized care coordination, expanded residential treatment options, and improved access to recovery services. By focusing on these populations, New Mexico can ensure that reforms are tailored to the specific challenges faced by each population.

Key Recommendations:

- For people with brain injury: Increase funding for the Brain Injury Services Fund (BISF) Program, establish specialized care coordination, and expand community-based supports (Would require a new 1915(i) SPA to expand community-based supports; no other new federal authority needed)
- For children and youth: Expand the reach of HFW and other evidence-based practices, create in-state residential treatment for young people who identify as female, ensure that residential treatment facilities are trained to serve special populations, and adapt the mobile crisis model for rural areas (No new federal authority needed)
- For individuals requiring NF placement: Address denials based on behavioral health issues, incentivize facilities to accept people with complex behavioral health issues, pilot small nursing facilities for this population, and provide staff training on working with people with complex behavioral health needs (No new federal authority needed)
- For individuals with SUD: Scale effective treatment models for pregnant/postpartum women, facilitate Medicaid funding for treatment provided in recovery housing, expand access to medication-assisted treatment (MAT), and consider focused initiatives aimed at stimulant and alcohol use disorders (AUDs) (Expanded access to MAT would require Substance Use and Mental Health Services Agency (SAMHSA)/Drug Enforcement Administration(DEA) approval but no new Medicaid approval; no other new federal Medicaid authority needed with exception of seeking Medicaid funding for contingency management, which could be addressed during next renewal of Turquoise Care 1115 demonstration in late 2029)

Strategy #6: Strengthening the Foundational Elements of New Mexico's Behavioral Health System Such as the Behavioral Health Workforce

A strong behavioral health system depends on a robust workforce, effective navigation tools, and reliable transportation. New Mexico faces provider shortages, especially in rural areas, and complex licensing and enrollment procedures. Consumers and providers alike struggle to find information about available services. This strategy recommends continued investment in workforce development, creation of centralized online hubs and navigation tools, and improvements to transportation. These foundational elements are critical to ensuring that services are sustainable and accessible to all who qualify for them.

Key Recommendations:

- Continue efforts to address workforce shortages and fund loan repayment programs (No new federal authority needed)
- Incentivize retention and career growth for Certified Peer Support Workers (CPSW) (No new federal authority needed)
- Participate in healthcare licensing compacts for additional provider types, including psychologists, advanced practice registered nurses (APRNs), social workers, and counselors (No new federal authority needed)
- Develop centralized online hubs and navigation tools for behavioral health and brain injury resources (No new federal authority needed)
- Improve consumer-facing resources on non-emergency medical transportation, expand non-medical transportation coverage, and explore a pilot of a new Medicaid non-law enforcement transportation service (Expanding non-medical transportation would require a new 1915(i) SPA – see Strategy #4)

Does New Mexico Need a Waiver?

A central finding of this study is that a major new federal Medicaid waiver is not needed at this time. Waivers can involve substantial administrative complexity, require ongoing federal negotiation and oversight, and introduce uncertainty—particularly in a changing federal policy environment when it is not clear what will be approved. Moreover, some of the most pressing needs identified in this study, including those related to housing, cannot readily be addressed through new federal Medicaid authority, regardless of waiver type. For example, at this point in time, there is little to no possibility that the federal government will approve a new waiver that allows Medicaid funds to be used to cover the cost of room and board – in group homes or in any other setting – for people with SMI, SUD or brain injuries living in the community.[i]

New Mexico expects that in the coming years, investments under SB 3 will create significant new supports for people with complex behavioral health needs who have been incarcerated or frequently use emergency or crisis services. Given that regional planning efforts are still in their early stages, it is not clear what specific strategies will be adopted. As such, the report recommends that in the next two to three years, after the state has more experience with SB 3, HCA assess the extent to which gaps remain in HCBS for these adults, in addition to those with brain injury. If people with complex behavioral health needs and brain injury are still facing service gaps, New Mexico may want to consider pursuing a 1915(i) SPA (as referenced in Strategy 4). A 1915(i) SPA allows New Mexico to: offer new HCBS to adults with needs less than an institutional LOC (e.g., care provided in a NF); fill discrete gaps in its current

service array; avoid the complexity and uncertainty of a major Medicaid 1115 demonstration; and phase in new benefits over a five-year period.

From a fiscal perspective, estimates in the full report suggest that a 1915(i) SPA, depending on final design, could serve approximately 7,185 individuals with SMI, SUD or brain injury statewide once fully phased in, with an estimated annual gross cost of $33.7 million, depending on take-up and utilization of services. Federal Medicaid matching funds would cover roughly 71% of these costs, leaving a state share of approximately $9.7 million annually. This cost estimate assumes service delivery would begin in 2030.

While a 1915(i) SPA is readily approvable by the federal government, including under the current Administration, it still requires significant state administrative resources and oversight. For example, the state would need to develop new services that are not offered today, determine rates for new services, and hire new staff to oversee the SPA. In addition, the state would need to work with MCOs to ensure that there are sufficient providers equipped to respond to an increase in the number of people who qualify for HCBS, as well as to provide the new services that would be made available under the potential 1915(i) SPA. Ultimately, it is New Mexico's decision-makers who will need to determine whether seeking approval for a 1915(i) SPA is appropriate and affordable, taking into account the estimated cost, state administrative burden, the capacity of the state's workforce, and competing priorities.

Conclusion

As New Mexico considers how to help people with SMI or SUD who experience regular confinement in county jails or intensive overuse of hospital emergency rooms or other emergency or crisis services, the central challenge facing the state is not the absence of federal authority, but how best to strengthen and align New Mexico's many notable behavioral health and re-entry initiatives. New Mexico already has established a relatively robust, evidence-based continuum of behavioral health services; secured approval of an ambitious Medicaid 1115 demonstration that provides it with resources and opportunities not available to most other states; and it has launched a major new regional planning initiative. Regardless of whether it eventually pursues new services through a 1915(i) SPA, New Mexico can make significant progress in the short-term by focusing on implementation of existing initiatives, expanding access to already-covered services, conducting more outreach and education, and closely coordinating its statewide work with regional planning under SB 3.

Introduction

Purpose of the Behavioral Health Assessment and Feasibility Study

During its 2025 legislative session, the New Mexico Legislature appropriated funding via House Bill (HB) 2 for the Health Care Authority (HCA) to study the "merits, feasibility, costs, and likely enrollment in a proposed new Medicaid waiver" for individuals living with complex behavioral health conditions and/or brain injury. As defined by the legislature, this includes individuals "with serious mental illness (SMI) or substance use disorder (SUD) who experience regular confinement in county jails or intensive overuse of hospital emergency rooms or other emergency or crisis services." In response, the Medical Assistance Division (MAD) of the New Mexico HCA (herein referred to as New Mexico Medicaid) contracted with Manatt Health and its subcontractors—Milliman and Kauffman and Associates Incorporated (KAI)—after a competitive procurement process to undertake the analysis. Along with addressing this core question about whether a waiver should be used, New Mexico Medicaid asked that Manatt Health more broadly address the strengths and gaps in New Mexico's behavioral health system, including factors that influence access, continuity, and coordination of care for high-need populations.

To meet the requirements of the legislature and to provide additional information and recommendations to New Mexico Medicaid, this study broadly identifies the strengths and gaps in New Mexico's behavioral health and brain injury systems and strategies for addressing them. Specifically, the study includes:

- **A comprehensive inventory and assessment of the continuum of behavioral health and brain injury services** currently available in New Mexico through Medicaid and state-funded sources, including those overseen by HCA's Behavioral Health Services Division (BHSD) and New Mexico's Children, Youth and Families Department (CYFD).
- **A review of gaps and barriers to accessing care along with actionable recommendations and feasibility analyses** to inform the design and implementation of future behavioral health and brain injury initiatives. These are based on insights from a comprehensive stakeholder engagement process implemented in partnership with KAI, analysis of utilization of Medicaid and state-funded services conducted by Milliman, and a systematic review of New Mexico's behavioral health policies, including comparison to other states and trends in national best practices.
- **Focused discussion of priority populations identified by New Mexico Medicaid,** including children and youth, individuals with brain injuries, and other high-need populations living with complex behavioral health conditions.
- **A detailed analysis of the potential role that a Medicaid waiver—or alternative federal authorities**—could play in New Mexico's efforts to improve its behavioral health and brain injury system for individuals living with complex mental health, SUDs, brain injury, or a combination of one or more of those conditions.
- **An assessment of the feasibility of securing federal authority to implement the recommendations,** along with **strategies for phasing them in over time** as part of a realistic effort to build a more integrated, equitable, and effective behavioral health and brain injury system.

Scope of the Issues Addressed

At the request of New Mexico Medicaid, the study takes a wholistic approach to identifying the services and issues that must be addressed to improve the state's behavioral health system for people living with complex behavioral health conditions and/or brain injury.

Call Out Box 1

Throughout this report, the term "behavioral health" is used to encompass both mental health and SUD.

What's Included?

- **An analysis of behavioral health and brain injury services across funding sources**. The study examines both Medicaid-funded and other behavioral health and brain injury services administered by the BHSD, including those provided with state dollars or with federal or other grant funding (e.g., SAMHSA's Community Mental Health Block Grant (MHBG), Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant, State and Tribal Opioid Response grants) and CYFD for children and youth. Unless otherwise noted, the study uses "behavioral health system" to encompass services across funding sources, not Medicaid alone. Brain injury services are also a focus, given that these conditions are at the root of many people's experiences with mental health, SUD, and/or justice system involvement.
- **A focus on housing and other health-related social needs (HRSN).** Since living with complex behavioral health conditions can lead to social isolation, struggles with housing, involvement with the justice system and challenges with other HRSN, the study takes a broad view of the array of services and supports needed for stability, connection, and recovery.
- **A discussion of facilitating factors that support access and high-quality services.** In recognition that coverage of a service by Medicaid or with other sources on paper does not automatically translate into people being able to receive it, the analysis also considers the facilitating factors needed to ensure access and quality. These include outreach and education, navigational supports, sufficient workforce capacity, and transportation options for in-person services.
- **A discussion of the feasibility of recommendations and suggested priorities.** At the request of HCA, the analysis reflects a comprehensive review of the gaps in the behavioral health system and opportunities to strengthen the system, but it would be unrealistic to address all of them at once. New Mexico already has a significant number of initiatives underway and must contend with new fiscal and administrative challenges posed by HR 1 (119th Congress) and other federal Executive Branch actions. As such, the report includes an assessment of the feasibility of the recommendations, offers a perspective on what to prioritize given the reality of fiscal, state administrative, and workforce constraints, and suggests ways to sequence and phase-in changes.

What's Not Included?

- **Final decisions**. The report is intended to serve as a resource to the New Mexico Legislature, New Mexico Medicaid, the BHSD, CYFD, and other interested stakeholders. As such, it includes recommendations, a preliminary assessment of their feasibility and suggested phasing strategies, but the report's recommendations will need to be reviewed and decided upon by New Mexico.
- **Detailed content and recommendations on Senate Bill (SB) 3.** SB 3, the Behavioral Health Reform and Investment Act (BHRIA) adopted by the New Mexico Legislature in February of 2025

and then signed into law by Governor Lujan Grisham, establishes a new regionally based approach to reforming and expanding behavioral health services. The effort is being overseen by a Behavioral Health Executive Committee, comprised of officials from HCA, BHSD, the Administrative Office of the Courts, and others.[ii] At times, this analysis notes the ways that the findings in this report could relate to work on SB 3, but this report is not intended to guide SB 3 implementation, which, by design, is rooted in regionally based planning and implementation.

- Analysis of federal Medicaid cuts included in HR 1 signed into law by President Trump on July 4, 2025.[iii] While the study discusses some of the implications for people living with complex behavioral health conditions and/or brain injury of HR 1 and the workload currently confronting HCA, it is not intended to provide a detailed analysis of the impact on New Mexico of HR 1. For further information on HR 1 and its impact on New Mexico, see **Call Out Box 4**.

Overview of Methodology

To conduct the analysis, Manatt Health relied on a mixed methods approach that included the following:

- **Comprehensive inventory of the covered services for individuals with behavioral health and brain injury needs through Medicaid or other sources**. Manatt Health based its assessment of covered services on a review of New Mexico's Medicaid State Plan; the approved Turquoise Care Section 1115 demonstration; home- and community-based services (HCBS) waivers, managed care and provider manuals, materials on services that the BHSD and CYFD provide with state funds and federal grant dollars, housing program policies, the Brain Injury Services Fund (BISF) program manual, and other resources. In general, New Mexico's covered services are compared to those recommended by Substance Abuse and Mental Health Services Administration (SAMHSA) in its framework[iv] for a "good and modern" behavioral health system, the American Society for Addiction Medicine (ASAM) continuum and other established sources. Additional details on the process for conducting the service inventory are available in **Section III**.
- **Stakeholder engagement process.** Manatt Health conducted a comprehensive stakeholder engagement process based on **40** structured interviews with behavioral health providers, individual Medicaid enrollees, managed care organizations (MCOs), state provider associations, HCA officials and representatives from other state agencies such as the CYFD, Department of Corrections and the Office of Housing in New Mexico Department of Workforce Solutions (see the **Appendix** for more information). This report's conclusions were also informed by three public listening sessions—one for New Mexican residents and their family members and caregivers who use behavioral health services; one for behavioral health providers; and one for tribal members and leaders.[3] Manatt Health partnered with KAI, an American Indian- and woman-owned firm that specializes in culturally grounded research and evaluation, to lead engagement with tribal members and leaders, in addition to interviews with individuals using Medicaid or state-funded behavioral health services. Finally, interested parties submitted public comments that were considered as Manatt Health prepared the report.[4]
- **Data analysis.** Manatt Health's partner, Milliman, analyzed three years of New Mexico's Medicaid and State-funded claims data on individuals with SMI, SED, or SUD to assess service utilization and costs, and prepared an estimate of the fiscal impact of selected recommendations.

[3] 254 total attendees—one for individuals, family members, and caregivers (45 attendees); one for providers and stakeholders (170 attendees); and one for tribal partners (39 attendees).
[4] The state received 26 public comments.

Manatt Health also examined how comparator states addressed key issues confronting New Mexico, as well as reviewed information on the best practices emerging around the country.

The leadership at HCA provided guidance on the parameters of the report, reviewed and approved the stakeholder engagement plan, and provided extensive assistance in understanding New Mexico's current behavioral health system, but the analysis and recommendations were prepared by Manatt Health with data analysis support by Milliman and stakeholder engagement support by KAI.

Structure of the Report

To provide some context for the analysis, the report begins in **Section I** with background on New Mexico's behavioral health and brain injury systems, including the population of individuals living with complex behavioral health issues and/or brain injuries; the key elements of New Mexico's behavioral health and brain injury systems; and major initiatives adopted or underway. **Section II** offers a detailed explanation of the federal authorities available to New Mexico to adopt Medicaid changes, including the merits of various Medicaid waiver authorities and a State Plan Amendment (SPA). **Section III** presents findings from Manatt Health's inventory of behavioral health, brain injury, and housing services currently covered in New Mexico. Drawing on the service inventory, data analysis, and stakeholder engagement process, **Section IV** presents results from a gap analysis and actionable recommendations for addressing them. In **Sections V and VI,** the report provides information on the feasibility of securing federal authority for the recommendations – with special attention in **Section V** on whether the state should pursue a new waiver – and suggests ways to sequence and phase-in implementation of the recommendations in alignment with other initiatives underway in New Mexico.

Section I. Background on New Mexico's Behavioral Health and Brain Injury Systems

To assess the scope of services currently available through New Mexico's behavioral health and brain injury systems and the merits of a waiver, it is helpful to understand the population of New Mexicans living with complex behavioral health and/or brain injuries; the key elements of New Mexico's current behavioral health and brain injury systems; and recent initiatives.

Populations Living with Complex Behavioral Health Issues and Brain Injury

People Living with Complex Behavioral Health Issues

New Mexico has a total population of 2,114,768, according to the U.S. Census Bureau estimates.[v] As of December 2025[vi], 806,143 people were enrolled in Medicaid, which offers a comprehensive array of services, including behavioral health services. In addition to Medicaid, New Mexicans may also receive behavioral health services through the BHSD (adults) or Children, Youth and Families Department (primarily children and youth). The focus of this report is on individuals served by the behavioral health and brain injury systems in New Mexico who live with relatively complex behavioral health conditions and/or brain injuries. This includes adults living with SMI and/or a significant SUD who use the emergency department, crisis services, or hospitals as a result of their condition; who have a history of incarceration; who have been homeless or are at risk of homelessness; or who have a brain injury. It also includes children and youth living with a severe emotional disturbance (SED). See **Call Out Box 2** for illustrative profiles of individuals served by the state's behavioral health and brain injury systems.

People Living with Brain Injury

There are currently no complete or fully accurate data on the prevalence of brain injury in New Mexico. According to the 2023 Senate Memorial 30 report, the number of individuals living with a brain injury-associated disability in New Mexico is estimated to be between 21,000 and 32,000.[vii] However, Medicaid data indicate a much smaller portion of the population has experienced a moderate to severe brain injury. In state fiscal year (SFY) 2025, 2,387 total adults age 18 or older had moderate-severe brain injury diagnosis[5] – representing substantially less than 1% of the total Medicaid population. It is important to note that Medicaid claims data likely undercount the number of Medicaid enrollees living with a brain injury because of inconsistencies in whether and how brain injury is documented.[viii,ix,x] Of note, people with brain injury experience high rates of co-occurring mental illness, SUD, and justice involvement.[xi,xii,xiii,xiv,xv,xvi]

Call Out Box 2: Illustrative Profiles of Individuals Served by New Mexico's Behavioral Health and Brain Injury Systems

- **John, 30:** John lives with schizophrenia and has experienced repeated cycles of hospitalization and homelessness. When consistently taking medication, he can remain stable, but without reliable housing, peer support, and reminders from his care coordinator, he often stops treatment—leading to relapse and crisis.
- **Maria, 42:** Maria has several long-standing SUDs, including alcohol and opioid use disorders (OUDs), has survived multiple overdoses, and needed surgical intervention for recurrent abscesses of her right arm and leg. All of this has resulted in serious, ongoing physical complications, including liver damage, and chronic pain, as well as cognitive deficits. She now requires continuous medical care alongside behavioral health treatment and support to manage her SUD, brain injury, and physical health needs.
- **David, 16:** David is a teenager struggling with severe depression and anxiety. He recently dropped out of high school and has limited family support. Due to the intensity of his symptoms and lack of a safe environment, David needs access to residential treatment services to stabilize his mental health and prevent self-harm or justice-system involvement.
- **Nicole, 32:** Nicole sustained a traumatic brain injury (TBI) in her early twenties after a car accident, leaving her with memory problems, impulsivity, and difficulty organizing daily tasks. Without consistent medical follow-up and supportive housing, she struggled to keep jobs and maintain relationships, eventually becoming homeless. Her cognitive challenges have often led to misunderstandings with others and missed court dates, resulting in repeated low-level arrests. When she has stable housing and structured reminders, Nicole is able to attend appointments, follow routines, and avoid further justice involvement—but without those supports, she cycles back into crisis.

As with any health data in New Mexico, there are sharp differences in the distribution of people living with complex behavioral health conditions and/or brain injury across geographic regions of the state. The vast majority of New Mexico's Medicaid enrollees and non-Medicaid users of services reside in the more populated areas of Bernalillo County (Albuquerque), followed by Doña Ana County (Las Cruces), Santa Fe County (Santa Fe), and Sandoval County (Rio Rancho area), where behavioral health providers and services tend to be far more available. About one-third of New Mexicans—approximately 698,000

[5] Excludes mild brain injury codes, including initial encounters for concussions without loss of consciousness.

people—live outside metropolitan areas, and roughly 10% reside in frontier areas, meaning they are far from urban centers of 25,000 or more people.[xvii,xviii,xix,6] In many of these rural and frontier areas, there are few, if any providers, and even the infrastructure required for tele-health (e.g., broadband internet) may not be available. At the same time, New Mexico has one of the highest poverty rates in the country (3rd highest in 2023), which is linked to increased prevalence of behavioral health conditions and homelessness.[xx,xxi,xxii]

Call Out Box 3: Core Principles of New Mexico's Behavioral Health System[xxiii]

According to HCA's Medicaid Behavioral Health Services Policy Manual, New Mexico strives to ensure its behavioral health system delivers care grounded in core principles that reflect the state's commitment to compassion, equity, and person-centered support. These principles should form the foundation for every interaction, treatment plan, and initiative aimed at helping individuals and families on their path to wellness.

Trauma-Informed Care. Providers aim to create safe, supportive environments that avoid re-traumatization and foster trust, transparency, and collaboration. Care should be delivered with sensitivity to cultural, historical, and gender contexts.

Recovery and Resiliency. The state supports a wholistic view of recovery, embracing clinical treatment, peer and family support, and culturally relevant services. Resiliency—the ability to bounce back from adversity—is nurtured through comprehensive, community-based programs that build protective factors and promote competence across all domains of life.

Nondiscrimination. The state is unwavering in its commitment to ensuring that no individual is denied services or excluded from participation based on race, ethnicity, age, gender identity, sexual orientation, disability, language, or any other non-merit factor.

Cultural Humility. New Mexico understands that culture is dynamic and that each person's beliefs and values are shaped by intersecting identities. Providers are encouraged to approach every encounter with openness, self-awareness, and a willingness to learn. Services should be delivered in the preferred language and format of those served, and written materials are adapted to meet diverse needs.

Quality. The state's vision is to foster innovation, inclusive partnerships, and data-driven improvements to ensure services evolve with community needs. Every effort will reflect a commitment to compassion, recovery, and clinical quality.

Major Elements of New Mexico's Behavioral Health and Brain Injury Systems

To provide health care services to people living with complex behavioral health conditions and/or brain injury, New Mexico relies on a number of different programs and funding streams that span federal and state dollars. Of these, the state's Medicaid program is by far the most significant, playing a vital role in providing care for low-income residents, including pregnant women, children, parents, adults without dependent children, and some older adults and people with disabilities.[xxiv] Across Medicaid and other initiatives, New Mexico spends almost a billion dollars a year on behavioral health, with approximately 295,000 individuals receiving services.[xxv,xxvi] Of these, approximately 75% are Medicaid managed care

[6] Twenty-six of the 33 counties are defined as rural (non-Metropolitan Statistical Area) counties.

enrollees, 19% are Medicaid fee-for-service enrollees, and 6% are not enrolled in Medicaid.[xxvii] Of the $1.02 billion budgeted in SFY 2025 across Medicaid, BHSD, and CYFD for behavioral health services, about 88% ($899 million) is expected to be spent on services for the Medicaid population.[7] The remaining ~12% ($120 million) is expected to support state-funded services, to include BHSD mental health and substance use services, opioid transfer funds and CYFD funding.[xxvii] Funding for brain injury services in the state is administered by the BISF, which is fully funded through state General Revenue.[xxvii] For SFY 2025, close to $1.198 million was allocated to the BISF, with approximately $555,000 earmarked for service costs.

More detail on each component of the system is below.

Medicaid Overview

New Mexico's Medicaid program is administered by the MAD within the HCA.[8,9] Medicaid is the largest health coverage program in the state, enrolling 806,143 adults and children as of December 2025,[xxviii] representing nearly 40% of the state's population. [xxvii] Specifically, Medicaid covers approximately more than half of the state's children and working age adults with disabilities, about a quarter of Medicare beneficiaries, and nearly two-thirds of nursing facility (NF) residents.[xxix,10]

In SFY 2025, the state allocated an estimated $1.02 billion across Medicaid, BHSD and CYFD for behavioral health services (Medicaid encompasses $899 million of the total; with $120 million for BHSD and CYFD). Medicaid behavioral health spending totaled $836 million in 2023 (the most recent year available). Behavioral health spending reflects 13% of all managed care spending and has more than doubled between 2019 and 2023 ($460 to $735 million).[xxx]

For purposes of overseeing Medicaid-funded behavioral health, HCA and MAD rely on the BHSD to coordinate adult behavioral health services, while the CYFD administers services for children and youth. The state collaborates across agencies and the Governor's Office to align on behavioral health planning and delivery.

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[7] Assumes the SFY 2025 Medicaid budget includes (in thousands) Medicaid Behavioral Health, Managed Care ($520,106); Medicaid Behavioral Health, Managed Care Expansion Population ($311,568), and Medicaid Behavioral Health, FFS ($67,763). Assumes the SFY 2025 state-funded budget includes (in thousands) BHSD Community Mental Health Services ($35,877.7), BHSD Substance Use Services ($45,106.4), the opioid transfer fund ($7,339) and CYFD funding ($33,619.3).

[8] Medicaid is a health coverage program funded by both the federal government and the state, and it extends coverage to low-income residents, including pregnant women, children, parents, adults without dependent children, and some older adults and people with disabilities. In 2025, the federal government covered about 77% of New Mexico's Medicaid costs, though this percentage can vary for certain groups, specific benefits, and administrative expenses. More information is available here: https://www.macpac.gov/medicaid-101/; Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier | KFF State Health Facts; and https://www.nmlegis.gov/handouts/LHHS%20062525%20Item%2015%20Behavioral%20Health%20Medicaid.pdf.

[9] The HCA was created through Senate Bill 16, passed during the 2023 New Mexico Legislative Session and signed into law by Governor Michelle Lujan Grisham in March 2024, thereby consolidating multiple health-related functions into a single executive agency. More information is here: HCA-Transition-Plan-PR.pdf

[10] New Mexico's income eligibility limit for non-elderly, nondisabled adults is 138% of the FPL but it is 305% of the FPL for children and 255% of the FPL for pregnant women. In New Mexico, CHIP operates as a Medicaid expansion program rather than as a "Separate CHIP" program. This means that Medicaid laws generally apply, and Medicaid FMAP is available after CHIP allotment funds are expended. More information is available here: fact-sheet-medicaid-state-NM.pdf.

Managed Care ("Turquoise Care")

Under its managed care program, known as "Turquoise Care," New Mexico uses MCOS to deliver and coordinate health care services for enrollees.[xxxi] Turquoise Care is the main delivery system for New Mexico's Medicaid program and covers physical health, behavioral health, and long-term care services, including HCBS, for approximately 80% of enrollees. HCA uses federal Section 1115 demonstration authority for its managed care delivery system and pays MCOs a monthly capitation or per member per month payment.

New Mexico implemented the current version of its longstanding managed care model in July 2024.[11] The state contracts with four MCOs: Blue Cross Blue Shield of New Mexico, Molina Healthcare, Presbyterian Health Plan, and UnitedHealthcare Community Plan.[12] MCOs must offer a standard set of services, including a comprehensive set of behavioral health services, which are described in detail in **Section III**.[13]

Fee-For-Service (FFS)

Approximately 168,700) of enrollees receive services from the state's fee-for-service (FFS) delivery system.[xxxii] Under FFS, the state contracts directly with "any willing provider" that meets the qualifications to provide services, and HCA pays for services rendered according to the reimbursement methodologies in the Medicaid State Plan. New Mexico's FFS populations include tribal populations that do not opt into managed care, enrollees in limited Medicaid benefit programs, and emergency medical services for immigrants who do not otherwise qualify for Medicaid. Further, certain benefits, like HCBS in the Developmental Disabilities (DD), Mi Via, or Medically Fragile Waivers (described below), are administered under FFS.

Tribal Delivery System

HCA also partners with Indian Health Service (IHS) and tribal health programs that provide care for Native American populations. MCOs are required to make best efforts to contract with IHS, Tribal 638, and Urban Indian Health Programs (I/T/Us), enabling care coordination and specialty access for tribal members.

Existing Medicaid Waivers in New Mexico

As described in further detail above, New Mexico operates much of its existing Medicaid program under 1115 demonstration authority. Most notably, it relies on the "Turquoise Care," 1115 demonstration to authorize the state's managed care delivery system and, among other things, access federal Medicaid matching dollars to fund important initiatives related to behavioral health and brain injury. Approved by the federal government through December 31st, 2029, Turquoise Care supports people living with complex behavioral health conditions and/or brain injury in the following key ways:[xxxiii]

- **Pre-Tenancy and Tenancy Supports:** Allows the use of Medicaid matching funds for two key supportive housing services—pre-tenancy and tenancy supports—for up to 450 individuals living with complex conditions who otherwise would be homeless and who are participating in one of two of New Mexico's permanent supportive housing (PSH) initiatives (see details in **Section III**).

[11] Replacing the Salud model (started 1997) and Centennial Care (started 2014).
[12] Prior to 1997, New Mexico's Medicaid enrollees received their care through a FFS model. A full summary of the state's program history is available in the State's Quality Strategy, here.
[13] Additionally, Presbyterian Health Plan serves children under custody of the state.

- **Short-term Post Hospitalization Housing (or Medical Respite).** Facilitates use of Medicaid matching funds to cover the cost of post-hospitalization housing for up to six months for people who are homeless and who are too ill to recover from sickness or injury on the street or in a shelter but do not require hospital level care. This service represents a rare exception to federal policy that bans the use of Medicaid funds for room and board outside of institutional settings and is available only after a hospitalization in settings that offer onsite clinical services, as well as care coordination and assistance connecting to ongoing care.[xxxiv]
- **Justice-Involved Reentry Demonstration (JUST Health Plus):** Provides Medicaid matching funds for a targeted set of services for 30 to 90 days prior to release from incarceration.[14] In all jails and prisons participating in the initiative, individuals can receive case management, Medication Assisted-Treatment (MAT), and a 30-day supply of medications at release. Optional services—such as peer support, community health worker services, and Hepatitis C treatment—are offered based on facility readiness and the availability of state funding.[xxxv, xxxvi] Medicaid-eligible juveniles are eligible for additional pre- and post-release services (i.e., targeted case management for 30 days pre-release to 30 days post release, screening and diagnostic services).[15] In July 2025, the initiative launched in three pilot New Mexico Corrections Department facilities; the state will phase in additional state facilities as well as county-based facilities in 2026 and 2027.[xxxvii]
- **High-Fidelity Wraparound (HFW):** HFW provides a comprehensive, wholistic, youth, and family-driven way of responding when children or youth experience serious mental health or other behavioral challenges. Individuals eligible for HFW in New Mexico are at-risk or have a history of using services and resources that are restrictive and out of their communities, and have experience with multiple systems (e.g., behavioral health, juvenile justice, special education, protective services).
- **Community Benefit Program:** The Community Benefit program provides HCBS for Medicaid enrollees who meet a Nursing Facility Level of Care (NFLOC) but choose to remain in their homes or communities rather than enter an institution. The program serves individuals with significant physical disabilities, but only if they otherwise would be in a NF. The Community Benefit program is similar to a 1915(c) waiver (see below); however, by operating the program under the Turquoise Care 1115 demonstration, New Mexico has some additional flexibilities beyond those typically permitted by federal rules. **27,688** people were enrolled in the Community Benefit program as of January 2026.[16] See **Section II** for additional information on HCBS programs.
- **Coverage of Services in Residential Settings Designated as Institutions for Mental Diseases for people with SMI, SED, or SUD**. New Mexico uses its Turquoise Care 1115 demonstration to pay for services provided to people who reside in an Institution for Mental Disease (IMD)—a facility with more than 16 beds that mainly treats people with mental health conditions or SUDs—on a

[14] Without the Turquoise Care 1115 demonstration, New Mexico would not be able to use Medicaid matching funds for services provided to individuals who are incarcerated due to a federal rule known as the "inmate exclusion." The inmate exclusion prohibits the use of Medicaid matching funds for incarcerated individuals unless they are receiving care in a community-based hospital for a period of 24-hours or more.

[15] These services are required by the Consolidated Appropriations Act of 2023. States must provide services during the pre-release period when it is feasible to do so or as soon as practicable post-release.

[16] The Community Benefit program allows a limited number of individuals – up to 7,789 – who do not qualify for standard Medicaid due to high income to enroll; those with incomes up to 300% of the Supplemental Security income Federal Benefit Rate may be eligible. As of January 6, 2026, 6,831 of these slots were being used.

short-term basis (30 days on average[17]), effectively opening up Medicaid coverage for short-term stays in treatment centers designated as IMDs. Without the Turquoise Care 1115 demonstration, New Mexico generally would be barred from paying for such services by the federal IMD exclusion, which bans the use of Medicaid funds for services provided to adults ages 21 to 64 who are patients in these settings.[xxxviii] This waiver authority does not allow New Mexico to use Medicaid funds to cover the room and board costs associated with residential treatment, but rather to cover the cost of Medicaid services during the short-term stay.[xxxix]

New Mexico uses three different 1915(c) waivers [see **Table 1 in Section II** for a detailed discussion of 1915(c) waivers] to provide HCBS to individuals with significant intellectual and DD so they can live in the community instead of an institutional setting.[18] The Developmental Disabilities Services Division of the HCA administers the waivers, which serve individuals who have an intellectual and/or developmental disabilities (I/DD), including when such disabilities are attributable to a brain injury.[19] The summary below describes these three HCBS waivers.

DD Waiver – Provider Operated

The DD waiver includes a comprehensive array of services for individuals with I/DD that are coordinated by a case manager on behalf of the enrollee, including living supports provided in a personal home or group home. As of November 2024, the DD waiver served approximately 4,600 individuals.[xl]

Mi Via Waiver – Self-Directed

The Mi Via Waiver serves people who meet the same eligibility criteria as the DD waiver but allows the approximately 3,300 participants to select and manage their own services within a set budget allocation with the support of a consultant.

Medically Fragile Waiver

The medically fragile waiver serves individuals of all ages who have been diagnosed with a medically fragile condition and a DD (or are developmentally delayed or at risk for developmental delay), resulting in the need for daily skilled nursing intervention.[xli]

State-Funded Behavioral Health Services

New Mexico provides an array of state-funded behavioral health services to ensure access for individuals who are uninsured or underinsured. In 2025, the state budgeted $36 million for BHSD community mental health, $45 million for substance use services,[xlii] and $34 million for CYFD services (11% of the total combined Medicaid, BHSD and CYFD behavioral health budgets); the state leverages

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[17] For people obtaining treatment for a psychiatric issue, Medicaid reimbursement is capped on individual stays at 60 days or less and the average length of stay across beneficiaries can be no more than 30 days; there is no cap on the duration of individual's stay for SUD treatment eligible for Medicaid reimbursement, but the state still must aim for a 30-day average length of stay for SUD patients.

[18] To qualify for services as a person with I/DD under any of these waivers, an individual must have DD (defined as a severe, chronic disability of an individual that is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the individual attains age 22; is likely to continue indefinitely; results in substantial functional limitations in 3 or more of the areas of major life activity; and reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated) and meet ICF/IID level of care criteria. For individuals with a TBI, this means that to qualify for one of the I/DD waivers, their TBI must have occurred prior to reaching 22 years of age, in addition to meeting all other waiver eligibility criteria.

[19] Individuals with a brain injury that occurs after they turn 22 are not eligible for the waivers.

federal grant funding for some of these services (see below).[xliii] Examples of state-funded services include: screening and assessments, assertive community treatment (ACT), a series of community-based supports; and select youth services such as mental health urgent care/outpatient crisis programs and crisis stabilization centers. In general, the services offered are similar to those available to Medicaid enrollees with some notable exceptions (see **Section III** for more information). In SFY 2025, 13,106 individuals received state-funded behavioral health services. Of those receiving services, more than 45% were adults with SUD.[xliv]

Brain Injury Service Fund (BISF)

New Mexico's HCA operates the BISF Program, a state-administered, short-term support initiative that assists residents who have sustained a brain injury, whether TBI or acquired (ABI) from causes such as stroke, aneurysm, anoxia, brain tumor, infection, or toxic exposure. The program serves New Mexico's residents who have a documented diagnosis from a licensed physician or psychologist of brain injury, are legal residents living in the community (or within 30 days of discharge from an institution), and are experiencing a crisis such as homelessness, inability to pay for needed services, or other urgent needs directly related to the brain injury.

Federal Grants

New Mexico leverages several federal grants to strengthen its behavioral health system, focusing on prevention, treatment, and recovery across diverse communities:

- SUPTRS BG:[xlv, xlvi] SAMHSA's objective through this formula-based block grant is to help states/territories plan, implement, and evaluate activities that prevent, treat, and help people recover from SUDs.
- MHBG:[xlvii,xlviii] The SAMHSA MHBG is a federal formula-based block grant program that provides funds to states to support comprehensive community-based mental health services for adults with SMI and children with SED. Since 2023, New Mexico has streamlined its approach by combining MH and SUD block grants into a single application, as permissible by SAMHSA.
- State Opioid Response (SOR) Grant[xlix]: SAMHSA's SOR Grant provides resources to U.S. states/territories through a Congressionally-directed formula to address the public health crisis of opioid and stimulant use, use disorders, and related overdose deaths.

New Mexico's Recent Behavioral Health Initiatives and Investments

In recent years, New Mexico has made a number of significant investments in behavioral health, each of which is changing the landscape of the state's behavioral health system. The state still is in the midst of implementing many of these initiatives. Indeed, one of the state's largest initiatives, implementation of SB 3, is only just now getting underway.

Legislative Activity

In 2025, the New Mexico Legislature passed three major bills aimed at strengthening the state's behavioral health system.[20] These bills launched the following initiatives:

- **New Regional Transformation Planning Effort and Related Workforce Investments.** SB 3 aims to make transformative changes in how behavioral health services are delivered across the

[20] For more information on investments in the behavioral health system during the 2025 legislative session, see here:
https://www.nmlegis.gov/handouts/LHHS%20062525%20Item%2014%20Health%20and%20Communities.pdf

state. It creates new behavioral health regions, each responsible for mapping local resources, finding gaps, and developing a four-year plan to improve services. Regions will choose up to five priority projects and include strategies to ensure that care is continuous and coordinated. The Act also introduces a single, statewide credentialing process for behavioral health providers to simplify hiring and reduce delays. In addition, it strengthens the workforce by requiring a statewide plan to recruit, train, and support behavioral health professionals.[21,22]

- **Funding for Behavioral Health Priorities.** Along with SB 3, the New Mexico Legislature passed SB 1, which creates a permanent trust fund to provide funding for regional efforts launched by SB 3. The trust fund will distribute 5% of its annual value to support investments in behavioral health. These dollars will be used for mental health and SUD treatment, prevention programs, infrastructure improvements, technology, and workforce development.[l] SB 1 also aims to bring in extra funding by matching state dollars with federal, local, and private contributions.[li]
- **Justice System Reform:** HB 8 updates how the state handles competency cases for justice-involved individuals by allowing some defendants who are not considered dangerous to receive competency restoration services in the community instead of an institution. The law also lets courts advise prosecutors to consider involuntary commitment or assisted outpatient treatment if a case is dismissed.[lii]

Provider Rate Increases

Over the past several years, New Mexico has invested $2.3 billion to increase Medicaid provider rates, including $90 million in Medicaid rate increases in the last three years for behavioral health providers. In 2024, behavioral health provider rates increased to 120% of Medicare[liii] and subsequently increased to 150% of Medicare rates in January 2025.[liv,23,lv] These changes – combined with other key initiatives like the creation of a new psychiatric nurse practitioner program at the University of New Mexico – helped the state expand its behavioral health workforce, contributing, for example, to a 125% increase in the number of psychiatric advanced practice registered nurses (APRNs) from 2020–2024.[lvi] Overall, the state attributes the enrollment of 4,000 new Medicaid providers due to Medicaid rate increases, with more than half of those new providers (57%) working in behavioral health.[lvii] The state made similar investments in provider infrastructure (via increased rates) and workforce to eliminate waitlists for DD services using American Rescue Plan Act funds.[lviii]

Mobile Crisis and Other New Behavioral Health Services

In February 2024, New Mexico received approval from the U.S. Department of Health and Human Services (HHS) to implement community-based mobile crisis intervention teams, enabling expanded access to Medicaid covered crisis services.[lix] Additionally, the approval included five evidence-based services aimed at expanding children's behavioral health services:

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[21] Appropriations through the Act will be managed by BHSD. Regions may request to repurpose unused balances to another priority within the region.

[22] Early Access funding of $26 million was announced to bridge gaps while regional plans are finalized. These funds can be used for program start-up costs, staff hiring and training, infrastructure, and outfitting mobile units, ensuring that crisis response reaches individuals where they are—particularly in rural and underserved areas. This approach reflects a shift toward community-based interventions that reduce reliance on emergency departments and law enforcement, while improving timely access to behavioral health care statewide.

[23] New Mexico has up to 325% higher rates for Medicaid behavioral health services than neighboring states. More information is available here:
http://www.nmlegis.gov/Entity/LFC/Documents/Program_Evaluation_Reports/Medicaid Accountability Report 2025 09 23.pdf

- Enhanced rates for Multi-Systemic Therapy (MST)
- Functional Family Therapy (FFT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Dialectical Behavioral Therapy (DBT)[lx]

Certified Community Behavioral Health Clinics

The Centers for Medicare and Medicaid Services (CMS) and the SAMHSA administer the CCBHC state demonstration program, which enables states to receive enhanced federal Medicaid matching funds for services provided at CCBHCs, which are designed to provide coordinated, comprehensive behavioral health care. New Mexico began participating in the demonstration in 2025 with five behavioral health clinics in seven counties. The state plans to add five new organizations as CCBHCs in 2026 to expand access to six more counties.[lxi]

CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age. This includes developmentally appropriate care for children and youth.

CCBHCs must meet standards for the range of services they provide and are required to get people into care quickly. The CCBHC model requires provision of nine core services:

- Crisis services;
- Outpatient mental health and substance use services;
- Person- and family centered treatment planning;
- Community-based mental health care for veterans;
- Peer family support and counselor services;
- Targeted care management;
- Outpatient primary care screening and monitoring;
- Psychiatric rehabilitation services; and
- Screening, diagnosis, and risk assessment.[lxii]

The initiative is designed to provide relatively robust reimbursement to CCBHCs, making it possible for them to provide a comprehensive set of integrated services. CCBHCs offer a promising vehicle for expanding and strengthening behavioral health services in the areas that they serve.

Centralized Provider Enrollment Platform

As mentioned above, SB 3 introduces significant changes to New Mexico's Medicaid provider enrollment platform. By June 30, 2027, the HCA is required to establish a universal behavioral health service provider enrollment and credentialing process for Medicaid, aimed at reducing the administrative burden on behavioral health service providers by streamlining and simplifying enrollment procedures.[24] Additionally, HCA, in collaboration with health care licensing boards and legislative committees, must form a working group to improve and streamline the verification of behavioral health licensing.

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[24] In November 2024, the state made updates to the provider enrollment system to help providers more easily navigate the site, submit applications online, track the status of their application, upload documents, sign forms electronically, and other features. More information is available here: Provider/PED Enrollment System Launches Nov. 6. Health Care Authority and the Medical Assistance Division, 30 Oct. 2024, www.hca.nm.gov/wp-content/uploads/BMS_GoLive_Email_9A.pdf.

Together, these measures are designed to make it easier for behavioral health providers to participate in Medicaid and enhance access to care across the state.

Investments in Rural Health

New Mexico's Rural Health Care Delivery Fund[lxiii,lxiv]

The Rural Health Care Delivery Fund was created in 2023 and has a total appropriation of $20 million from the state general fund for the SFY 2026 through 2028 funding cycle. Funding is available to support projects that create and/or expand integrated primary and behavioral health care services in rural communities, helping ensure that New Mexicans can access care close to home.

Federal Rural Health Transformation Program Funding

Created by Congress as part of HR 1, and signed into law by President Trump on July 4, 2025, the RHTP will distribute $10 billion annually to state awardees from Federal Fiscal Year (FFY) 2026 through 2030 ($50 billion total).[lxv] On December 29, 2025, CMS awarded New Mexico $211 million dollars for the award period.[lxvi] Implementation will begin in early 2026.

New Mexico's vision for these funds includes the following behavioral health-focused investments:[lxvii]

- Healthy Horizons Initiative: Will expand specialty care, including behavioral health, by building regional networks, increasing provider training, and leveraging telehealth, specialty consults, and remote patient monitoring to reach populations with the highest needs. Behavioral health screening and treatment will be embedded within chronic and maternal care models, with streamlined referral pathways and targeted provider training to ensure early identification and intervention for conditions such as depression, anxiety, and SUD.
- Rooted in New Mexico Initiative: Will expand training and mentorship for behavioral health professionals, support retention through provision of incentives (e.g., paid training time, housing stipends, bonuses, certification support), and promote culturally responsive care.
- Rural Health Innovation Fund Initiative: Will encourage communities to design and lead local programs that address behavioral health and other non-medical drivers of health, fostering sustainable, community-tailored solutions.
- Bridge to Resilience Initiative: Will provide technical assistance and operational support to rural providers, helping them integrate behavioral health services and improve financial sustainability.
- Rural Health Data Hub Initiative: Will deliver actionable data to guide the state's planning, monitoring of behavioral health (and other rural health outcomes), and ensure transparency.

Call Out Box 4: Impact of HR 1: Estimates from HCA

The July 2025 passage by Congress of the budget reconciliation law, HR 1 (Section 71401 of Public Law 119-21), is expected to result in significant federal Medicaid cuts; a loss of coverage among Medicaid enrollees, including those living with behavioral health conditions and/or brain injury; and a substantial increase in the workload confronting the HCA.[lxviii,25]

HR 1 requires states to implement mandatory work reporting requirements by January 1, 2027, for adults ages 19 through 64 who are enrolled through Medicaid expansion or expansion-like coverage

[25] For more information on the Medicaid changes in HR 1, see State Health and Value Strategies, Changes-to-Medicaid-in-the-Budget-Reconciliation-Law_Revised.pdf

Call Out Box 4: Impact of HR 1: Estimates from HCA

under a Section 1115 demonstration.[26] Further, HR 1 requires states to redetermine eligibility for adults enrolled through Medicaid expansion or an expansion-like Section 1115 demonstration once every six months.

Impacts of HR in New Mexico are expected to include:

- Over 98,000 New Mexicans—more than 10% of New Mexico's Medicaid population—are expected to permanently lose Medicaid coverage as a result of HR 1,[27] and more than 250,000 will be subject administrative burdens associated with work reporting requirements and new co-pays required by the law.[lxix]
    - Medicaid expansion adults with SMI, SUD, or brain injury are at particularly high risk of losing coverage under work reporting requirements and frequent eligibility redeterminations.
    - Their behavioral health issues, compounded by unstable employment or housing, often make it harder to navigate paperwork requirements and produce necessary documentation.[lxx]
- 5,648 individuals could lose at least one month of coverage due to new limits on retroactive coverage starting January 1, 2027.[lxxi]
- Loss of $8.5 billion in federal funding for provider payments between 2028–2037. Coverage losses and any potential decreases in rates could create substantial funding shortfalls for providers, threatening their sustainability and/or causing them to re-consider their participation in Medicaid.[lxxii]
- More than 50 safety net providers could lose critical funding, and 6-8 hospitals could close within 18–24 months.[lxxiii]
- 18 months and $35 million in state general funds are needed to support integrated Medicaid and Supplemental Nutrition Assistance Program information technology systems changes including the Call Center and YES.NM.GOV.[lxxiv]
- The state may be at risk of penalties due to a high Medicaid payment error rate (14.4% in New Mexico compared with 11.7 nationally).[lxxv]

[26] HR 1 specifies exemptions from work requirements for individuals with substance use disorders or "disabling" mental disorders from Medicaid work requirements under the "medically frail" designation. Participation in a SUD treatment program is also listed as an exemption in the bill. However, the extent to which eligible individuals will be able to obtain and maintain coverage will depend on how these requirements are operationalized (i.e., using data to the maximum extent possible to verify individuals without requiring them to submit documentation).

[27] 9,680 active Medicaid non-citizens will likely be disenrolled permanently beginning October 2026; and 88,530 expansion adults likely permanently disenrolled due to work requirements beginning January 2027.

Section II. Background on Federal Authorities Available in Medicaid

To inform the discussion of recommendations in this report, Manatt Health provides a detailed review of the federal authorities available to the state to cover services required by people living with complex behavioral health conditions and/or brain injury. These authorities encompass "traditional" routes to covering services such as SPAs, as well as a range of waiver options.

It is important to note that the federal government imposes additional process, oversight, and monitoring on waivers, and it requires that they are "budget neutral" or "cost neutral" to the federal government.[28] This is because the purpose of a waiver is to allow a state to disregard federal rules that otherwise would apply to its use of Medicaid funds. As described throughout this report, Manatt Health's recommendation with respect to New Mexico's current service gaps is to address them largely using vehicles other than a major new Medicaid 1115 demonstration.

Medicaid Authorities Used to Cover Services

Medicaid offers a variety of options that states use to cover services for people with behavioral health and brain injury-related needs. These include:

Medicaid State Plan: The Medicaid State Plan is a written agreement between a state and the federal government that describes a state's administration of its Medicaid program and includes the state's core Medicaid services. In most states—including New Mexico—the majority of covered mental health and SUD benefits are authorized under the Medicaid State Plan; these can include a diverse range of services ranging from early intervention services to inpatient hospitalizations [lxxvi]

Call Out Box 5: Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Requirements[lxxvii]

A cornerstone of the Medicaid program, EPSDT establishes federal benefit standards in Medicaid designed to ensure that children and youth under age 21 have access to a comprehensive set of health care services, including everything from preventive services and screening to diagnostic services and treatment.

Under EPSDT, states must provide all Medicaid-covered services that could be listed in the State Plan—even if they are not listed—that are necessary to correct or ameliorate physical and mental health conditions for children and youth. This includes any service allowed under federal Medicaid law when medically necessary, not just those typically offered to the general population.

A number of states have faced lawsuits for failure to meet EPSDT requirements for children and youth with complex behavioral health conditions, resulting in settlement agreements and consent decrees

[28] CMS considers an 1115 demonstration as budget neutral to the federal government if it "does not result in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration." See "Budget Neutrality," https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality. CMS defines cost neutrality for 1915(c) waivers as, "waiver program costs are less than (or equal to) the cost of institutional programs for the same population enrolled in an HCBS waiver." See "Cost Neutrality," hcbs-1e-cost-neutrality.pdf.

that have required the addition of respite care, mobile crisis, intensive care coordination, intensive in-home services, and youth and family peer support for these young people.[lxxviii]

Alternative Benefit Plan: States use an Alternative Benefit Plan (ABP) to cover benefits for the Affordable Care Act (ACA) Medicaid expansion population—low-income adults with incomes up to 138% of the federal poverty level who became eligible for Medicaid because of the ACA.[29,30] States have the flexibility to cover a more limited set of benefits under their ABP as compared to their State Plan benefit package so long as the ABP meets a set of minimum requirements.[lxxix]

Section 1115 Demonstrations: Section 1115 demonstrations, also often called 1115 waivers, allow states to make major changes in Medicaid eligibility, benefits, and cost-sharing, and/or provider payments by "waiving" any number of federal Medicaid requirements. Of particular note, Section 1115 demonstrations can be used to secure federal Medicaid matching funds for services that otherwise could not be covered via an authority known as "costs not otherwise matchable." For example, New Mexico uses this "cost not otherwise matchable" authority to pay for services for people residing in "institutions for mental diseases" or who are incarcerated and otherwise subject to exclusion. The Secretary of HHS has broad discretion to determine when to approve or renew Section 1115 demonstrations. Given this broad Secretarial discretion, the purposes for which Section 1115 demonstrations are used can shift dramatically with Administration changes. For example, the Biden Administration approved 1115 demonstrations to cover services that address HRSN, but the Trump Administration has indicated it is unlikely to approve such demonstrations.[lxxx]

Call Out Box 6: Strict Limitations on Medicaid's Coverage of Room and Board Even Under Waivers

With rare exceptions, Medicaid cannot pay for room and board costs outside of nursing and other institutional-level care facilities. Indeed, the federal government routinely inserts into 1115 demonstration and other waiver materials explicit clarification that under no circumstances can Medicaid funds be used for room and board. Even 1115 demonstrations that allow states to provide services to people in IMDs prohibit coverage of any portion of their room and board expenses. Similarly, New Mexico's Community Benefit, DD and Mi Via waivers do not allow for the coverage of room and board costs, only for the cost of services.

There are two partial exceptions to this rule:

1. One-time expenses. States can secure authority to cover one-time expenses (e.g., security deposits, set-up fees, home modifications) to support transitions out of nursing facilities or other provider-owned settings, but coverage does not include ongoing rental assistance. New Mexico uses its Medicaid 1115 demonstration to cover one-time transition and moving costs, home remediations, and home accessibility modifications for people who otherwise would require NFLOC, but it cannot cover ongoing room and board expenses under this benefit.

[29] In 2026, 138% of the FPL is equivalent to $21,597.

[30] Before the ACA, Medicaid mostly covered children, pregnant women, parents, and certain older adults or people with disabilities, but the ACA allowed states to expand Medicaid to include adults ages 19–64 who don't have dependent children and meet income limits (up to 138% of the federal poverty level; $21,597 for an individual in 2025). New Mexico adopted this expansion starting January 1, 2014, which significantly increased coverage for uninsured adults and brought in additional federal funding to support the program.

2. Biden-era 1115 demonstrations. Between 2021 and early 2025 (before the new federal administration came into office), CMS approved a handful of state 1115 demonstrations that provided six months of rent and utility costs for a targeted set of enrollees, as well as up to six months of short-term post-hospitalization housing (or "medical respite"). New Mexico is one of the states that secured the opportunity to cover medical respite services under the Biden Administration. However, recent CMS guidance indicates that federal policy now is moving away from demonstrations that allow Medicaid coverage of room and board in community-based settings, even for targeted populations and with a six-month time limit.

Managed Care-Specific Authorities. Medicaid managed care plans can cover "in lieu of services" (ILOS) or "value-added services"[31], which are services that aren't otherwise covered through the Medicaid State Plan or a waiver authority.

HCBS Options:[lxxxi,lxxxii] States have the option, but are not required, to cover HCBS for populations who have a disability or are elderly. HCBS include services like personal care, home-delivered meals, and non-medical transportation that allow people to stay in their homes and avoid nursing facilities or other institutional settings. States can choose to offer HCBS to a variety of target populations, including individuals with mental illness, SUD, and brain injury, using one or more of the following vehicles.

- **1915(c) waivers,** which allow states to provide a package of HCBS to people whose needs are such that they would otherwise be served at an institutional level of care (LOC). Beginning July 1, 2028, states will have access to a **new 1915(c) waiver** option established by HR 1 to offer a package of HCBS to individuals at less than an institutional LOC.
- **1915(i) SPAs,** which allow states to offer HCBS to people with functional needs at or below an institutional LOC (e.g., inpatient, NF, Intermediate Care Facility (ICF) for Individuals with Intellectual Disabilities (IID), etc.).[32]
- **1115 demonstrations.** Among other uses described above, states can use an 1115 demonstration to offer HCBS to individuals with functional needs at or below an institutional LOC, while giving states flexibility to "waive" additional Medicaid rules that apply to HCBS programs. For example, New Mexico uses the Turquoise Care 1115 demonstration to offer the Community Benefit program to people with needs at NFLOC (similar to a 1915(c) program) and

[31] Medicaid ILOS are alternative services that Medicaid MCOs can opt to provide (if approved by the state) instead of traditional Medicaid benefits without the need for waiver approval. ILOS are permitted when they are medically appropriate and cost-effective compared to standard care and may be used as immediate or long-term substitutes for covered services to improve health and quality outcomes for enrollees. Value-added services are additional services outside of the Medicaid benefit package (i.e., State Plan and/or Medicaid managed care contract) that are delivered at MCOs' discretion. Examples of value-added services offered by New Mexico's MCOs include: SUD helpline, non-medical transportation, and select outpatient therapy tools and interventions (e.g., Seeking Safety, Selfcare, BeMe Health).

[32] By federal law, a 1915(i) SPA can only serve Medicaid enrollees with incomes at or below 150% of the federal poverty level. (Social Security Act § 1915(i)(1)). However, in 2021, CMS released guidance giving states flexibility to "disregard" certain income for people who need HCBS, permitting people at higher income levels to be eligible for 1915(i). See State Medicaid Director Letter #21-004, at https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21004.pdf.

has flexibility beyond federal rules to streamline the process for redetermining program eligibility. It typically takes multiple years to secure a Medicaid 1115 demonstration.[33]

See **Table 1** below for a more detailed comparison of HCBS options. All HCBS options are subject to a robust set of federal rules intended to establish critical protections for individuals with disabilities. **These** include rules related to determining eligibility for HCBS, person-centered planning, conflict-free case management,[34] quality, program oversight, and provision of services in home- and community-based settings (see **Call Out Box 7**), among other areas.[35] These rules require state resources to oversee and implement.

Other Medicaid Authorities. Medicaid managed care plans can also cover "in lieu of services" (ILOS) or "value-added services."

Call Out Box 7: Home- and Community-Based Settings Requirements[36]

HCBS must be provided in home- and community-based settings, as defined by a CMS rule issued in 2014. The rule is designed to ensure that HCBS are provided in environments that are truly home-like and do not replicate the loss of autonomy and other features associated with institutional care. With this rule, CMS established an outcomes-focused definition of home- and community-based settings for the first time, instead of defining these settings for "what they are not." Key characteristics of home- and community-based settings include:

- Integrated into and provide full access to the greater community, including participation in community life, employment opportunities, control of personal resources, and receipt of community services to the same degree as individuals not using Medicaid HCBS.
- Selected by the individual from among settings options.
- Ensure individuals' rights of privacy, dignity, and respect.
- Optimize individual autonomy in making life choices and facilitates individual choice regarding services and supports.
- For provider-owned or controlled residential home- and community-based settings, meet additional requirements regarding individual control, freedom, choice, privacy, and physical accessibility.

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[33] The National Association of Medicaid Directors indicates it typically takes four to five years to secure approval of and implement a new Medicaid 1115 demonstration. See https://medicaiddirectors.org/resource/how-1115-waivers-work/,

[34] Federal conflict-free rules prohibit the same entity from both delivering services and assessing need for and conducting case management of such services. See 42 Code of Federal Regulations (CFR) 441.730(b) for 1915(i) and 42 CFR 441.301(c)(1)(vi) for 1915(c).

[35] See 42 CFR 441 Subpart G for 1915(c) waivers and 42 CFR 441 Subpart M for 1915(i) SPAs. When states use an 1115 demonstration to cover HCBS, 1915(c) rules typically apply for HCBS programs serving people at an institutional level of care and 1915(i) rules typically apply for HCBS programs serving people with needs less than an institutional level of care.

[36] For more information, please see the following sources: 42 CFR §441.301(c)(4); 42 CFR. §438.3(o); Preamble to HCBS Final Rule, https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider; CMS, Final Rule, Medicaid HCBS, https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider; CMS, SMD # 20-003, https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20003.pdf.

- Home- and community-based settings are **not:** nursing facilities, IMDs, ICF/IIDs, hospitals, and settings that have "qualities of an institutional setting, as determined by the Secretary" of HHS.

Table 1. Comparison of HCBS Options

	Eligibility				Benefits			State Administrative Considerations	
	Only Institutional LOC	**May Be Less Than Institutional LOC**	**Entitlement Once Implemented**	**Permits Capped Enrollment**	**Can Cover Full Set of HCBS**	**Planning Funding Available via HR 1**	**Renewal Required**	**Complexity of Federal Approval (H/M/L)**	**Requires Budget (BN)/Cost Neutrality (CN)**
1915(c) Waiver	Yes	No	No	Yes	Yes		Yes	Yes	M	Yes, CN
New 1915(c) Waiver Under HR 1	No	Yes	No	Yes	Yes		Yes	Yes	TBD^	Yes, CN
1915(i) SPA	No	Yes	Yes	No	Yes		No	Yes*	M	No
1115 Demonstration	No	Yes	No	Yes	Yes		Yes	Yes	H	Yes, BN

*Renewal of a 1915(i) SPA is only required if benefits are limited to a targeted population.

- ^CMS has not yet released guidance on the new 1915(c) option authorized under HR 1; as a result, there are still unknowns about core waiver features.

Deep Dive: National Landscape of HCBS Targeted to People with Complex Behavioral Health Needs and Brain Injury

While nearly all states have 1915(c) waiver programs (or the equivalent under an 1115 demonstration) targeted to people with I/DD or seniors/adults with physical disabilities, states are less likely to have 1915(c) waivers specifically targeted to people with mental illness or brain injury. As of 2024, Kaiser Family Foundation found that 21 states had 1915(c) waivers targeted to individuals with brain injury or other spinal cord injuries, and 11 states had 1915(c) waivers targeted to people with mental illness (children and/or adults).[lxxxiii] Typically, these waivers are for people with mental illness or brain injury with co-occurring physical health needs requiring a NFLOC. Federal rules do not permit a state to target a 1915(c) waiver to people with SUD.[37] While there is no comprehensive tracker of states with a 1915(i) SPA, based on review of states' materials, Manatt Health estimates that approximately 12 states have a 1915(i) SPA focused on adults with complex behavioral health needs and/or brain injury. As noted above, some states also offer HCBS to people with complex behavioral health conditions or brain injury under an 1115 demonstration.

[37] 42 CFR 441.301(b)(6)

Section III. Inventory of Covered Services

To inform the discussion of how New Mexico can improve care for people living with complex behavioral health issues or brain injury, Manatt Health conducted a comprehensive inventory of Medicaid and non-Medicaid-funded services for people living with behavioral health conditions and/or brain injury. In this **Section**, Manatt Health describes how it conducted the inventory and major takeaways, breaking the results down into an analysis of 1) behavioral health and related HCBS, 2) services for people living with brain injury, and 3) housing services and supports. For purposes of the inventory, Manatt Health only addresses the question of whether services are covered; in **Section IV,** we provide available data and stakeholders' perspective on the extent to which New Mexico's residents can access the covered services.

Process for Conducting Assessment

Manatt Health conducted a comprehensive review of New Mexico's documentation of its covered services and fee schedules; assessed the covered services against what ideally should be covered according to frameworks produced by nationally recognized organizations when available; and compared New Mexico to other states, including on a topic-by-topic basis, states considered "leading edge" with respect to key issues.

- **For Medicaid services,** Manatt Health reviewed New Mexico's Medicaid State Plan; Turquoise Care Section 1115 demonstration (including the Community Benefit program); and Medicaid managed care and provider manuals. Note that when assessing New Mexico's Medicaid-covered behavioral health services, Manatt Health largely limited the scope of the review to services designated as behavioral health services in New Mexico's HCA Medicaid Behavioral Health Policy and Billing Manual. As such, the findings noted do not address other types of care that people with behavioral health needs typically use, like primary care, specialty physical health care, and pharmacy.
- **For non-Medicaid-funded or "state-funded" services,** Manatt Health reviewed New Mexico's non-Medicaid fee schedule and the BISF Program manual and MHBG, SUPTRS BG, and SOR grant program materials to understand services covered by state or non-Medicaid federal funds available to individuals who are uninsured or underinsured. (Note: for purposes of simplicity, this report refers to these services as state-funded services.)
- **For housing programs,** Manatt Health reviewed New Mexico's housing program policies and use of U.S. Department of Housing and Urban Development (HUD) and federal grant dollars along with BHSD and Medicaid-funded coverage of housing support services.

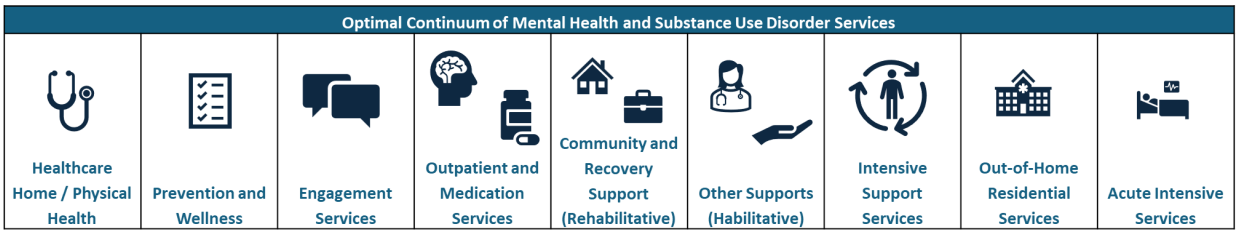
In addition, Manatt Health interviewed subject matter experts, reviewed the state's web sites, and analyzed New Mexico-specific reports related to behavioral health, housing, and brain injury produced by the Legislative Finance Committee (LFC) and others.

New Mexico's Coverage of Mental Health and SUD Services

To assess New Mexico's coverage of mental health and SUD services, Manatt Health used SAMHSA's framework for a "good and modern mental health and addiction system," supplemented with information from the ASAM (3rd Edition) on the continuum of services that should be available to individuals with behavioral health needs. Under this framework, a "good and modern" system includes services for individuals with behavioral health needs that span prevention to a full range of treatment

services to inpatient care.[lxxxiv] SAMHSA also recommends that such a system includes habilitative services to help individuals learn new skills. See **Figure 1** for a high-level overview of the continuum.[38]

Figure 1. Optimal Continuum of Mental Health and SUD Services



Key Findings

New Mexico **covers a robust set of mental health and SUD services for individuals enrolled in Medicaid and individuals who are uninsured or underinsured.** For people enrolled in Medicaid, New Mexico covers nearly all recommended services across all categories of SAMHSA's framework, with the exceptions noted below. Notably, New Mexico offers:

- A **suite of evidence-based practices for both youth and adults,** including ACT, HFW, DBT, EMDR, trauma-focused cognitive behavioral therapy, multisystemic therapy, and Coordinated Specialty Care for First Episode Psychosis.
- The **full ASAM continuum of services** (Third Edition) for SUD treatment and withdrawal management.[39] The State will be moving to the Fourth Edition of the ASAM continuum in 2026.
- A **robust set of crisis services,**[40] including telephone crisis services, face-to-face outpatient clinic crisis services, crisis stabilization services, crisis triage centers, mobile crisis intervention services, and mobile response and stabilization services (MRSS).
- **Short-term residential treatment for youth with mental health and/or SUD conditions and adults with SUD** (Note: the State intends to submit a SPA in 2026 to cover residential treatment for adults with mental health needs).
- **Support from people with lived experience,** including peer support services and recovery services. In addition, peer support specialists play a role in delivery of many other services, including ACT, comprehensive community support services (CCSS), mobile crisis intervention services, and MRSS, among others.
- A range of **services and supports addressing the needs of families and caregivers**, including behavioral health respite, and FFT.
- **Various services and programs that provide navigational supports available to** people with complex behavioral health needs CareLink New Mexico Health Home and CCBHCs provide

[38] SAMHSA's framework is available at: https://static1.squarespace.com/static/673270e240ed9149225e31e1/t/67803120f173404753516900/1736454432139/Good-and-Modern-Addictions-and-Mental-Health-Service-System-2010.pdf. The ASAM continuum is available at: https://www.asam.org/asam-criteria/about-the-asam-criteria. Note that some services included in the SAMHSA framework are not included in the scope for this report (e.g., physical health services, wellness) and were not included in this assessment.

[39] New Mexico is in the process of transitioning to the Fourth Edition of the ASAM Criteria.

[40] Specifically, New Mexico covers many of the services recommended by CMS and SAMHSA in September of 2025 in a State Health Official letter that describes best practices for implementing the crisis continuum under Medicaid and CHIP. See https://www.medicaid.gov/federal-policy-guidance/downloads/sho25004.pdf.

varying levels of intensive of case management and care coordination. Managed care plans provide care coordination and services such as ACT, CCSS, and HFW include elements of navigational support.

For people who are uninsured or underinsured and are obtaining state-funded services, a wide array of services is offered, but services do not span the full SAMHSA framework.

However, there are some discrete gaps:

- **New Mexico Medicaid does not cover some habilitative services in SAMHSA's framework for individuals with needs less than NFLOC.** Most notably, personal care and homemaker services, and assisted living services are not offered to individuals with SMI, SED, or SUD except if the person is enrolled in the Community Benefit program (and therefore, has complex co-occurring physical health conditions). Today, only 3% of New Mexico's adult Medicaid enrollees with an SMI or SUD are enrolled in the Community Benefit program.[41] As noted above, many habilitative benefits such as homemaker services, can only be covered through an HCBS program.[42]
- **A few key evidence-based or other leading practices are not explicitly covered in Medicaid** such as the Individual Placement Support (IPS) model of supported employment and residential treatment specific to perinatal populations.
- **Some important benefits are unavailable through state funds for individuals who are uninsured or underinsured.** These include mental health intensive outpatient treatment for adults and partial hospitalization for youth and adults; some higher levels of care for youth (e.g., non-accredited residential treatment centers and group home services and treatment foster care (TFC) I and II), and inpatient SUD treatment and withdrawal management services for adults (ASAM 4 and 4-WM).

[41] In SFY 2025, 2,321 adults with SMI or SUD had a Community Benefit waiver claim out of a total of 81,511 total adult Medicaid enrollees with SMI or SUD.

[42] New Mexico also does not cover assisted living services for people with complex behavioral health needs who are not enrolled in the Community Benefit program. While the lack of coverage of this service is a gap according to the "good and modern" framework, Manatt Health does not recommend covering this service for this population at this time for reasons described in Call Out Box 7.

New Mexico's Coverage of Brain Injury Services

For brain injury services, Manatt Health drew on national research, stakeholder interviews, and earlier New Mexico-specific research (e.g., the Senate Memorial 30 report, a brain injury report commissioned by the State of New Mexico Health and Human Services Legislative Subcommittee[lxxxv]) to identify an optimal set of services. While people living with brain injury rely on a wide array of services, including primary care, specialty care, and rehabilitative services, Manatt Health, for purposes of the inventory, focuses on HCBS and housing and tenancy supports.

Medicaid Authorities Used to Cover HCBS Services for People with Brain Injury

New Mexico has not elected to pursue a dedicated HCBS option focused on individuals with brain injury. Instead, individuals with brain injury can be eligible potentially for HCBS through the Community Benefit Program or one of the state's three 1915(c) waiver programs.

Other State and Federal Funding

New Mexico's HCA operates the BISF Program, a state-administered, short-term support initiative that assists residents who have sustained a brain injury, whether traumatic (TBI) or acquired (ABI) from causes such as stroke, aneurysm, anoxia, brain tumor, infection, or toxic exposure. The program serves New Mexico's residents who have a documented diagnosis from a licensed physician or psychologist of brain injury, are legal residents living in the community (or within 30 days of discharge from an institution), and are experiencing a crisis such as homelessness, inability to pay for needed services, or other urgent needs directly related to the brain injury. Importantly, BISF acts as the "payer of last resort," meaning it only provides support when no other funding or payer source is available. The BISF Program is funded solely through state General Revenue funding. Sources of revenue that previously supported the program, including revenue from traffic violations, were eliminated in 2023 with the passage of HB 139.

Covered Services

Through the Community Benefit program and the state's 1915(c) waivers, New Mexico covers a continuum of HCBS that can help address the needs of eligible individuals affected by brain injuries. Overall, HCBS available under these programs are comparable to those provided through specialized brain injury 1915(c) waivers in other states.[lxxxvi] Services offered include, but are not limited to:

- **Home health aide and personal care services** that provide assistance with activities for daily living (ADLs) and IADLs;[43]
- **A variety of other types of home health care,** including private duty nursing; speech, language, occupational, physical, and cognitive rehabilitation therapies;
- **Adult day health services** that provide daytime support outside of the home;
- **Assisted living services** that provide personal care and support services, among others, to individuals residing in assisted living (note: these services do **not** cover room and board per Medicaid rules);

[43] ADLs are the basic self-care tasks people need to function day-to-day, such as bathing, dressing, eating, toileting, and moving around. They measure physical independence and are often used in health care to assess a person's ability to care for themselves. IADLs are more complex tasks that support independent living, like managing finances, cooking, shopping, housekeeping, and handling transportation. These require planning and cognitive skills, and difficulties with IADLs often indicate a need for additional support. More information may be found here: https://my.clevelandclinic.org/health/articles/activities-of-daily-living-adls

- **Environmental modifications**;
- **Non-medical transportation**;
- **Employment supports**;
- **A variety of other professional services and therapies,** including behavior support consultation, nutrition counseling, acupuncture, chiropractic services, massage therapy, among others;
- **Home-delivered meals**; and
- **Community transition** services.

However, there are several important gaps:

- New Mexico's Community Benefit program and 1915(c) waiver programs are only open to individuals who need NFLOC. Individuals with brain injury **whose needs are less than an institutional level of care cannot access any Medicaid-funded HCBS**.
- Because the Community Benefit program focuses on aging populations with disabilities and people with significant physical disabilities, **New Mexico Medicaid does not offer certain services to support individuals with other types of functional needs that help them live independently in the community.** Most notably, New Mexico Medicaid offers limited supports that address IADLS and services that would support people with life skills.
- While the Community Benefit program offers home modifications and assistive technology as part of occupational, physical, and speech therapy, **it lacks some services that promote independence or substitute for human assistance** such as standalone assistive/enabling technology services (e.g., communication aids like text-to-speech applications and physical support devices like adapted bicycles, medication trackers), and vehicle modifications.
- The Community Benefit program **does not provide remote supports that can help individuals access assistance via technology** (e.g., staff supporting individuals remotely via audio/video communication, using motion sensors) that may promote an individual's independence, increase service flexibility, enhance access to supports in rural and remote areas, and ease workforce shortages in a cost-effective way.

For more information, see **Table 2** below, which provides a crosswalk of New Mexico's HCBS offerings in the Community Benefit program relative to other state brain injury-specific waiver programs in Colorado, Indiana, North Carolina, and Nebraska. These states were selected to determine how comparable the current New Mexico HCBS service package is to more specialized waiver offerings across a diverse set of states.

Table 2. New Mexico HCBS Service Array for the Community Benefit Program as Compared to Peer States

Range of Covered Services *[Based on a Review of Brain Injury Waiver Services in CO, IN, NC, NE and NY]*	**New Mexico Community Benefit Program Service Offerings**	**New Mexico Community Benefit Services Gaps***
Personal Care / Attendant Care *Assistance with ADLs and IADLs*	• Home health aide • Personal care services	• Remote supports
Skills Development *Assistance with building skills to support community integration and independence*	None	• Services promoting skills development service (e.g., independent living/life skills training)
Home Health Care	• Private duty nursing • Speech and language therapy	None

Range of Covered Services *[Based on a Review of Brain Injury Waiver Services in CO, IN, NC, NE and NY]*	**New Mexico Community Benefit Program Service Offerings**	**New Mexico Community Benefit Services Gaps***
Skilled medical services provided in the individual's home	• Occupational therapy • Physical therapy • Cognitive rehabilitation therapy	
Day Services *Services provided during the day in a community setting outside the home*	• Customized community supports • Adult day health	None
Residential / Round-the-Clock Services (also sometimes called residential habilitation services) *Support for individuals who require 24-hour care or supervision in a community living arrangement that may be provider-owned; does **not** cover room and board*	• Assisted living	None
Respite Care *Services designed to support the primary caregiver and provide them with temporary relief*	• Respite	None
Equipment, Technology, & Modifications *Provision of adaptive aids and modifications to the home or vehicle to increase independence and safety*	• Environmental modifications	• Assistive technology • Personal emergency response system • Specialized medical equipment and supplies • Vehicle modifications
Non-Medical Transportation *Transportation assistance for access to community activities and HCBS services*	• Non-medical transportation (only offered in self-directed model)	• Non-medical transportation not available in agency model
Supported Employment *Services to help individuals find and maintain employment in the community*	• Employment supports	None
Other Professional Services, Therapies / Behavioral Health *Various other health and therapeutic interventions (e.g., mental health assessments, behavior supports, and counseling)*	• Behavior support consultation • Nutrition counseling • Emergency response • Acupuncture • Biofeedback • Chiropractic • Hippotherapy • Massage therapy • Naprapathy	• Caregiver training
Home-Delivered Meals *Nutritional support for individuals unable to prepare their own meals*	• Home delivered meals	None
Community Transition Services *Non-recurring expenses for individuals transitioning from an institution to a community residence*	• Community transition services	None
Self-Directed Goods and Services	• Related goods	None

Range of Covered Services *[Based on a Review of Brain Injury Waiver Services in CO, IN, NC, NE and NY]*	New Mexico Community Benefit Program Service Offerings	New Mexico Community Benefit Services Gaps*
Allows individuals to purchase items or services not otherwise covered, using their allocated budget, to meet needs identified in their person-centered plan	• Start-up goods (self-directed only)	

*Note: This table does not address whether New Mexico's service limits for covered benefits are adequate.

Housing and Related Support Services

The question of whether a state covers appropriate supportive housing for people living with complex behavioral health conditions and/or brain injury requires an expansive assessment of initiatives that span the world of housing, behavioral health, and other medical services.

Building a Continuum of Housing Services

Building a housing continuum for people with complex behavioral health issues requires the following elements:

(1) Capital: Funding for financing for acquisition and development costs of housing.
(2) Rental assistance: Funding to subsidize rents for populations with limited or fixed income.
(3) Supportive services: Funding for housing search and navigation, case management, and tenancy-sustaining services to support ongoing housing tenure and stability.

The resulting system should include services in accordance with the continuum below:

Outreach and Navigation Services	Transitional or Interim Housing Assistance	PSH
Programs that identify, engage, and navigate individuals experiencing homelessness or housing insecurity to available services within New Mexico's housing continuum.	Temporary housing assistance and supportive, tenancy-sustaining services that keep individuals off the street, housed, and safe as long-term housing needs are assessed.	Long-term housing assistance and supportive, tenancy-sustaining services for chronically homeless individuals to ensure positive health and housing outcomes.

Assessing New Mexico's Continuum of Housing Services for People with Behavioral Health and Brain Injury-Related Needs

New Mexico has established much of the basic infrastructure needed for a continuum of evidence-based housing interventions for people with behavioral health and brain injury needs, including programs that offer PSH and short-term housing assistance. This includes:

- **Linkages,** a program that uses BHSD dollars to fund rental subsidies and basic tenancy supports for over 500 units of PSH for people with SMI, including those with co-occurring SUDs. Linkages can be combined with Medicaid-funded pre-tenancy and tenancy services, as noted below.
- **SAHP,** which includes federally subsidized affordable housing units designated for people with behavioral health and I/DD-related needs. It also can be combined with Medicaid-funded pre-tenancy and tenancy services.

- A range of **short-term housing options** that provide short-term rental assistance or temporary housing.
- **Pre-tenancy and tenancy services:** Funding with Medicaid dollars, pre-tenancy and tenancy services assist people receiving rental assistance through Linkages or SAHP to prepare for housing entry and maintain housing stability. In order to access pre-tenancy and tenancy services, an individual must be enrolled in Linkages or SAHP.
- **Short-term post-hospitalization housing or "medical respite":** The Turquoise Care 1115 demonstration allows New Mexico to cover post-hospitalization clinical services in a short-term housing setting for individuals who are homeless and too ill to recover from sickness or injury on the street or in a shelter, but do not require hospital-level care.
- **Outreach and housing navigation services.** New Mexico administers various outreach and navigation services providing case management and pre-tenancy supports for individuals with behavioral health needs, relying on state dollars and non-Medicaid federal funds.
- **Requirement for MCOs to have a housing specialist.** New Mexico requires its MCOs to have a full-time Supportive Housing Specialist dedicated to working with Members to assess housing needs and identify appropriate resources, as well as to provide training and technical assistance to the MCO's care coordinators.[lxxxvii]

Other national best practices that New Mexico is currently demonstrating include:

- Creating set-aside units in Low-Income Housing Tax Credit (LIHTC)-funded projects to support individuals with complex behavioral health needs, including cognitive impairment.
- Coordinating project-based rental assistance in partnership with public housing authorities, including via the HUD Supportive Housing Program for People with Disabilities, other federal vouchers, and state rental assistance.
- Providing non-congregate shelter or interim housing to help bridge transitions from unsheltered settings to PSH.

In addition, the BISF provides state-funded one-time assistance for individuals with brain injury to pay initial or emergency rent, security deposit, and utility start-of-service or one-month maintenance of service charges.

Section IV. Major Gaps, Recommendations, and Implementation Steps

New Mexico's behavioral health system faces several notable gaps. Although coverage of services is relatively strong on paper—as discussed in **Section III**—there are significant access issues, particularly in rural and frontier areas where services such as ACT, PSH, and crisis care are limited. Some high-need individuals do not qualify for certain HCBS that could support their ability to live successfully in the community, and there are challenges in finding appropriate step-down options for those transitioning from inpatient care or residential treatment. The availability of PSH falls short of demand, and navigational supports are often fragmented. People with brain injury are not always identified and may not receive adequate services or support. Some intensive Medicaid-funded services, as described in **Section III**, are not available to uninsured or underinsured individuals.

To build on its existing strengths and address gaps in the current system, Manatt Health's analysis recommends six major strategies. It would not be feasible for New Mexico to implement all of the

suggested strategies simultaneously ,since New Mexico already has a significant number of initiatives and resource-intensive changes underway as a result of SB 3, and also due to new fiscal and administrative challenges posed by HR 1 (119th Congress) and other federal Executive Branch actions.

As such, the report recommends sequencing and phasing implementation of any changes as follows:

- ***Short-term (in next two years):*** **Prioritize strengthening access to already-covered services**
  - Strategy #1: Increase access to already-covered behavioral health and brain injury services, with a focus on expanding access to ACT and crisis services.
  - Strategy #2: Leverage existing New Mexico initiatives to expand PSH and transitional housing.
- ***Medium-term (in two to three years):*** After strengthening access to existing services, pursue improvements to the state's navigational supports infrastructure and consider a 1915(i) SPA to fill gaps in services for people living with complex behavioral health needs and brain injury.
  - Strategy #3: Streamline and strengthen navigational supports.
  - Strategy #4: After gaining experience with SB 3 implementation, assess whether discrete gaps remain in the state's service continuum. If gaps remain, consider expanding community-based services for people living with complex behavioral health conditions and/or brain injury through a 1915(i) SPA.

This **Section** describes each of these strategies in more detail. In addition, it provides proposed recommendations for New Mexico to:

- Address gaps for populations of focus—individuals with brain injury, children and youth, people requiring NF placement, and individuals with SUD, including pregnant women (Strategy #5), and
- Strengthen the foundational elements of its behavioral health system, including the workforce, consumer and provider navigation, and transportation (Strategy #6)

Under any scenario, it will be important to align implementation of new strategies with the work already underway in New Mexico.

Strategy #1: Increase access to already-covered behavioral health and brain injury services.

Introduction

New Mexico's behavioral health system covers a robust continuum of services for individuals with behavioral health and brain injury-related needs. However, the state faces persistent access challenges that limit utilization of these critical services, particularly in rural and frontier areas. For many of the people living with complex behavioral health conditions and/or brain injury, it is all too common for them to find themselves cycling among the streets or shelters, being arrested for nuisance crimes such as public urination or landing in the emergency department or a psychiatric hospital on a repeat basis.[44,] Many stakeholders highlighted that after a hospitalization or stint in jail, people are discharged back to the streets where they cycle begins anew. In SFY 2025, at least 840 Medicaid enrollees with a history of incarceration or homelessness experienced a psychiatric hospitalization or had a behavioral health-

[44] New Mexico's incarceration rates stand out nationally (647/100,000 compared to 614/100,000 in the U.S. in 2024). More information is available at the Prison Policy Institute:
Prison Policy Initiative. "New Mexico Profile." Prisonpolicy.org, 2019, www.prisonpolicy.org/profiles/NM.html.

related emergency department admission or crisis episode[45] Addressing these gaps requires targeted strategies to enhance availability and public awareness of already-covered services, as well as updating and refreshing some services.

Recommendation 1.1: Increase the number and reach of ACT teams, especially in underserved areas, ideally as part of regional priorities under SB 3.

Context

Since at least 2005, New Mexico has covered ACT teams as a benefit in Medicaid and as a state-funded service.[lxxxviii] ACT is an intensive, community-based intervention to help individuals with SMI maintain stability and avoid crises such as hospitalization and homelessness.[46] It is one of the oldest and most widely-researched evidence-based practices for people with SMI, and it has been shown to reduce hospitalization, increase housing stability and improve quality of life.[lxxxix, xc, xci] Each ACT team typically consists of 10–12 members, including a designated team leader, and provides comprehensive services such as medication management, counseling, crisis intervention, and support for daily living.[47] ACT teams go to people's place of residence or meet them on the street if they are experiencing homelessness, actively working to engage them in treatment.

Currently, while it is difficult to get a precise count, there appear to be approximately eight ACT teams operating in the state, largely concentrated in urban areas, leaving many rural communities without access to this important service. The challenge of extending ACT teams to rural areas is not unique to New Mexico, but strategies are available for doing so.

Recommendations and Implementation Steps

New Mexico is well-positioned to expand the number of ACT through a number of strategies.

- **Leverage work already underway as part of SB 3 regional planning** by the University of New Mexico's Behavioral Health Technical Assistance Center to **identify gaps in ACT teams and identify the regions in greatest need.**
- **Integrate ACT expansion into the expansion of CCBHCs** to additional regions of the state, for example, by requiring or funding CCBHCs to operate ACT teams**.** The CCBHC prospective payment system methodology may make it easier for these entities to stand up ACT as a new service line.
- **Adopt discrete modifications to the ACT model for rural and frontier areas**, leveraging the existing language already in New Mexico's behavioral health provider manual that allows for modifications to staff-to-member ratios and the size of teams to reflect rural/urban barriers. Other states such as Montana have made these modifications, although it should be noted that researchers continue to evaluate the impact of such changes on the effectiveness of ACT.
- In alignment with the regional planning process, **assess whether enhanced reimbursement rates for ACT services are needed to support recruitment and retention of multidisciplinary teams,** potentially with further add-ons for rural and frontier areas to reflect travel times and smaller caseloads.

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[45] New Mexico Health Care Authority. (2025). *Medicaid and State-Funded dataset* (restricted administrative data). Medical Assistance Division.

[46] ACT teams must comply with administrative, financial, clinical, quality improvement, and information infrastructure standards set by MAD.

[47] All ACT staff must be certified or trained per ACT fidelity standards, measured by a verified screening tool.

- **Monitor fidelity and outcomes using a standardized fidelity review process** – with adjustments for rural and frontier regions –and track metrics such as the number of ACT teams, the number of individuals served and outcomes such as reduced hospitalizations, emergency department visits, and justice involvement.

Feasibility Criteria	Description
Impact	• Expanding ACT teams can be expected to significantly improve access to intensive behavioral health services, reduce hospitalizations, emergency department visits, and justice involvement
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• Requires planning and coordination among state agencies, MCOs, new regional entities, and behavioral health providers (e.g., CCBHCs)
Workforce	• Recruiting multidisciplinary teams in rural/frontier areas is difficult; it may require new incentives, telehealth integration, or other innovative staffing strategies

Recommendation 1.2: Support ACT teams in developing specialized expertise on SUD and justice system involvement.

Context

New Mexico's provider manual requires that the ACT team include a licensed behavioral health professional with expertise in SUD and explicitly notes that people with a diagnosis of a SUD cannot be excluded from ACT services. Even so, ACT teams in New Mexico often struggle to effectively serve people for whom a SUD is their primary diagnosis. In response, ACT teams can provide Integrated Dual Diagnosis Treatment (IDDT), an evidence-based modality of ACT that merges mental health and SUD services into the same ACT team. When ACT teams provide IDDT, it allows the team as a whole – not just a single member assigned responsibility for SUD issues – to help address enrollees' co-occurring health concerns in an integrated way.[48] It also provides a pathway through which to offer medications for SUDs, such as buprenorphine-based formulations for OUD and injectable naltrexone or other Food and Drug Administration (FDA)-approved oral medications for AUD.

Similarly, New Mexico's behavioral health provider manual allows that ACT teams can be forensic teams, but it is not clear the extent to which any ACT teams within the state have this capacity. A Forensic ACT team ("FACT team") includes active coordination and planning with the court systems and probation/parole officers, as well as a certified peer on the team with personal experience with incarceration. Following an individual's release from jail or prison, FACT teams play a critical role in helping the person become reintegrated into the community. They provide wraparound services such as psychiatric care, medication management, counseling, and assistance with housing and employment. FACT teams also coordinate closely with probation or parole officers to ensure compliance with legal requirements while prioritizing recovery and rehabilitation.[xcii]

A number of other states already support FACT teams (e.g., California, North Carolina)[xciii, xciv] and ACT teams with IDDT functionality (e.g., Ohio).[xcv]

[48] For additional information about IDDT, see https://case.edu/socialwork/centerforebp/practices/substance-abuse-mental-illness/integrated-dual-disorder-treatment

Recommendations and Implementation Steps

To expand the capacity of ACT teams to address the specialized needs of people with a primary diagnosis of SUD and/or who have been incarcerated, New Mexico should consider providing additional support to ACT teams to develop IDDT and FACT capacity.

- **Leverage the existing expertise at the University of New Mexico (UNM) Behavioral Health Technical Assistance Center** on IDDT and FACT to **support interested ACT teams in building out their specialized expertise** through training and technical assistance.
- **Provide enhanced reimbursement to ACT teams that 1) meet IDDT standards, or 2) can operate as a FACT team.**
- **Modify the state's provider manual to define the standards for ACT teams that meet IDDT standards and FACT team standards.** For example, the policy could clarify that an ACT team with IDDT expertise should have staff trained on SUDs beyond a single delegated individual, incorporate harm reduction approaches, and include prescribers of medications for SUD. A FACT team could include a justice partner and a peer with lived experience, as well as relationships with the judiciary, probation, and parole agencies.
- **Establish structured coordination between FACT teams and JUST Health Plus**, New Mexico's re-entry initiative for people leaving jail or prison.

Feasibility Criteria	Description
Impact	• Improves outcomes for high-need populations by providing tailored, intensive, community-based services • Long-term offsetting cost savings expected through reduced hospitalizations and homelessness
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• State may be able to leverage existing contract with UNM to provide training • Requires coordination across multiple entities (BHSD, MAD, MCOs, University of New Mexico, judiciary, corrections) • May need to adjust rates for ACT teams that meet IDDT standards and for FACT teams • Requires updates to New Mexico's provider manual • Administrative burden could be managed through phased implementation and pilot programs
Workforce	• FACT teams need specialized staff: psychiatrists, clinicians, case managers, a criminal justice partner, and peer support specialists; all of which are in short supply in New Mexico • Recruitment and retention strategies, plus telehealth integration, will be critical

Recommendation 1.3. Strengthen the availability of crisis services, including mobile crisis teams.

Context

In recent years, New Mexico has prioritized building out its crisis continuum, recognizing that crisis services are critical to connecting people with complex behavioral health needs to community-based services, keeping people out of emergency departments and psychiatric hospitals, and preventing people from entering the justice system. As documented in **Section III** of this report, New Mexico now covers a robust set of crisis services, including telephone crisis services, face-to-face outpatient clinic

crisis services, crisis stabilization services, and crisis triage centers, in addition to new crisis services described below.

Most recently, in February 2024, CMS approved a SPA that authorized New Mexico to launch a new mobile crisis and MRSS benefit.[xcvi] The benefit includes two components:

- **Community-based mobile crisis intervention services** offered 24 hours per day, 365 days per year by a two-person mobile crisis team that includes at least one behavioral health care professional;[xcvii] and
- **MRSS** targeted toward children, youth, and their families, which follow up the use of mobile crisis to help de-escalate the crisis and achieve stabilization. A child or youth can obtain up to 56 days of stabilization services under the benefit.

Currently, there are seven mobile crisis team across the state, and no providers in New Mexico are offering MRSS. CYFD currently is reviewing the MRSS benefit and determining if it can recruit providers. In interviews, providers expressed concerns about recruiting staff, including for after-hour shifts, and noted it is especially difficult to launch mobile crisis teams in rural areas where caseloads are small and travel distances are significant.

Quote: "I've never used crisis services. I'd take him to the emergency room. I've never called the crisis line because I'm afraid the cops will kill him" Mom of a son with significant mental health issues, December 2025.

Federal CCBHC requirements mandate that CCBHCs offer—either directly or through a Designated Collaborating Organization (DCO) —emergency crisis intervention services, 24-hour mobile crisis teams, and crisis receiving/stabilization services.[xcviii] While CCBHCs indicated that the cost-based payment methodology they are paid—called a prospective payment system, or PPS — makes it more viable to offer mobile crisis services, it can still be challenging.

There is also an insufficient number of crisis triage centers in New Mexico, with only four facilities serving adults and one facility serving children across the entire state (all of which are located in or near urban areas). Crisis triage centers also provide crucial crisis stabilization services that divert individuals from emergency departments and jails.

Recommendations and Implementation Steps

New Mexico could:

- **Provide capacity building funding for new mobile crisis and MRSS teams.** Given the challenges with standing up mobile crisis and MRSS teams, New Mexico may want to consider providing more capacity building funds to teams, potentially at a regional level via the SB 3 planning process. Mobile crisis teams can be especially difficult to launch due to workforce constraints, difficulty sustaining a model that must operate 24-7 without reimbursement for "down time" and concerns about staff safety and wellbeing. Along with the issues identified by stakeholders above, until people gain confidence that they can call mobile crisis response without facing undue delays or risking law enforcement involvement, they will avoid doing so, which, in turn, undercuts the financial viability of mobile crisis teams.
- **Work with the legislature to require commercial insurers to cover mobile crisis services and MRSS**. Currently, New Mexico's mobile crisis system is entirely financed by Medicaid. Some states have passed legislation requiring commercial health plans to cover emergency behavioral health services[xcix].New Mexico's legislature could enact a similar law, bringing new revenue streams to mobile crisis providers, which would increase the sustainability of the models.

- **Convene a working group of CCBHCs to develop strategies for launching sustainable mobile crisis and MRSS service lines**. New Mexico is in the midst of expanding its CCBHC program, with five new providers launched as of January 1, 2026. The State envisions that CCBHCs will promote "meeting people where they are and making sure comprehensive care is available when and where it's needed." c Given the importance of CCBHCs to New Mexico's efforts to expand access to comprehensive behavioral health care across the state, it is important that CCBHCs are able to develop a sustainable business model for crisis services. HCA should convene a working group of both existing and new CCBHCs to understand challenges with establishing and maintaining mobile crisis services, develop strategies to make provision of mobile crisis more sustainable for CCBHCs, and identify ways to incentivize CCBHCs to adopt MRSS.
- **Adjust the state's MRSS and mobile crisis models to reflect New Mexico's largely rural landscape.** While MRSS is a well-established evidence-based practice, HCA should review whether to adapt it on a temporary basis, if not longer, to incorporate some modifications to the model to increase its viability in New Mexico. For example, HCA may want to revisit the staffing and supervisory requirements for MRSS teams. Similarly, HCA should review the staffing and supervisory requirements for mobile crisis teams to identify flexibilities that may make them more financially viable in rural areas of the state.

Feasibility Criteria	Description
Impact	• Expansion of mobile crisis and MRSS is a critical strategy for diverting people from emergency departments and the justice system
Federal Authority Considerations	• No new federal authority required
State Administrative Complexity	• Requires state efforts to implement recommendations and identify new staffing approach to MRSS that reflects on-the-ground workforce shortages
Workforce	• Workforce shortages create challenges in more broadly expanding mobile crisis teams and MRSS; • Recommendations may require additional specialized training on crisis response and MRSS • Recommendations aim to reduce the workforce burden of launching these models

Recommendation 1.4: Conduct outreach to explain that individuals with behavioral health needs or brain injury who have co-occurring physical health disabilities may qualify for the Community Benefit program.

Context

As discussed above, the Community Benefit program offers a robust set of HCBS to individuals enrolled in managed care who otherwise would require NFLOC. This includes a full array of services that someone with complex behavioral health needs might require, including a personal aide who can check in on the person, assist them with taking medications, and prompt them to engage in community activities. People who option into the self-direction option also can secure transportation to community events (not just medical appointments). There are few, if any gaps, in the services that someone might need, but it is not well understood by enrollees, their families or even by New Mexico's behavioral health providers that the Community Benefit program is available to people with complex behavioral health if they have co-occurring physical health needs that would otherwise require NFLOC. Currently, it

is estimated that 8%[49] of members receiving Community Benefit services have a diagnosis of SMI or SUD.

In practice, the Community Benefit should be serving individuals with complex behavioral health needs, especially because individuals with SMI are at nearly double the risk of multiple physical health conditions (e.g., metabolic diseases such as diabetes and obesity; hypertension; epilepsy; respiratory, vascular, kidney and gastrointestinal diseases; and cancer).[ci] Based on its data analysis, Milliman estimates that approximately 900 current Medicaid enrollees who have SMI and/or SUD could be eligible for Community Benefit, but are not enrolled in the program.[50]

Recommendations and Implementation Steps

New Mexico could:

- **Update the state's websites and informational materials** on the Community Benefit program to **highlight that individuals with complex behavioral health conditions can qualify** for the Community Benefit program if they have co-occurring physical health needs that necessitate a NFLOC.
- **Integrate a discussion of the Community Benefit program into New Mexico's behavioral health provider manual,** which currently does not reference the Community Benefit program as an option for people with complex co-occurring physical and behavioral health needs.
- **Convene New Mexico's Medicaid MCOs to review their administration of the Community Benefit program** to update their outreach and assessment materials to encompass co-occurring behavioral health conditions.[51]

Feasibility Criteria	Description
Impact	• Improves access to HCBS for individuals with co-occurring physical and behavioral health conditions, reducing unnecessary institutionalization, and promoting community integration
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• Requires updates to educational materials, provider manual, and outreach processes; coordination with MCOs
Workforce	• No significant increase in clinical workforce needs

Recommendation 1.5: Retain current Medicaid payment rates for behavioral health services to support provider participation.

Context

As noted earlier in the report, New Mexico has invested $2.3 billion to increase Medicaid provider rates,[cii] including $90 million in Medicaid rate increases for behavioral health providers, raising Medicaid behavioral health reimbursement rates to 150% of Medicare in January 2025.[ciii, civ] Feedback from behavioral health providers emphasized that these rate increases have been particularly important for outpatient providers that deliver primary prevention and treatment services like screening and counseling. With the implementation of HR 1, New Mexico expects that it will lose $8.5 billion in federal

[49] In SFY 2025, 2,254 Medicaid enrollees with SMI or SUD had a Community Benefit claim out of 27,688 total individuals enrolled in the Community Benefit waiver.
[50] Includes all Medicaid adults (18+) with SMI or SUD who had a short-term stay in a nursing facility in SFY 2025.
[51] The brochure for the program is available here: https://www.hca.nm.gov/wp-content/uploads/MAD-792-CB-Brochure-2024-Revised-7.01.25.pdf.

funding for provider payments between 2028-2037 (See **Call Out Box 4**).[cv] If the State substantially cuts behavioral health provider rates, it will further exacerbate challenges accessing existing behavioral health services.

Recommendations and Implementation Steps

As the State implements HR 1, it should **seek to retain the current Medicaid payment rates for behavioral health services to the maximum extent possible.**

Feasibility Criteria	Description
Impact	• Critical impact on maintaining existing access to behavioral health services
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• No new administrative burden for the State
Workforce	• Will help retain existing workforce

Strategy #2: Leverage existing New Mexico initiatives to expand PSH and transitional housing.

Introduction

As described in detail in **Appendix B,** New Mexico has established the basic infrastructure for a continuum of evidence-based housing interventions for people with behavioral health and brain injury needs. Through Linkages and SAHP, the state provides rental assistance and tenancy-sustaining services to New Mexicans with behavioral health needs experiencing homelessness or housing instability. BHSD and New Mexico Mortgage Finance Authority (MFA) also implement an array of local short-term housing programs and navigation and outreach services that serve individuals with behavioral health needs.

With its Turquoise Care 1115 demonstration, New Mexico secured key opportunities to leverage Medicaid funds to pay for pre-tenancy and tenancy supports. It also won the ability to use Medicaid funds for a medical respite benefit, which covers up to six months of room and board and supportive services for people who are homeless and who are too ill to recover from sickness or injury on the street or in a shelter but do not require hospital level care.[cvi]

While New Mexico has a strong foundation from which to build, the number of people served through PSH initiatives is small relative to the need. The state also has important opportunities to increase utilization of pre-tenancy and tenancy services, as well as medical respite care, and to make it easier for providers and consumers to navigate housing opportunities.

Call Out Box 8: How Much More Supportive Housing Does New Mexico Need?

While better data are needed, it is clear that the current inventory of housing programs for individuals with behavioral health and brain injury needs does not meet the demand.

Estimates of the number of people experiencing homelessness in New Mexico, including those with behavioral health needs, vary heavily due to methodology, the complexity in identifying homeless

residents, and a lack of a statewide, centralized tracking source.[52] BHSD's New Mexico Supportive Housing Strategic Plan for 2024-2028 estimates that the total number of people who are currently homeless or precariously housed (i.e., living in temporary or unsafe conditions with others or motels/hotels) falls between 15,000 and 20,000 people. The estimated number of additional beds or housing units needed to assist all New Mexicans experiencing homelessness ranges from approximately 6,500 to 8,400, but not all of these individuals are living with behavioral health issues or brain injury.[cvii]

The proportion of homeless and precariously housed individuals with mental health and/or substance use needs also ranges statewide from just 13% in most parts of the state to over 50% in Albuquerque.[53] The Corporation for Supportive Housing previously estimated that roughly 2,664 individuals who are justice-involved or with mental health and substance use needs are currently without available housing units,[54] while more recent estimates project over 4,300 without available housing. While stronger data, including for homeless individuals with brain injury, would help refine these estimates, the current inventory of housing programs for individuals with behavioral health and brain injury needs does not meet demand, with a likely current gap for at least 3,000-4,000 people.

Recommendation 2.1: Expand PSH to reduce unmet need.

Context

Currently, the Linkages program serves approximately 550 people while SAHP serves 370 for a total of 920 people. This represents approximately one-third of the PSH capacity that is needed in the state for people with complex behavioral health issues or brain injury (See **Call Out Box 8**). Of particular concern among stakeholders is that the housing agencies and behavioral health service agencies that together operate Linkages and SAHP only serve select regions of the state, leaving some rural and frontier areas with no access to these programs.

Recommendations and Implementation Steps

To expand PSH in New Mexico, the state should consider:

- **Expanding rental assistance, maximizing use of federal funds when possible.** New Mexico may be able to increase the number of Linkages rental vouchers with state general fund dollars. The legislature already increased appropriations for the program by $5 million in fiscal year 2025, bringing it to $10.2 million. Even if additional state general fund dollars are not available, the state still may be able to direct additional federal housing resources to expand Linkages. For example, Housing New Mexico may be able to provide more Housing Choice Vouchers (often referred to as Section 8 vouchers) or Mainstream Vouchers (for people with disabilities ages 18 to 61 who are homeless, leaving institutions, or at risk of either) to individuals living with

[52] Point in time counts, for example, may underestimate the number of individuals experiencing homelessness because they have difficulty identifying hidden homeless populations, including individuals who are couch surfing or housed and living in unsafe housing conditions.

[53] For example, in 2023, half of unsheltered homeless individuals in Albuquerque self-reported having SMI, and 45% reported having SUD, which deviated significantly from self-reports in other parts of the state, where 13% experiencing unsheltered homelessness self-reported SMI and 13% self-reported SUD.

[54] Note: See Figure III-9 (page 15) of New Mexico Supportive Housing Strategic Plan 2024-2028 (Available here: https://www.carmichaelconsultants.com/wp-content/uploads/2024/02/New-Mexico-Supportive-Housing-Strategic-Plan-2024-2028.pdf). This estimate does *not* include individuals with brain injury in need of supportive housing.

complex behavioral health issues appropriate for Linkages. It may also be able to prompt the SAHP program to set aside LIHTC units specifically for Linkages enrollees.

- **Expanding set-aside units for people with behavioral health needs.** New Mexico could leverage recent federal updates to the LIHTC included in HR 1 (see **Call Out Box 4** for details) to expand set-aside units for people with behavioral health needs via SAHP. If New Mexico secures additional set-aside units in LIHTC developments for individuals with behavioral health needs or brain injury, the state could also consider leveraging some of these units for future Linkages participants. While some SAHP units have been made more affordable through HUD Section 811 project-based rental assistance, not all SAHP units are affordable to people with behavioral health or brain injury needs who may be reliant on supplemental security income (SSI)/social security disability income (SSDI) for their incomes. Through future funding expansions for the Linkages program, BHSD and MFA could direct Linkages rental assistance to set-aside units within LIHTC properties. This strategy would increase the housing inventory available to the Linkages program.

HR 1 made significant increases and changes to LIHTC that can increase affordable housing development by 1.22 million more units nationwide over the next decade. The law (1) permanently increases the amount of tax credits that states can award to housing developments serving low-income households; (2) makes it easier for states to leverage federal tax credits when using private activity bonds to finance housing; and (3) provides a significant boost in available funding to states beginning in 2026.

- **Expanding clinical eligibility criteria for Linkages beyond behavioral health.** If the state has more resources to pay for rental assistance via Linkages, BHSD could consider expanding eligibility criteria **to explicitly target individuals with brain injury needs.** Currently, individuals with brain injury are not eligible for Linkages unless they also have concurrent behavioral health issues.

Feasibility Criteria	Description
Impact	• Expanding PSH will significantly reduce homelessness among individuals with behavioral health needs
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• Requires coordination between BHSD, MFA, housing authorities, and LIHTC developers; administrative processes for voucher allocation and set-aside agreements
Workforce	• Minimal direct workforce impact; may require additional case managers and housing navigators to support expanded capacity

Recommendation 2.2: Increase utilization of Medicaid-covered pre-tenancy and tenancy services.

Context

Utilization is low for the pre-tenancy and tenancy services available under the Turquoise Care 1115 demonstration, resulting in approximately 70 percent of available slots for these services going

unused.[55] Specifically, 130 out of the capped allotment of 450 slots for pre-tenancy and tenancy services are being used. The state recently expanded Linkages' rental subsidies, which could prompt greater use of pre-tenancy and tenancy supports, but providers also report it is challenging to enroll in Medicaid and bill for these services. In some instances, they bill CCSS as a substitute for pre-tenancy and tenancy supports – even though it offers a lower reimbursement rate – because they are more familiar with the CCSS benefit.

Recommendations and Implementation Steps

To increase utilization of pre-tenancy and tenancy services, New Mexico could consider:

- **Issuing Medicaid billing guidance, updating provider manuals (a process that BHSD has already begun), and providing training and technical assistance to Linkages and SAHP providers** to explain how to bill for these services.[56] This could also include guidance to providers on billing for pre-tenancy and tenancy services versus CCSS to avoid duplication of benefits.
    - If these efforts are successful, New Mexico in the longer term may need to increase the number of pre-tenancy and tenancy services slots above the current cap set at 450.
    - As part of this effort, the state could also broaden eligibility for pre-tenancy and tenancy services to individuals living with complex behavioral health issues and/or brain injury who receive their rental assistance through programs other than Linkages or SAHP (e.g., via locally funded PSH arrangements). This could be done through an amendment to the existing Turquoise Care 1115 demonstration when it comes up for renewal in 2029.[57]
- **Supplementing tenancy-sustaining services in Linkages and SAHP** to ensure that individuals enrolled in these programs with especially high needs receive additional wrap-around supportive services, such as ACT.[58] Only a subset of individuals in Linkages and SAHP will require this additional support, but for those that do, these additional services can help prevent a return to homelessness.
    - Several communities in other states have taken this approach, and they have seen promising results. For example, in Dallas and Collins counties, Texas, the North Texas Behavioral Health Authority, Meadows Mental Health Policy Institute, Housing Forward North Texas, and All-Neighbors Coalition launched a joint program offering PSH along with more intensive wrap-around supportive services models (e.g., ACT or an intensive case management team). Specialized teams comprised of behavioral health providers

[55] Under its Turquoise Care 1115 demonstration, New Mexico has the authority to use Medicaid funds to pay for pre-tenancy and tenancy support for up to 450 enrollees who are receiving rental vouchers from Linkages or SAHP. Currently, stakeholders report that only roughly 130 Linkages enrollees are receiving these two services. It is difficult to pinpoint exactly why these Medicaid-funded services are underutilized. It may be caused by people enrolling in Linkages and SAHP with just the programs' state-funded case management services and/or service providers not being enrolled in or reluctant to bill Medicaid.

[56] BHSD SME estimated that roughly 130 Linkages enrollees are currently receiving pre-tenancy and tenancy supports.

[57] Under the Trump Administration, CMS has not approved any new Medicaid 1115 demonstrations that cover room and board expenses, but in December of 2025, it did approve a request from Rhode Island to use Medicaid 1115 authority to cover pre-tenancy and tenancy support services.

[58] Note: The state could similarly explore implementing MST and HFW for youth with complex behavioral health needs enrolled in PSH via the Youth Homelessness Demonstration Program (see Appendix for more details).

and people with lived homelessness experience help unhoused individuals with mental health or substance use needs move to PSH. They provide behavioral health care, including SUD support, psychiatric services, medication management, and crisis intervention.

- Similarly, HUD's Veteran Affairs' supportive housing program (HUD-VASH) includes more intensive supportive services such as ACT teams in lieu of standard case management service.

Feasibility Criteria	Description
Impact	• High impact on expanding PSH via effective use of tenancy support and related services
Federal Authority Considerations	• CMS approval required if the state eventually reaches cap on Medicaid-funded pre-tenancy and tenancy services and/or to expand eligibility criteria to encompass brain injury; could be done during next renewal of the Turquoise Care 1115 demonstration in 2029
State Administrative Complexity	• Builds on existing infrastructure for tenancy support services
Workforce	• Requires provider enrollment in Medicaid to increase uptake of Turquoise Care 1115 demonstration's pre-tenancy and tenancy services

Recommendation 2.3: Grow transitional and interim housing programs.

Context

New Mexico currently administers an array of short-term housing programs through BHSD and MFA that provide transitional or interim housing for individuals with behavioral health needs, especially those with SUD. However, enrollment in these programs is limited as most operate in only select counties and face significant funding constraints. While these programs provide a strong base for transitional and interim housing programs, the state has the opportunity to further expand these programs by braiding federal and state funds to serve more people across the state.

Recommendations and Implementation Steps

To expand short-term and transitional housing, New Mexico could:

- **Leverage federal and state funding opportunities.** New Mexico may be able to identify additional federal funding from MHBG or HUD's Community Development Block Grants (CDBG), Emergency Services Grant (ESG), or HOME-American Rescue Plan (HOME-ARP).
- **Leverage already-approved state dollars for target populations**. In August 2025, the New Mexico Department of Workforce Solutions' Office of Housing announced $120 million in new housing projects. [59] BHSD may want to determine if there is an opportunity to use some of these funds to help ensure that providers are adequately serving individuals with behavioral health and brain injury needs and/or braiding with other state funding sources to create permanent or short-term housing for this population. In particular, these dollars could be allocated towards outreach and navigation programs to help eligible individuals enroll in

[59] More information is available here: https://www.governor.state.nm.us/2025/08/19/governor-announces-120-million-for-housing-and-homelessness/.

available housing programs, which stakeholders suggest are currently limited and result in underutilization of available services.

Feasibility Criteria	Description
Impact	• High impact on expanding availability of temporary rental assistance and supportive services statewide
Federal Authority Considerations	• Use of federal grant dollars requires approval of overseeing agency (e.g., SAMHSA)
State Administrative Complexity	• Largely builds on existing interim and transitional housing infrastructure • State already demonstrates agency-level expertise in administering dollars from these federal sources in partnership with housing authorities and providers statewide
Workforce	• Requires building provider capacity to deliver supportive services

Recommendation 2.4: Standardize referral pathways and entry processes into supportive housing.

Context

Currently, many enrollees, their families and providers are unaware of the housing options available to them, preventing full utilization of New Mexico's housing services continuum. Stakeholders cite as reasons a lack of coordination between behavioral health providers and street medicine providers; a lack of knowledge among institutional providers about available housing options; and a disjointed approach to assessing the housing needs of clients as they leave jails and psychiatric hospitals.

Recommendations and Implementation Steps

New Mexico could:

- **Standardize the referral pathways and entry processes into housing services for individuals in the populations of focus,** including PSH, transitional or interim housing. For example, New Mexico could develop outreach materials and memoranda of understanding (MOUs) for MCOs and providers to use in partnership with homeless service providers and advocacy organizations to chronicle how referrals should be made for housing and related behavioral health services. These MOUs could prioritize the use of CPSWs and community support workers (CSWs) to conduct outreach, including through street medicine, an effective model for connecting with hard-to-reach individuals.
- **Develop or fund training for discharge planners in jails, prisons, hospitals, nursing facilities and SUD treatment programs on housing needs, options, and referral procedures.** Any such training could include Linkages, SAHP, and other local PSH programs, as well as the relatively new medical respite benefit if it becomes more widely available across the state.
- **Support creation of a universal housing assessment that screens individuals for risk factors for homelessness and homelessness status to identify appropriate housing and accompanying supportive services for individuals with SMI, SUD, or brain injury.** Ideally, such a tool would be used across entry points, including hospitals, FQHCs, CCBHCs, OTPs, carceral settings, and community-based settings by a variety of providers.

Feasibility Criteria	Description
Impact	• High impact on expanding access to housing services continuum through strengthened identification and referral pathways

Federal Authority Considerations	• No new federal authority required
State Administrative Complexity	• Requires HCA to develop a template MOU; a universal housing assessment tool; and training for discharge staff
Workforce	• Providers would need to invest time in understanding and participating in MOUs and in using the assessment tool • May require enhanced provider training on screening and delivering transitional services

Recommendation 2.5: Expand medical respite implementation.

Context

The Turquoise Care 1115 demonstration allows the state to implement short-term post-hospitalization housing, also referred to as a "medical respite" benefit, which provides up to six months of room and board and recuperative or rehabilitative services to people who are homeless and who are too ill to recover from sickness or injury on the street or in a shelter but do not require hospital level care. Numerous stakeholders – including enrollees and providers – highlighted that it currently can be extremely hard to discharge individuals from hospitals because there is no safe place for them to recover.

In addition, the Turquoise Care 1115 demonstration provides New Mexico with the ability to use up to $99.5 million in Medicaid funding (including both state and federal share) for infrastructure to support implementation of medical respite and a second, separate benefit that provides nutritional support to pregnant enrollees. The dollars are available to New Mexico for the duration of its current 1115 demonstration at a 50/50 matching rate (i.e., the federal government will pay half the cost of allowable infrastructure investments). They can be used for planning purposes, technology investments, and other steps designed to stand up additional medical respite providers.

New Mexico's medical respite benefit went into effect on June 1, 2025.[cviii] Currently, it is available at only one 50-bed pilot site in Albuquerque, operated by Albuquerque Health Care for the Homeless, a Federally Qualified Health Center.[60] HCA has informed CMS that it intends to expand the medical respite benefit to nine additional sites over the course of the demonstration (i.e., by 2029), with specific sites and a phase-in schedule to be determined as provider capacity and physical space is secured.

Recommendations and Implementation Steps

New Mexico could:

- **Leverage the Turquoise 1115 demonstration infrastructure funds to establish additional medical respite sites around the state**, drawing on lessons from the Albuquerque pilot, ideally in collaboration with the SB 3 regional planning process. While the federal funds are already approved and available, they must be matched with state dollars at a 50-50 rate, which would require a state appropriation.
- **Encourage the creation of strong "handoff" protocols** to connect medical respite enrollees with longer-term PSH via Linkages, SAHP or other initiatives when establishing new respite sites.
    - For example, the City of Albuquerque committed to reserving 40 housing vouchers per year for members exiting medical respite.

[60] See page 229 in New Mexico's approved 1115 demonstration: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-turquoise-care-demo-approval-07222025.pdf

Feasibility Criteria	Description
Impact	• High impact on expanding access to transitional post-hospitalization recuperative housing
Federal Authority Considerations	• CMS already has approved infrastructure funds per Attachment N of the special terms and conditions for the Turquoise Care 1115 demonstration
State Administrative Complexity	• Likely requires RFP or similar process to procure providers for other pilot sites • Need to engage local stakeholders, identify implementation partners, and prepare administrative and clinical protocols (e.g., via MOUs and provider training) similar to the Albuquerque pilot
Workforce	• May need to engage local providers to understand constraints in potential communities of interest • Will require provider training to implement medical respite in compliance with waiver protocols

Strategy #3: Streamline and strengthen navigational support.

Introduction

It is often challenging for people with complex behavioral health conditions and brain injury to determine which services they might qualify for and how to access them. As such, they may require additional assistance navigating the options available. States offer navigational supports through a variety of programs and services. For example, federal Medicaid rules require that Medicaid managed care plans coordinate care for all of their enrollees, with more intensive requirements for assessments and development of treatment or service plans for enrollees with special health care needs or who need Long-Term Services and Supports (LTSS).[cix] Beyond managed care, states also typically offer a variety of case management initiatives and navigational supports focused on populations with the most complex needs. For example, some states choose to provide case management via an optional State Plan benefit.[61] States are required to conduct person-centered planning—which is a core part of case management—for their HCBS programs.[cx] Some states choose to implement an optional Health Home benefit or certify CCBHCs, both of which are required to offer care coordination and case management. Additionally, certain high-intensity services like ACT and HFW include elements of navigational support. While the scope of activities may vary across programs and services, common elements typically include an assessment of needs, development of a care plan, coordination and referrals across providers/services, and ongoing monitoring and follow-up with individuals.

Quote: "I've done systems navigation work for the past 25 years. We have a tough system to navigate! Information is not easy to access. It is easier to navigate the DDW system than find behavioral health services." Beneficiary Public Listening Session, December 10, 2025.

Call Out Box 9. Definitions

Nationally, there are a variety of definitions for the terms case management, care coordination, and care management. New Mexico primarily uses the terms as follows:

[61] See 42 CFR 440.169

- **Case management** is a highly targeted service for individuals with complex needs, focused on personalized support to help address an individual's care and service needs. New Mexico's DD, Mi Via, and Medically Fragile Waivers offer a case management benefit. Case management is also offered through Health Homes and CCBHCs.
- **Care coordination** focuses on communication and collaboration among multiple providers and care settings. New Mexico's MCOs provide care coordination. Care coordination is also offered through Health Homes and CCBHCs.
- **Care management** in New Mexico refers to a service offered by Health Homes.

While there are no established standards for how states should structure navigational supports, SAMHSA offers a series of case management principles for people with SUD that are also relevant for people with mental health conditions and brain injury. [cxi] The principles establish that among other characteristics case management should:

- *Offer the patient a single point of contact with the health and social services system.*
- *[Be] patient centered.*
- *[Be] community based.*
- *[Be] culturally sensitive and non-stigmatizing.*
- *[Be] pragmatic [where the] case manager may also teach skills helpful to recovery (e.g., assertive communication, collaboration with a team of providers, day-to-day skills for living in the community).*[cxii]

Additionally, research has shown that care coordination and case/care management embedded at the site of care can lead to better outcomes (e.g., lower unnecessary utilization) and improved patient experiences, particularly for individuals with complex or chronic needs.[cxiii,cxiv,cxv] Accordingly, the federal government has encouraged states to establish community-based care coordination and case management models for people with complex behavioral health needs. Congress has authorized enhanced federal Medicaid matching funds for the Health Home Medicaid State Plan option and CCBHC demonstration, and in 2023, the Center for Medicare and Medicaid Innovation launched the Innovation in Behavioral Health Model, which funds states to implement care management models based at behavioral health provider organizations.

New Mexico Landscape

New Mexico uses a variety of Medicaid authorities and state funds to cover **navigational supports for people with mental health conditions, SUD, and brain injury**. Individuals may receive support via one of the mechanisms below.

MCO care coordination is available statewide to individuals enrolled in Medicaid managed care (Turquoise Care).[62] Within 30 days of enrollment, the MCO is expected to attempt to complete a Health Risk Assessment (HRA) for all enrollees to determine whether the member needs more intensive care coordination. Individuals with SMI, SED, SUD, or brain injury are automatically determined to need "Level 2" care coordination, which requires the care coordinator to conduct an in-person

[62] The Turquoise Care Contract, defines care coordination as "deliberately organizing Member care activities and sharing information among all of the participants concerned with a member's care to achieve safer and more effective care." See here for more information: https://www.hca.nm.gov/wp-content/uploads/MAD-792-CB-Brochure-2024-Revised-7.01.25.pdf

Comprehensive Needs Assessment (CNA), develop a Comprehensive Care Plan, and engage with the member regularly.[cxvi] MCOs are required to employ or contract with dedicated care coordinators and supervisors with expertise in the needs for individuals with complex behavioral health needs, including SUD and brain injury. For individuals enrolled in the Community Benefit program, MCO care coordinators help with developing the care plan and coordinating services.[63] New Mexico requires MCOs to fully delegate care coordination responsibilities to community-based providers for infants and perinatal enrollees, including those participating in the Comprehensive Addiction and Recovery Act Program, which is designed to support families whose child has been born substance exposed. MCOs may also delegate to other community-based providers (e.g., CCBHCs, Health Homes).

Medicaid State Plan benefits. New Mexico offers several Medicaid State Plan benefits that provide navigational support. In addition, some State Plan benefits (e.g., MST, coordinated specialty care for first episode psychosis) embed case management as part of their broader definition. State Plan benefits focused on navigational support include:

- **CCSS** provides individuals with SMI, SED, or SUD with services and resources necessary to promote recovery, rehabilitation, and resiliency. CCSS consists of a variety of face-to-face and community interventions to support independent functioning in the community. This includes skills for independent living, learning, working, socializing, and recreation. CCSS also provides assistance with identifying and coordinating services and supports identified in an individual's treatment plan, supports an individual and family in crisis situations, and provides individual interventions to develop or enhance an individual's ability to make informed and independent choices.
- **CareLink Health Home** is targeted towards individuals with SMI, SED, or SUD. Ten Health Home exist across 10 New Mexico counties (Bernalillo, Curry, De Baca, Grant, Hidalgo, Lea, Quay, Roosevelt, Sandoval, San Juan). The program seeks to enhance integration and coordination of primary, acute, behavioral health, social, and long-term care services and supports. Services include the six federally required core services: comprehensive care management; care coordination; prevention, health promotion, and disease management; comprehensive transitional care; individual and family support services; and referral to community and social support services.[64]
- **ACT** is an intensive, highly individualized behavioral health service for individuals discharged from hospitals after multiple or extended stays, or who are difficult to engage in treatment, and have continuous high service needs that are not being met in more traditional service settings. Interdisciplinary staff teams are available 24 hours a day, seven days a week, providing navigational supports as part of a broader set of intensive, integrated rehabilitative, crisis, treatment, and community support services. ACT services are provided in a community setting or at home.

CCBHC demonstration. CCBHCs are required to serve anyone who requests care for mental health or substance use regardless of their insurance status, ability to pay, or place of residence. CCBHCs are federally required to provide care coordination to all individuals served and targeted case management to individuals with significant mental health and SUD needs. As part of targeted case management, CCBHCs assist these individuals with sustaining recovery and gaining access to needed medical, social,

[64] Health Homes are an optional Medicaid State Plan benefit, established by Section 2703 of the ACA ((1945 of the Social Security Act)) to coordinate care for people with Medicaid who have chronic conditions.

legal, educational, housing, vocational, and other services and supports, particularly during times of transition. New Mexico requires that its CCBHCs align their care coordination approach with either the MCO care coordination or CareLink Health Home standards.

Turquoise Care 1115 demonstration: The Turquoise Care demonstration authorizes the following initiatives:

- **HFW** is a comprehensive, wholistic, youth and family driven way of responding when children or youth experience serious mental health or behavioral challenges. HFW provides intensive care coordination, using the HFW model, across services, levels of care, systems, community stakeholders, and support systems.
- **JUST Health Plus initiative** offers case management to justice-involved individuals in the period immediately prior to their release from a correctional facility.

State funds. New Mexico offers case management to individuals with SMI or SUD who are uninsured or underinsured. For individuals with brain injury, the BISF offers short-term service coordination services for individuals with brain injury that include assessing, planning, coordinating, customizing, and monitoring services funded by the BISF Program. The state uses a variety of other funding streams to provide navigational supports, including SSI/SSDI, State Outreach, Access, and Recovery (SOAR) and MHGB funding.

Stakeholder Feedback

Stakeholders consistently called for reforms to the current navigational supports landscape, citing support is fragmented, at times overlapping and insufficient, and there is no single accountable lead. As noted above, stakeholders flagged that it is difficult for people living with complex behavioral health conditions to navigate the service options available to them. Several stakeholders noted that the state's numerous and sometimes overlapping services and programs for people with SMI, SED, and SUD can create a burden on members instead of helping them. People want effective, high-intensity navigational support for people with complex behavioral health conditions and/or brain injury, especially if it can be provided by community-based providers who truly know the members and available community resources. However, it needs to be well organized and clear which entity is responsible for working with an individual member. Many stakeholders noted that, when available, ACT teams can work well to help individuals with SMI and/or co-occurring SUD maintain stability and avoid crises such as hospitalization, homelessness, or involvement with the justice system.

Many stakeholders recommended the state implement a new case management program to address gaps. Yet, programs such as ACT, HFW, CCSS, Health Homes, OTPs, and CCBHCs are available and were designed to play a lead role in delivering intensive navigational support. Manatt Health found that individuals in New Mexico—their family members, caregivers, or providers— are often not aware these offerings exist and face challenges accessing and being routed to the programs available to them.

For individuals with brain injury who are enrolled in Medicaid, MCOs are expected to play a primary role in providing care coordination. Stakeholders raised concerns that MCO care coordination is not sufficiently specialized to address the unique needs of these individuals.

Recommendation 3.1: Establish a framework for routing individuals to the right case management program, care coordination, or high-intensity services that include navigational supports.

Context

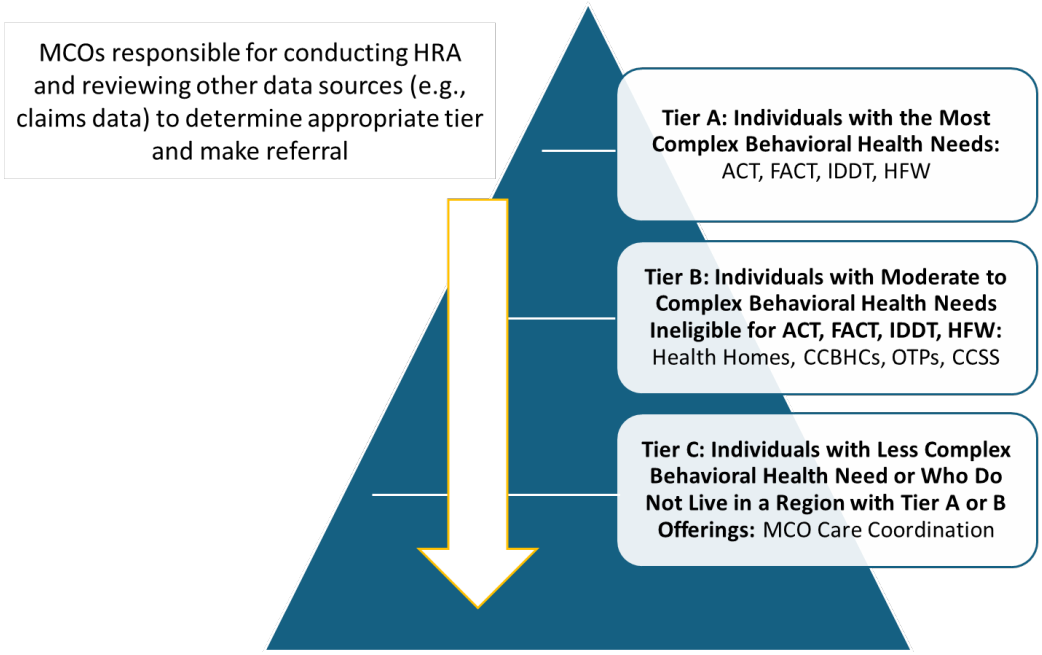
Having multiple navigational supports programs and services can offer meaningful benefits when the system functions well. For example, individuals with less significant needs may only need a minimal level of support; individuals with complex behavioral health conditions may benefit from more intensive, specialized support. However, it is unclear whether in the current system individuals are being routed to the programs available to them when appropriate. For example, New Mexico's MCOs hold the primary responsibility for identifying and referring eligible managed care enrollees to a CareLink Health Home, which provide specialized care coordination and case management to people with SMI, SED, and SUD, yet only approximately 5,000 of the 38,000 enrollees eligible for a Health Home are currently enrolled, leaving it unclear whether the remaining eligible individuals were never referred, declined participation, or are engaged in another form of navigational support. Stakeholders also raised concerns that the availability of navigational support for people with complex behavioral health conditions is inconsistent. For example, in some regions there is limited ACT provider capacity and Health Homes and CCBHCs are not available statewide.

Recommendations and Implementation Steps

New Mexico could:

- **Consider establishing tiered framework for routing individuals to the right case management program, care coordination, or high-intensity service that includes navigational supports**, based on an individual's acuity level and needs. Similar to today, MCOs would be responsible for assigning individuals to a program or referring to a service based on the member's needs (as identified in the HRA and other data sources), availability of ACT, FACT, IDDT, HFW, CCBHC, Health Home, OTP, and CCSS providers in the region, and other factors (e.g., established existing relationships).

Figure 2. Navigational Support Framework



- **Tier A. Individuals with the most complex behavioral health needs should be routed to Tier 1, which could consist of ACT, FACT, and IDDT for adults and HFW for children and youth.** These services provide intensive frequent face-to-face contact and navigational support integrated into treatment. New Mexico's eligibility for ACT and HFW are as follows; New Mexico will need to define eligibility for FACT and IDDT.
  - **ACT**: age 18 and older, have been diagnosed with a SMI, and have a psychiatric disorder that has included significant behavioral health services, repeated hospitalizations, and/or incarcerations due to mental illness. These types of psychiatric disorders severely impede ADLs and may include schizophrenia, schizoaffective disorder, bipolar disorder, or psychotic depression.
  - **HFW**: Children or youth who meet all of the following criteria: have a current or historical designation of SED; functional impairment in two or more domains identified by the Child and Adolescent Needs and Strengths tool; have current or historical involvement in two or more systems such as special education, behavioral health, child welfare or juvenile justice, or at risk for such involvement in the case of children aged 0 to 5; **and** are at-risk or in an out of home placement.
- **Tier B. Individuals with moderate to complex behavioral health conditions who are ineligible for ACT, FACT, IDDT, and HFW should be routed to a Health Home, CCBHC, OTP (individuals with SUD), or CCSS provider**. New Mexico will need to establish a standard, statewide definition of individuals who fall within this tier. To address concerns that current models are insufficient and the level of support is inconsistent across the state, New Mexico should consider developing a standardized care model for Tier B, including, expectations on: coordination and information sharing across provider types to help ensure a person's whole-person needs are addressed; establishing a person-centered care plan; and performance measurement and accountability. While

these models generally include these activities, additional guidance would help ensure individuals across the state in Tier B receive a similar level of support.
    - **Tier C. Individuals with less complex behavioral health needs or those who live in a region where Tiers A or B options are unavailable should have access to MCO care coordination, as determined by the MCO.**
- **Explore additional, specialized requirements for childre**n. For example, requiring child/youth-serving providers to align their approach with the "FOCUS" model, an "intermediate" care coordination framework for children and youth with lesser complex needs, who are system involved, at risk of deeper or multi-system involvement, and whose challenges exceed the resources of a single organization.[cxvii]

Feasibility Criteria	Description
Impact	• A tiered framework would reduce fragmentation, improve routing to appropriate programs, and enhance outcomes for individuals with complex behavioral health needs
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• Requires development of statewide standards, tier definitions, eligibility criteria, and integration with MCO processes; significant stakeholder engagement needed
Workforce	• Will require training for MCO care coordinators and community-based providers on tiered framework and referral processes; may need additional staff for intensive tiers (ACT, HFW)

Recommendation 3.2: Require MCOs to delegate care coordination for complex cases to providers.

Context

While New Mexico's intent is for CCBHCs and Health Homes to play a primary role in delivering navigational support for individuals with SMI, SED, and SUD, stakeholders—including MCOs—report that today, this does not consistently occur in regions where a Health Home or CCBHC is operating. In addition, the extent to which MCOs are referring individuals to State Plan options that offer case management and navigational supports is unclear.

OTPs are federally required to provide comprehensive services and care coordination, including individualized care plans addressing medical, behavioral health, and social needs.[cxviii] Because OTPs maintain frequent, structured contact with patients, programs can monitor progress, update care plans, and actively connect individuals to needed services—making this model well suited for managing complex conditions and improving outcomes.

Recommendations and Implementation Steps

New Mexico could:

- **Consider establishing contractual requirements for MCO delegation of care coordination to Health Homes, CCBHCs, and OTPs and referrals to ACT, FACT, IDDT, and CCCS for navigational supports when appropriate.** For individuals obtaining navigational support through one of these specialized models, MCOs would continue to be responsible for baseline care coordination and care transitions functions required by federal rules, but should take a lighter touch than for individuals only receiving MCO care coordination.[cxix] Additionally, the state could ensure

managed care contracts includes requirements for MCO coordination with any Tier 1 and Tier 2 providers. As the State is making this transition, HCA could provide technical assistance to MCOs regarding payment and monitoring of delegated care coordination to ensure the best possible experience for enrollees, recognizing that MCOs would remain responsible, regardless of whether care coordination is delegated or whether a member does not engage in their assigned navigational supports model.

- **Convene MCO workgroup** to provide technical assistance on care coordination delegation to Health Homes and CCBHCs and develop strategies to mitigate concerns.
- **Establish MCO and delegated provider oversight and monitoring processes** with clear performance metrics to track compliance and quality of delegated care coordination**.**
- **Update MCO contracts** to account for new requirements for delegated care coordination**.**
- **Establish requirements for collaboration between MCO care coordination and providers** offering Tier A and B interventions; update MCO contracts accordingly.

Feasibility Criteria	Description
Impact	• High impact on access to care coordination, case management, and intensive services with navigational supports for individuals with SMI, SED, SUD as this creates an accountable entity for each enrollee, based on their acuity
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• Largely building on existing infrastructure • Will need to work with MCOs to address delegation concerns
Workforce	• Providers may need to hire additional staff to meet demand

Recommendation 3.3: Develop more specialized and intensive care coordination for people living with brain injury.

Context

Despite contractual requirements to have MCO care coordinators and supervisors with dedicated expertise to meet the needs of individuals with brain injury, stakeholders raised concerns that care coordinators often lack sufficient brain injury-related clinical expertise and training, as well as knowledge of available resources. There are also concerns that caseloads for brain injury care coordinators are too high and that the standard CNA completed by MCO care coordinators does not adequately assess brain injury needs. Without sufficient expertise, training, and nuanced assessments, care coordinators may be unprepared to identify needs and make referrals to appropriate services.

Quote:
"So once again, it's an education gap. It's education, education, education. That is the biggest theme here. I think we need mandatory acquired brain injury training for all care coordinators. I think we need a CNA with specific decision support, and I think we need oversight that referral pathways are followed." Brain Injury self-advocate, December 1, 2025.

Recommendations and Implementation Steps

- **While there should be a single individual who is the "quarterback," many people with brain injury require a care coordination team** that includes individuals with expertise in brain injury, LTSS, physical health, behavioral health, employment, housing and other HRSN. HCA should work with MCOs to develop a more robust brain injury care coordination model that includes brain injury-

specific training for care coordinators serving the brain injury population and requires care coordination teams to have regular access to clinically trained staff (e.g., nurses or brain injury-trained specialists).

- **HCA and MCOs should work to modify the HRA and CNA to comprehensively screen for brain injury and brain injury-related needs** and to meaningfully inform service and treatment planning, and to connect individuals to the right services.

Feasibility Criteria	Description
Impact	• More highly trained care coordinators with access to clinical expertise will be more effective in helping individuals navigate the system and connect with appropriate services
Federal Authority Considerations	• No new federal authority required beyond updates to MCO contract
State Administrative Complexity	• Will require managed care contract updates and actuaries to consider updates as part of MCO capitation calculation
Workforce	• No new workforce required; current workforce needs additional training

Strategy #4: Expand community-based services for people living with complex behavioral health conditions and/or brain injury.

Introduction

As discussed in **Section III** and the introduction to this section, while New Mexico covers a wide array of community-based services for people with complex behavioral health and brain injury needs, there are gaps that may inhibit individuals' ability to live as successfully as possible in the community. Manatt Health recommends that New Mexico consider pursuing targeted benefit expansions to address these gaps.

Recommendation 4.1: Consider a new 1915(i) SPA to address gaps in HCBS for at-risk populations if still needed after the state gains experience with SB 3 regional planning efforts.

Context

*See **Section V**.*

Recommendations and Implementation Steps

As described in more detail in **Section V**, Manatt Health recommends that in the medium term, New Mexico consider pursuing a 1915(i) SPA to cover new HCBS aimed at helping people with complex behavioral health needs and brain injury live successfully in the community. Given the significant changes coming to New Mexico as a result of SB 3, the report recommends that New Mexico consider gaining experience with SB 3 before pursuing a new 1915(i) SPA. After a few years of SB 3 implementation, New Mexico could assess whether discrete gaps remain in the state's service continuum, as well as whether a 1915(i) SPA can help offer sustainable Medicaid financing for some of the regional SB 3 initiatives.

Feasibility Criteria	Description
Impact	• Fills significant gaps in benefits for individuals with complex needs related to SMI, severe SUD, and brain injury who are at

Feasibility Criteria	Description
	risk for incarceration, homelessness, and repeated hospitalizations or emergency department visits
Federal Authority Considerations	• CMS regularly approves similar SPAs; approach is not at risk with changing federal priorities • Negotiation process may be lengthy, but shorter than 1115 demonstration
State Administrative Complexity	• Must develop new service definitions for services not covered today, develop rates for new services, and adjust rates for existing services to reflect the 1915(i) population of focus • In line with HCBS rules, state must determine eligibility for 1915(i) benefits (similar to role determining LOC for a 1915(c) waiver), establish conflict-free assessment and case management processes and infrastructure, conduct significant quality reporting, and meet home and community-based settings requirements, among other rules for HCBS programs[cxx] • Require approximately four full-time equivalents (FTEs) for implementation
Workforce	• Most benefits require building new direct support professional capacity, in addition to new capacity to provide conflict-free case management • Assistive technology and remote supports benefits would not require new workforce

Recommendation 4.2: Align State-funded benefit package with current Medicaid State Plan behavioral health benefit package, especially for intensive outpatient and partial hospitalization services.

Context

As discussed above, a number of more intensive Medicaid-covered behavioral health benefits are not offered through state funds to people who are uninsured or underinsured. These include (but are not limited to) evidence-based practices for youth, mental health intensive outpatient treatment for adults and mental health partial hospitalization for youth and adults, and higher levels of care for youth and adults. In addition, HCBS covered under the Community Benefit program are not offered through state funds.

With HR 1's required work requirements and more frequent redeterminations for individuals eligible under the ACA's Medicaid expansion, New Mexico expects that at least 88,000 will lose their Medicaid coverage and become uninsured.[cxxi] States are required to exempt from work requirements those individuals who have a "disabling mental disorder," "substance use disorder," or who are participating in drug or alcohol treatment. (Individuals with a brain injury do not have a specific exemption category under federal law, but they may also be exempt if they can qualify as having a "serious or complex medical condition" or a "physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living.")[cxxii]

However, people with complex behavioral health issues or brain injury are at risk of "falling through the cracks" and losing coverage even if they should be exempt. This is because conditions like SMI and SUD are associated with impairments that make it more difficult to navigate "red tape" and complete paperwork.[cxxiii, cxxiv, cxxv]

As a result, there will be an increased need for state-funded services and community-based supports to help individuals with complex behavioral health conditions remain stable and avoid costly emergency department and crisis visits.

Recommendations and Implementation Steps

- **Strive to offer the current Medicaid State Plan behavioral health benefit package via state funds for individuals who are uninsured and underinsured** to the extent that funds are available**.** While ideally, New Mexico would also offer Community Benefit and 1915(i) services to individuals who are uninsured/underinsured, Manatt Health recognizes that it likely would be cost prohibitive for the state to do so.

Feasibility Criteria	Description
Impact	• Aligning state-funded benefits with Medicaid would ensure continuity of care for uninsured/underinsured individuals, reduce gaps in access, and prevent costly emergency or crisis interventions
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• Requires revising state benefit design, updating provider contracts, and ensuring alignment with Medicaid standards; requires budget planning and legislative approval for funding
Workforce	• Providers may need training to deliver expanded services under state funding; potential need for additional staff if demand increases significantly

Strategy #5: Adopt tailored strategies for populations of focus.

Introduction

New Mexico is interested in specific recommendations for the following priority populations: individuals with brain injury, children and youth, individuals requiring NF placement, and individuals/pregnant people with SUD. These priority populations were selected given high levels of health care need(s) and high risk of adverse outcomes without appropriate care and support. Each of the recommendations below focuses on addressing the unique gaps and challenges experienced by these populations in the state today.

Recommendation 5.1: Adopt tailored strategies for people living with brain injury.

Brain injury represents a major public health challenge in the United States, with an estimated 3.8 million people sustaining a new brain injury annually.[cxxvi] Brain injuries encompass both traumatic and non-traumatic (acquired) brain injury, such as those caused by an insult to the brain from an outside physical force, infection, a toxic or chemical substance, or tumors.[cxxvii] While severity of brain injury can vary widely, brain injury often marks the beginning of a chronic condition, bringing persistent symptoms such as ongoing pain, headaches, hormonal imbalances, fatigue, sleep problems, incontinence, stroke, and epilepsy.[cxxviii] Brain injuries can require ongoing rehabilitation, and frequently necessitate long-term supports, result in job loss or educational disruption, and require relatives to leave employment to provide care as a consequence of brain injury. Additionally, people with brain injury experience high rates of mental illness, SUD, and justice involvement.[cxxix, cxxx, cxxxi, cxxxii, cxxxiii, cxxxiv]

In New Mexico, deaths from TBI surpass those from opioid overdoses, with rates at 25.5 per 100,000 for TBI compared to 23.1 per 100,000 for opioid-related deaths.[cxxxv] Native American communities in the state are disproportionately impacted, experiencing nearly 40 deaths per 100,000 residents.[cxxxvi]

There are currently no complete or fully accurate data on the prevalence of brain injury in New Mexico. According to the 2023 Senate Memorial 30 report, the number of individuals living with brain injury associated disability in New Mexico is estimated to be between 20,000 and 30,000.[cxxxvii] Medicaid data indicate that a much smaller portion of the population has experienced utilization related to a moderate to severe brain injury. In SFY 2025, 2,387 total adults age 18 or older had a claim indicating that they had a moderate-severe brain injury diagnosis[65] – representing less than 1% of the total Medicaid population. However, it is important to note that Medicaid claims data may not provide an accurate total of the number and service needs of Medicaid enrollees living with a brain injury and their functional needs because of inconsistencies in whether and how brain injury is documented.

While New Mexico's Community Benefit program was not designed specifically for people with brain injury, it serves the elderly and people with disabilities who meet NFLOC. As such, it is a key source of services for people who require NFLOC due to brain injury. People with brain injury can also qualify for services through three of the state's waivers that serve people with I/DD if their brain injury occurred before age 22 and they meet all other eligibility criteria for the waiver program (e.g., need care at an ICF/IID LOC).

Outside of Medicaid, New Mexico operates a BISF program, which both serves as a payor of last resort for services need by people with brain injury and also sponsors the New Mexico Brain Injury Resource Center, which offers information and resources to people with brain injury. As noted above, sources of revenue that previously supported the program—including revenue from traffic violations—were eliminated in 2023 with the passage of HB 139. No single entity fully "owns" the brain injury population, resulting in limited awareness of brain injury issues, a lack of screening and under diagnosis. Further, New Mexico has a very limited number of clinicians with brain injury expertise, and MCO staff responsible for care coordination for people with brain injury often have limited training.

Recommendation 5.1.1: Fund BISF to act as a lead State hub for brain injury.

Context

Currently, there is no single system that takes on the responsibility for addressing the needs of individuals with brain injury in New Mexico. Multiple systems serve individuals in a fragmented way, determined by their stage in treatment and recovery, the timing of brain injury acquisition and diagnosis and the extent to which they are eligible for Medicaid and state-funded HCBS. Stakeholders specifically noted gaps in identification and screening processes for brain injury, as well as a lack of information and support in transitioning across systems and providers. There are also insufficient efforts and training resources available to develop provider capacity and programing equipped to support individuals with brain injury.

Recommendations and Implementation Steps

New Mexico should **expand the capacity of the BISF Program as the lead state hub for the system of supports associated with brain injury.** In this role, the BISF Program would collaborate with other state agencies and community partners to provide brain injury identification, screening and support services; increase public and professional awareness of brain injury; offer education, training, and technical

[65] Excludes mild brain injury codes, including initial encounters for concussions without loss of consciousness.

assistance to providers and organizations supporting individuals with brain injury; advance brain injury policy; and continue to manage state-funded services for people who are uninsured or underinsured. The expanded BISF Program should be responsible for:

- **Increasing public awareness** on the context, causes, and long-term effects of brain injury; the importance of follow-up; and resources that may be available to people with brain injury.
- **Conducting provider education and training** to develop and implement brain injury-focused programing and evidence-based service delivery models. One of the goals should be to expand specialty capacity by increasing the number of rehabilitation neuropsychologists, rehab psychologists, and therapists with neuro certifications in the state.
- **Promoting universal brain injury screening**: New Mexico should develop a universal brain injury screening tool that can be used across mental health, substance use, domestic violence, homeless services, corrections, pediatrics, educational and other systems. This might include an online screening tool such as Online Brain Injury Screening and Support System. Colorado's approach may serve as a model where this tool is confidentially available on-line at no cost to anyone aged 13 and older. It helps individuals determine if they have a history of brain injury and provides tips for managing related challenges.[cxxxviii]
- **Developing a robust brain injury resource navigation program**: New Mexico should significantly expand services available through the BISF Program's Brain Injury Resource Center. The Center should be responsible for connecting individuals experiencing brain injury and their families to services and supports; providing a warm hand-off to service delivery systems; and providing follow up. Oregon's Brain Injury Program may serve as a model; it provides advocacy, counseling, navigation, and coordination without the state having a dedicated brain injury waiver.[cxxxix] The resource navigation program should also produce and disseminate materials, such as a roadmap to services (available in multiple languages), to help individuals and families understand available options and how to access support. As part of these efforts, the state should prioritize underserved populations, including tribal communities.
- **Expand funding and establish a stable funding source for BISF** to increase program capacity to meet the needs of individuals who do not otherwise have coverage for brain injury-related services and supports. The state should seek to pay providers equivalent rates for people enrolled in Medicaid and people receiving services through BISF because they do not qualify.

Feasibility Criteria	Description
Impact	• Likely high impact on expanding access to brain injury services through availability of accessible information, increased awareness, more efficient navigation system, expanded screening and brain injury identification, and improved provider education
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• Expands on existing infrastructure and BISF organization
Workforce	• State will be able to draw and build on existing expertise within BISF program • May be challenging to build additional provider expertise in brain injury unless meaningful incentives are offered

Recommendation 5.1.2: Establish more specialized and intensive care coordination for people living with brain injury.

See Recommendation 3.3.

Recommendation 5.1.3: Offer additional community-based supports to people with brain injury.

Context

Individuals who have sustained a brain injury often have long-term supports needs related to their injury. These services commonly focus on social and functional needs, rather than ongoing medical treatment, and are ideally delivered in home and community-based settings. Inadequate access to HCBS can lead to adverse health outcomes, behavioral challenges, social isolation, and household financial strain.[cxl,cxli,cxlii,cxliii,cxliv,cxlv,cxlvi,cxlvii,cxlviii] Some states have used Medicaid 1915(c) waivers to develop services for individuals with brain injury; 20 states currently have dedicated brain injury waivers.[cxlix] These programs offer many of the same services provided to other groups with long-term support needs but are more likely to include services that reflect the specific needs of working-age adults and individuals with cognitive impairments (e.g., supported employment, behavioral support services). Other states include brain injury populations in their LTSS systems serving individuals with other types of disabilities.

New Mexico's Community Benefit program serves as a primary pathway to HCBS for individuals with brain injury. While the Community Benefit program provides a robust package of services, comparable to specialized brain injury waivers in other states (see **Comparison Table 2**), there are some notable gaps in services that, if filled, would allow the state to better meet the needs of individuals with brain injury. Additionally, the Community Benefit program is only available to people who need NFLOC; individuals with brain injury at a lower level of need do not have access to HCBS.

Quote:
"One of the problems for people specifically with TBI or acquired brain injury is that MCOs, they base the support that a person can receive like caregiving support or going to skilled nursing facilities specifically on ADLS and they don't include IADLs. But one of the big problems that also comes in when a person is first getting out of a facility, they need more support to help them get used to the community, help them learn tasks and skills, be able to live independently." Brain Injury Survivor and Self-Advocate, December 5, 2025.

Recommendations and Implementation Steps

As described in **Section V,** in the medium-term, New Mexico should consider pursuing a 1915(i) SPA to fill gaps in HCBS offered to people with brain injury, in addition to extending eligibility for HCBS to individuals with brain injury with needs less than NFLOC. See **Section V** for additional detail.

Recommendation 5.2: Adopt tailored strategies for children & youth.

New Mexico has high rates of poverty, adult substance use, unemployment, single parent or non-biological parent guardianship, and low educational attainment. These factors, among others, put children at a higher risk of poor behavioral health outcomes in the state.[cl,cli,66] New Mexico ranks last among states according to a composite assessment of youth prevalence of mental illnesses and rates of

[66] In 2022, state data showed that New Mexico had the highest rate of adverse childhood experiences in the nation. More information is available here:
Adverse Child Experiences in New Mexico. New Mexico Department of Health, 11 Oct. 2022, www.nmhealth.org/publication/view/general/7848/.

access to care.[cliii] According to 2022 data, there were nearly 250,000 youth with SED in the state.[cliii,67,68] Under New Mexico's definition, SED includes conditions such as major depression, anxiety disorders, bipolar disorder, and trauma-related disorders. Similarly, while drug use in the state among youth has declined, rates remain higher than national averages.[cliv] In SFY 2025, there were 78,120 children and youth with SED or SUD statewide – representing close to 11% of the state's total Medicaid and population. Among children and youth ages 15 and older enrolled in Medicaid, 52,483 had a first diagnosis of a psychiatric disorder, a critical indicator needed for early action and intervention. Among children and youth up to age 18 enrolled in Medicaid, close to 70,000 had a psychiatric inpatient, emergency department, or crisis service utilization, or received behavioral health therapy services in SFY 2025.[69]

New Mexico has expanded services for children and youth living with complex behavioral health issues and increased reimbursement rates for these services. New Mexico covers a comprehensive set of services for children and youth living with SED, including MRSS, HFW via its Turquoise Care 1115 demonstration, and several other important evidence-based practices (multisystemic therapy, FFT, EMDR, DBT, and trauma informed cognitive behavioral therapy) through the State Plan.[70] HCA offers enhanced reimbursement rates for these services with additional add-ons for providers serving children and youth in rural areas. It also has increased Medicaid reimbursement rates for TFC and residential treatment centers in recent years. To support providers in developing the capacity to implement HFW and the other evidence-based practices, the CYFD has contracted with the Center of Innovation for Health and Well-Being at New Mexico State University.

For now, significant gaps still remain in access to care remain for children and youth living with complex behavioral health issues. It is too early to assess the effectiveness of the state's recent

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[67] SED is defined as an individual from birth up to age 18 who currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Source: https://www.hca.nm.gov/wp-content/uploads/BEHAVIORAL-HEALTH-POLICY-AND-BILLING-MANUAL-APPENDICES-DRAFT.pdf
Severe Emotional Disturbance (SED) Checklist. Behavioral Health Collaborative New Mexico, 14 Jan. 2021, www.hca.nm.gov/wp-content/uploads/BEHAVIORAL-HEALTH-POLICY-AND-BILLING-MANUAL-APPENDICES-DRAFT.pdf.

[68] SED is treated with a combination of evidence-based psychosocial therapies like cognitive behavioral therapy (CBT) and family-based therapy, as well as pharmacotherapy, when appropriate. Effective treatment also involves a coordinated, family-centered approach that includes connecting youth to necessary services, involving family, and providing a range of support services like education, pro-social activities, and mental health or substance use disorder treatment centers. https://www.samhsa.gov/resource/ebp/treatment-considerations-youth-young-adults-serious-emotional-disturbances-serious
"Treatment Considerations for Youth and Young Adults with Serious Emotional Disturbances and Serious Mental Illnesses and Co-Occurring Substance Use." Www.samhsa.gov , www.samhsa.gov/resource/ebp/treatment-considerations-youth-young-adults-serious-emotional-disturbances-serious .

[69] New Mexico Health Care Authority. (2025). *Medicaid and State-Funded dataset* (restricted administrative data). Medical Assistance Division.

[70] The state secured approval of its SPA establishing these services on February 6, 2024, with an effective date of July 1, 2023. https://www.medicaid.gov/medicaid/spa/downloads/NM-23-0006.pdf. Prior to approval for these explicit modalities and therapeutic models, providers may have been billing more generic therapy and case management codes to provide some of these services.

investments in children and youth with complex behavioral health conditions, but recent data indicate that there still are significant gaps. For example, no providers are yet offering the mobile response stabilization service that CMS approved in March of 2024. A LFC report issued in November of 2025 found that Medicaid spending on multisystemic therapy – an intensive evidence-based treatment model for children and youth with anti-social behaviors and high rates of involvement in the juvenile justice system – has declined from $6.4 million in calendar year 2015 to $5.3 million in calendar year 2024 despite more young people enrolled in Medicaid.[clv] (It is possible that this trend reflects changes in the codes billed by providers, but a lack of data and consistent monitoring make it difficult to determine.)

Along with gaps in community-based services, stakeholders noted that the state lacks residential treatment spots for youth who identify as female, is experiencing increases in Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Plus (LGBTQ+) youth living with complex behavioral health issues who are homeless or at-risk of homelessness, and often must send children out of state if they have behavioral health issues and autism or an intellectual or developmental disability.

Quote: "Once you get outside of the Albuquerque, Santa Fe and the I-25 corridor, there just are a huge lack of resources… and we actually end up boarding behavioral health children in our pediatric main hospital because there's just no place for them to go." New Mexico provider, December 8, 2025.

Call Out Box 10. Kevin S. Settlement[clvi]

The Kevin S. lawsuit, filed in 2018, challenged New Mexico's failure to provide safe, stable placements and adequate behavioral health services for trauma-impacted children in foster care. A 2020 settlement required sweeping reforms, including trauma-responsive care, culturally appropriate placements, and improved behavioral health access, all under the oversight of three national child welfare experts. A lack of sufficient progress[clvii] and persistent gaps—such as workforce shortages, lack of foster homes, and inadequate services for Native children—prompted a corrective action plan in 2023 and a second remedial order in 2025. In the context of this report, Manatt Health did not make recommendations in this space given the state already is working under the remedial order and substantial state resources are dedicated to the effort.

Recommendation 5.2.1: Monitor and expand the state's new HFW benefit and other key services for children and youth living with SED.

Context

Currently, CYFD tracks the number of certified HFW providers and the number of facilitators. New Mexico Medicaid can track utilization of HFW and other evidence-based practices available to children and youth (e.g., multisystemic therapy) by reviewing claims data, but it does not necessarily do so routinely.

Recommendations and Implementation Steps

- CYFD could **work with HCA to routinely gather and review data on utilization and related outcome measures** as part of assessing whether the changes to these services are working as intended. For example, it would be helpful over time to assess whether HFW is contributing to reductions in the need for out-of-home placements and crisis interventions.

Feasibility Criteria	Description
Impact	• Systematically monitoring implementation of HFW and other EBPs will allow for assessment of whether changes are working as intended and increase accountability
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• Requires interagency coordination (CYFD and HCA), development of data-sharing agreements and standardization of reporting
Workforce	• Provider training required; may require additional workforce

Recommendation 5.2.2: Fund the creation of in-state residential treatment spots for young people who identify as female and ensure that residential treatment facilities are trained to serve special populations.

Context

While residential treatment is clinically appropriate only in rare circumstances, it is important to have some residential treatment spots available within New Mexico to avoid out-of-state placements. Today, while New Mexico has three residential treatment facilities for young people who identify as male, the state has none for female children and youth. In addition, stakeholders noted that given concerns about rising rates of LGBTQ+ youth living with complex behavioral health issues who are homeless or precariously housed (e.g., couch surfing), it is important that in-state facilities be equipped to serve LGBTQ+ youth. And finally, stakeholders noted that today, facilities may not be well equipped to serve youth with autism and other I/DD who have co-occurring complex behavioral health needs.

Recommendations and Implementation Steps

New Mexico could:

- **Fund a residential treatment site for girls** (as CYFD has already proposed)**,** ensuring it provides clinically appropriate care and does not become a place where young people remain simply because they lack community-based placement options.
- **Require staff at in-state residential treatment facilities to be trained in serving LGBTQ+ children and youth, in addition to children and youth with autism and other I/DDs.**

Quote: "We just don't have anywhere to put those kids." New Mexico service provider, December 9, 2025.

Feasibility Criteria	Description
Impact	• Ensures clinically appropriate in-state residential options for girls and LGBTQ+ youth, reducing reliance on out-of-state placements and improving opportunities for family engagement and continuity of care
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• Requires site selection, licensing, compliance with residential treatment regulations, development of clinical and operational standards, and intensive oversight and monitoring; significant interagency coordination needed

Feasibility Criteria	Description
Workforce	• Specialized staff recruitment and training required (trauma-informed care, LGBTQ+ competency, autism/I/DD expertise); requires additional workforce

Recommendation 5.2.3: Adjust the state's existing crisis model for children and youth (known as MRSS) to reflect New Mexico's largely rural landscape.

See Recommendation 1.3.

Recommendation 5.3: Adopt tailored strategies for individuals requiring NF placement.

New Mexico lacks NF beds ready to serve individuals with complex behavioral health conditions and concurrent physical health conditions Across a range of providers and consumer advocates, New Mexico stakeholders raised concerns about finding NF beds for individuals living with complex behavioral health and physical health issues. These are individuals who require a NFLOC and cannot be served in the community even with robust HCBS.[71] Currently, it is difficult to find a bed in a NF for these individuals, especially if they have high mental health needs, dementia-related issues, a history of SUD, complicated documentation or guardianship status, or if they previously have assaulted a healthcare provider. Some stakeholders described the situation as "redlining" or "blacklisting" people with significant behavioral health issues. Without a bed in a NF, these individuals end up boarding in psychiatric institutions or acute care hospitals for months or even years at a time. In an analysis conducted in 2025, HCA identified 44 enrollees residing in hospitals as their primary residence due to the inability to get them admitted to a NF, costing the state over $10,000 daily and $3.9 million annually.[clix]

If the state implements Recommendation 1.4 - Conducting outreach and disseminating materials to explain that individuals with SMI or brain injury who have complex physical health conditions can qualify for the Community Benefit program under some circumstances – then some individuals can be connected to HCBS earlier in their trajectory. Over time, this approach could help divert people from decompensating to the extent that they need care in a NF.

Recommendation 5.3.1: Address NF denials of individuals based on behavioral issues or a history of mental health and/or SUD if the individual currently is stabilized.

Context

Currently, nursing facilities can turn away patients with complex mental health and/or SUD conditions or behavioral issues based on the rationale that they cannot effectively serve them even if they are stabilized. While state regulations currently allow for denial in certain circumstances[clx] – including to protect patients and NF staff – providers may be relying on regulations to automatically deny patients without an individualized assessment of need and the facility's ability to serve the individual.

Recommendations and Implementation Steps

New Mexico could take actions—listed sequentially—to preclude such denials while ensuring that nursing facilities are equipped to care for this high-needs population, including:

[71] Defined as any patient hospitalized for greater than two weeks after physical health and behavioral health conditions have stabilized AND the patient is rejected from all in state nursing facilities.

- Issuing clarifying guidance to reinforce that current regulations do not allow for blanket denials of patients.
- Requiring mandatory training for nursing facilities on serving individuals who have co-occurring behavioral health and physical health needs.
    - SAMHSA recently concluded a three-year grant that established a Center of Excellence for Behavioral Health in Nursing facilities to provide training, resources, and support to nursing facilities serving residents with complex mental health and/or SUDs. While the grant period has expired, the resources developed by the Center remain available and could be used by New Mexico. They provide help with some of the most relevant issues confronting NF staff serving residents with complex behavioral health conditions, such as how to de-escalate volatile behavior, caring for individuals who have survived a suicide attempt, working with non-verbal clients and addressing OUDs among NF residents.
- Requiring nursing facilities to report data and supporting information for all denials related to behavioral health and exploring whether the state's Long-Term Care Ombudsman could assist with appeals if denials are inappropriate.

Feasibility Criteria	Description
Impact	• Reduce inappropriate hospital boarding and improve access to NF care for individuals with complex behavioral health needs
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• Requires stakeholder engagement, compliance monitoring, and state resources to support training and education
Workforce	• No major workforce expansion needed, but existing staff need new training on serving people with complex behavioral health needs

Recommendation 5.3.2: Institute changes to the state's NF payment methodology to incentivize facilities to accept patients with complex behavioral health needs.

Context

See Recommendation 5.3.1.

Recommendations and Implementation Steps

New Mexico could:

- Review ways to provide enhanced reimbursement for nursing facilities that treat individuals with complex behavioral health conditions. For example, the state could set an acuity adjustment for mental health and cognitive impairment as more than twenty states already do.[clxi]
    - In Wisconsin, for example, skilled nursing facilities can receive an additional $24.87 per resident per day for providing specialized psychiatric rehabilitative services to residents with a mental illness.
    - In Delaware, they receive an additional 10% of the primary care rate component for patients who frequently exhibit disruptive psychosocial behaviors.

Feasibility Criteria	Description
Impact	• Financial incentives can drive provider behavior and increase bed availability
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• Requires rate-setting changes, actuarial analysis
Workforce	• No implications

Recommendation 5.3.3: Pilot "Green House" model of small nursing homes for individuals with SMI/SUD.

Context

The Green House Project represents a model in eldercare designed in the early 2000s as an innovative alternative to traditional nursing facilities. Each residence accommodates 10–12 elders in self-contained, home-like settings featuring private bedrooms and bathrooms, a central hearth and dining area, and an open kitchen—while medical equipment is discretely tucked away in closets to preserve a domestic atmosphere. Staffing is intentionally streamlined: certified nursing assistants receive more than 150 hours of advanced training and are empowered to manage residents' daily care with support from nurses and therapists, eliminating traditional supervisory and administrative layers. Low staff-to-resident ratios and this flattened hierarchy foster deeper relationships, enable more consistent contact, and have been shown to reduce staff turnover.[clxii] While the model is considered a best practice for all elders in need of NFLOC, the community-based, small environment is particularly ideal for those living with the stigma and isolation often associated with mental illness or SUDs.

Recommendations and Implementation Steps

New Mexico could: convene representatives from HCA, BHSD, behavioral health providers, consumer advocates, and payers to lead planning and implementation efforts. Collectively, they could:
Modify the Green House design to include staffing, training, therapeutic space(s), daily operational processes, and safety features for individuals with SMI and SUD-related needs.

- Develop admission criteria.
- Identify locations with strong community supports and proximity to behavioral health resources or adapt existing facilities.
- Recruit and train staff.
- Establish clinical oversight processes.
- Establish metrics to evaluate and continuously improve upon the model or address emerging issues.

Feasibility Criteria	Description
Impact	• Provides an innovative, person-centered alternative for individuals with complex behavioral health needs
Federal Authority Considerations	• No new federal Medicaid authority required
State Administrative Complexity	• Involves changes to facility design, licensing, operational standards, and oversight
Workforce	• Requires specialized training and recruitment for small-home model

Recommendation 5.4: Adopt tailored strategies for individuals with SUD, including pregnant women.

New Mexico consistently has high alcohol-related and drug overdose related death rates relative to other states.[clxiii] New Mexico's Department of Health (DOH) reports that the state had the seventh highest total drug overdose death rate in the nation in 2023 (most recent data available).[clxiv] It historically also has had the highest alcohol-related deaths in the nation, with the most recent national data (2021) showing its rate at more than twice the national average.[72,clxv] Stakeholders remain deeply concerned about the toll taken by SUDs on New Mexicans living with the condition, as well as the reverberations through the community in the form of homelessness, and intergenerational transmission of trauma and despair.

People living with SUD can achieve recovery through a range of treatments, including combinations of medications, counseling, peer support, and community-based services.[clxvi] In terms of raw numbers, New Mexico has seen recent improvement in drug death rates due to more aggressive policy interventions, such as expanding availability of naloxone, an opioid overdose reversal medication, and educating the public about its effectiveness.[clxvii] However, the state's death rate from drug overdose has outpaced the national rate consistently since at least 1999 (and widened in recent years). Rio Arriba, Socorro, Sierra, and San Miguel counties recorded the highest rates of overdose deaths in the state in 2021—the most recent year for which the department published county-level overdose rates.[clxviii,clxix]

The number of alcohol-related deaths also decreased in 2023 for the second consecutive year. Even so, New Mexico still remains far above the national average in deaths linked to alcohol—nationally, one in ten deaths among working age adults (ages 20-64) is attributable to alcohol, but in New Mexico this ratio is twice as high at one in five deaths.[clxx] In response, the state established an Office of Alcohol Misuse Prevention in 2023 aimed at reducing the impact of AUDs through screening, program evaluation, and funding strategies.

The latest data analyzed by Milliman indicate that 59,665 adult and youth Medicaid enrollees in New Mexico were living with a SUD, as were an additional 5,933 individuals receiving state-funded services.[clxxi] New Mexico treats SUD at a rate higher than the national average, leading to over 98,000 people receiving treatment in 2022, including in residential treatment settings supported by the state's flexibility under its 1115 demonstration to reimburse for care provided in IMDs. Despite this, HCA estimates that more than 9,000 New Mexicans need medications for their SUD but are not receiving them.[clxxii] For some SUDs, particularly methamphetamine and cocaine use disorders, there are no medications approved by the FDA for treatment. For other SUDs, effective FDA-approved medications exist but are underutilized. This is despite New Mexico's efforts beginning in May 2024 to expand access to medications for both opioid and AUDs through its more than 30 DOH Public Health Offices. A July 2025 LFC evaluation identified declines in substance use screenings, weak referral systems, absence of medications on state-purchased mobile health units, and a stalled marketing campaign as contributing factors to the low numbers of individuals with SUDs treated with medications as a result of this expansion.[clxxiii]

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[72] McKinley and Rio Arriba counties had the highest rates of 235.9 per 100 thousand and 161.6 per 100 thousand, respectively, more than twice the state rate. More information is available here: New Mexico Legislative Committee. *Medication-Assisted Treatment in Public Health Offices*. New Mexico Legislative, 23 July 2025, www.nmlegis.gov/Entity/LFC/Documents/Program_Evaluation_Reports/ALFC%20072225%20Item%2010%20MAT%20Public%20Health%20Offices.pdf.

People with SUD leaving incarceration are at particularly high risk for return to substance use and its resultant harms, including fatal overdose.[clxxiv] Pregnant women with SUD constitute another population of interest due to significant gaps in care and complications associated with their SUDs. In a 2016-2019 study, nearly a third of pregnant women in the study population used some kind of substance during their pregnancies, with almost all engaging in polysubstance use (using multiple substances). Only 3% of those women received treatment for their SUD.[clxxv] Perinatal substance use also takes a toll on infants. The rate of hospitalizations for neonatal abstinence syndrome — a group of conditions associated with withdrawal symptoms when an infant has been exposed to a substance in the womb — tripled between 2010 and 2020 in New Mexico, rising from 4.3 to 13.6 per 1,000 newborn hospitalizations.[clxxvi]

New Mexico, like much of the country, is also experiencing an increase in polysubstance use as people combine illicit opioids and stimulants. With the influx of fentanyl and other contaminants in the drug supply, people who use drugs may not always know what they are getting. Not only does this complicate SUD treatment but it is also associated with an increase in physical health conditions such as persistent skin wounds, abscesses, and Hepatitis C.[clxxvii]

Call Out Box 11: Project Extension for Community Healthcare Outcomes (ECHO)[clxxviii,clxxix]

Launched by the University of New Mexico in 2004, Project ECHO uses a telementoring model to connect specialists with primary care providers in rural and underserved areas. Originally created to address hepatitis C treatment gaps, it now covers a wide range of health conditions, including behavioral health, and education topics. In New Mexico, ECHO has had a transformative impact: 100% of counties participate, over 314,000 residents benefited from health programs in 2024, and more than 336,000 attendances have been logged since 2006. The model improves access to specialty care, reduces costs, and strengthens local capacity by fostering collaborative learning and ongoing mentorship. Studies show ECHO reduces emergency visits and hospitalizations while increasing outpatient care, making it a cost-effective solution for improving health outcomes in rural communities. Since 2006, the New Mexico Legislature and the DOH have provided annual funding of $1.6 million for Project ECHO.

Recommendation 5.4.1: Scale effective treatment models (e.g., Milagro, Lund Home, Chrysalis House).

Context

Specialized, comprehensive treatment models for pregnant and postpartum women have become a best practice over the past several decades. Beginning with SAMHSA's Pregnant and Postpartum Women demonstration grant program in 1993, the model of wholistic, family centered SUD treatment that supports women keeping their dependent children with them while engaging in services has evolved from residential only to span residential and outpatient settings.[73] Even so, subject matter experts report that the need for specific, non-judgmental residential and outpatient SUD treatment services for pregnant women and women with dependent children in New Mexico outpaces availability, particularly in more rural areas.[clxxx]

[73] Congress has continuously funded SAMHSA's pregnant and postpartum women program, and the Substance Use Prevention Treatment and Recovery Services block grant prioritizes women with dependent children and requires states to expend a certain amount of funds, unique to each state and as approved by SAMHSA, on SUD treatment services designed for this population.

Recommendations and Implementation Steps

New Mexico could scale high-quality treatment models found within the state as well as adopt models from other states**.** For example:

- Project Milagro at the University of New Mexico Medical Center provides comprehensive outpatient-based prenatal care, medications for opioid and AUDs, counseling, case management, and access to psychiatric consultation.[clxxxi]
- Vermont's Lund Home provides residential treatment for pregnant and parenting people where parents and children under age 6 share a bedroom and live communally with a small number of other families while the whole family receives treatment, support, and case management to continue care into the community.[clxxxii]
- Similarly, Chrysalis House in Maryland specifically serves pregnant and parenting people with SUD with step-down levels of care across the ASAM continuum for longer term treatment and recovery support.[clxxxiii]

Feasibility Criteria	Description
Impact	• Expected to reduce harmful consequences of SUD, including overdose, on pregnant and parenting individuals and their children; potentially reduce adverse childhood experiences, having a preventive effect on children of parents with SUD; and reduce the need for child welfare involvement
Federal Authority Considerations	• No new federal authorities would be needed[74]
State Administrative Complexity	• Need to work with MCOs solicit providers with requisite experience, training, and financial acumen to establish new and expand existing facilities to serve this population; license and monitor these facilities; establish performance measures for tracking quality and review reimbursement rates • Could be done in concert with SB 3 and regional planning
Workforce	• ECHO Institute has established a new program, the New Mexico SUD in Pregnancy ECHO program, kicking off in Spring 2026; state can work with the Institute to recruit participants

Recommendation 5.4.2: Facilitate access to Medicaid funding for recovery services in National Alliance for Recovery Residences "Level III: Supervised Residence" recovery housing.

Context

It is increasingly recognized that the difference between relapse and continued recovery often comes down to a safe, stable, and recovery-oriented housing setting. The National Alliance for Recovery Residences recommends a continuum of recovery housing across four "levels" with varying degrees of

[74] One potential exception would be if New Mexico wanted to see federal Medicaid matching funds for services provided to pregnant enrollees during extended stays in residential treatment. It, however, would be preferable to use state funds for extended stays to for pregnant enrollees to avoid the need to attempt to secure an amendment to the Turquoise Care 1115 demonstration for this purpose.

support and clinical services.[75] BHSD and Housing New Mexico have been expanding access to recovery housing through initiatives such as the Recovery Housing Project, but stakeholders report that Level III: Supervised Residence recovery housing remains in short supply because it must be overseen by a behavioral health agency. Level III: Supervised Residences offer supervised, structured support by trained or credentialed peer recovery specialists, often including life skills training, peer support, recovery groups, job readiness, and development of personalized recovery plans.

Recommendations and Implementation Steps

To expand the supply of this type of recovery housing, New Mexico could:

- Consider allowing certified Level III: Supervised Residences to operate under a broader array of agencies as long as sufficient supervision and support is available.
- Review its CCSS and recovery support services to provide clarification on when and how services provided by Level III Supervised Residences can be billed to Medicaid.

Call Out Box 12

Group homes that serve people needing assistance with ADLs and IADLs are not typically used to house people with SUD who do not have other co-occurring disabilities. Instead, recovery residences serve individuals needing SUD-related recovery support services. Recovery residents can support each other in a peer-to-peer approach, often with a house manager who is also typically a person in recovery from SUD.

Feasibility Criteria	Description
Impact	• Could enhance long-term recovery for people with SUDs, reduce relapse and its consequences, including homelessness
Federal Authority Considerations	• No new federal authority would be needed
State Administrative Complexity	• Need to clarify the extent to which CCSS and recovery services include services provided in NARR Level III: Supervised Residences
Workforce	• Existing NARR Level III: Supervised Residence providers may need training on Medicaid billing and accounting rules

Recommendation 5.4.3: Expand mobile/satellite access for methadone/ buprenorphine.

Context

Medications for OUD, specifically buprenorphine and methadone, are proven to reduce opioid-related overdose and all-cause mortality risk by over 50%.[clxxxiv] However, as described above, these medications are underutilized by New Mexicans who could benefit from them. Barriers to access, such as

[75] These have historically been labeled levels 1-4, with level 1 being a peer-run, non-clinical recovery residence, such as an Oxford House, through to the highest level 4, which includes a combination of supervised peer and professional, on-site clinical staff, in a model that overlaps the ASAM level 3.1 as described in the 3rd edition of the ASAM Criteria. In the spring of 2025, NARR and ASAM partnered on a renaming of the NARR levels of recovery housing to reduce confusion and better align the transition between treatment and recovery support services.

transportation, limited number of providers, and pharmacies that do not stock buprenorphine contribute to this issue, especially outside of population centers.

Recommendations and Implementation Steps

New Mexico has opportunities to expand access for methadone by:

- Leveraging mobile van opportunities and new technologies that make it possible to dispense methadone more efficiently and at remote sites.[clxxxv]
    - Operating as licensed extensions of existing brick-and-mortar opioid treatment programs (OTPs), mobile units can bring medications for OUD to more communities — especially in New Mexico's rural and frontier areas—overcoming barriers of transportation and stigma.
    - This would likely require capacity building dollars to expand existing OTPs to procure and operate mobile vans or establish remote sites or expand the capabilities of recently purchased mobile health care units, identified in the July 2025 Legislative Report.[clxxxvi]
- These latter units could also serve as administration sites for monthly injectable buprenorphine formulations, thus overcoming some of the pharmacy and medication administration barriers to access.

Feasibility Criteria	Description
Impact	• Can increase the uptake of buprenorphine and methadone
Federal Authority Considerations	• No federal Medicaid authority needed; expanding mobile or satellite access points would require SAMHSA and federal Drug Enforcement Administration approval
State Administrative Complexity	• Need to inspect and approve new mobile and satellite access points for controlled medications; local zoning rules for locating mobile units may need to be reviewed and considered • Need to assist in identifying and supporting partnerships between OTP organizations and other health care entities, including CCBHCs or FQHCs, for satellite units
Workforce	• Expansion of mobile/satellite sites requires additional workforce

Recommendation 5.4.4: Consider expanding contingency management.

Context

Contingency management is the primary evidence-based treatment for stimulant use disorder. With a dearth of effective treatment options for people with stimulant use disorder, it will be important to monitor the effectiveness of BHSD's contingency management pilot and to consider expanding it.

Recommendations and Implementation Steps

New Mexico should consider:

- Assessing whether it can maximize access to federal funds for ancillary services, such as the drug screening tests and case management services that contingency management requires.
- Seeking approval for Medicaid coverage of contingency management under the Turquoise Care 1115 demonstration when it is up for renewal in late 2029.
- Whether opioid settlement dollars could be used for contingency management for people with co-occurring OUD and stimulant use disorders. Contingency management has been shown to be effective in increasing retention in MAT for OUD.[clxxxvii]

Feasibility Criteria	Description
Impact	• Would reduce the harmful consequences of methamphetamine and cocaine • If also included in the treatment of OUD, could increase retention in care and improve uptake of medications for OUD
Federal Authority Considerations	• Medicaid coverage would require an approved 1115 demonstration for contingency management; Manatt Health recommends pursuing this feature when the Turquoise Care demonstration is next renewed in 2029
State Administrative Complexity	• Current data reporting requirements to SAMHSA for contingency management supported by SOR grant funds are considerable. Expansion under these conditions would require additional data reporting capacity at both state and provider-levels
Workforce	• Providers would need to undergo intensive training to implement contingency management, including on implementation of specific tools and protocols

Recommendation 5.4.5: Expand medications for alcohol use disorder via a dedicated initiative focused on alcohol use disorder.

Context

In light of the extraordinarily high rates of AUD and the already-robust Project ECHO infrastructure within New Mexico, the state should consider focusing existing resources—or adding new resources—to focus specifically on expanding the use of medications for AUD.

Recommendations and Implementation Steps

While the effectiveness of medications for AUD is comparatively less than that of medications for OUD, the FDA-approved medications for AUD, especially naltrexone and acamprosate, are well-tolerated, safe, reduce heavy drinking, and prevent relapse.[clxxxviii] A specific initiative could include:

- Working with Project ECHO to expand or create a new, dedicated Project ECHO program. focusing on AUD and its treatment with long-term medications geared at health care providers in specialty behavioral health treatment facilities, primary care, and hospitals. In particular, this should include offering providers more information and support in prescribing medications for AUDs for the longer term as part of wholistic treatment plans.
- This could be combined with a push from the state, in concert with the New Mexico Medical Society and the New Mexico chapter of the ASAM, to increase rates of screening, brief intervention, and treatment for high-risk alcohol use and AUDs.

Feasibility Criteria	Description
Impact	• Could reduce negative consequences of these conditions, including emergency department utilization, hospitalizations, and related health conditions and social impacts of alcohol use
Federal Authority Considerations	• No new authorities would be needed
State Administrative Complexity	• Limited administrative duties for the state outside of potentially finding additional resources for the initiative, advertising and marketing the initiative, and tracking key performance measures

Feasibility Criteria	Description
Workforce	• Would be a workforce enhancing initiative that would rely on existing Project ECHO staff and subject matter experts within New Mexico

Strategy #6: Strengthen the foundational elements of New Mexico's behavioral health system.

Introduction

A high-functioning behavioral health system depends not only on the availability of services, but also on the strength and sustainability of its foundational elements— such as a robust workforce, tools to help consumers access services, and reliable transportation to care. In New Mexico, persistent workforce shortages, especially in rural and frontier areas, have contributed to long wait times, limited access to care, and increased reliance on emergency departments for behavioral health crises. Stakeholders across the state consistently identify workforce capacity, administrative burden, and infrastructure limitations as major barriers to delivering behavioral health services.

To address these systemic barriers, the following recommendations address the core infrastructure of New Mexico's behavioral health system. This includes expanding and supporting the behavioral health workforce through targeted investments and training, developing user-friendly tools and outreach initiatives to help consumers and providers navigate the system more effectively. Additionally, the strategy calls for improvements in both medical and non-medical transportation options to ensure that all New Mexicans—regardless of geography or insurance status—can access the care and supports they need.

New Mexico already has made substantial investments in strengthening these foundational elements over the years, and SB 3 and the state's (anticipated) share of the Rural Transformation Health Fund are expected to be aimed squarely at continuing this work. As such, the recommendations in this analysis build upon those existing initiatives to a large degree.

Recommendation 6.1: Expand and strengthen the behavioral health workforce.

Context

New Mexico's behavioral health system includes a diverse network of providers such as community mental health centers, private practices, hospitals, and nonprofit organizations. The workforce supporting these services is composed of psychiatrists, psychologists, licensed counselors, social workers (both licensed and unlicensed), physicians with a specialty/expertise in SUD treatment, psychiatric nurse practitioners, peer support specialists and CSWs. The state's behavioral health workforce is highly concentrated in urban counties, particularly Bernalillo, Doña Ana, Sandoval, and Santa Fe.[clxxxix]

New Mexico faces significant behavioral health workforce challenges. Nearly all counties are designated as Mental Health Professional Shortage Area, and rural regions often lack psychiatrists, psychologists, and licensed counselors entirely. High turnover rates and difficulties in recruiting providers exacerbate these gaps, particularly in areas with limited infrastructure. These shortages contribute to long travel and wait times for care and increased reliance on emergency departments for behavioral health crises.[cxc,cxci]

A 2024 survey of approximately 6,300 community members across 11 New Mexico counties found that over half of all survey respondents have difficulty accessing mental and behavioral health care.[cxcii]

Respondents indicated specific shortages for OUD treatment, behavioral health services for children, and care during emergency situations. These shortages are expected to worsen substantially in the next ten years, with widening gaps between projected supply and demand for all behavioral health provider types. The federal Health Resources and Services Administration projects that New Mexico will need over 3,000 new behavioral health providers by 2037.[cxciii]

Another challenge facing New Mexico's behavioral health system is the aging workforce. More than one-third of psychiatric APRNs in the state are over the age of 55, with 13.5% aged 65 or older. This demographic trend signals a risk of further workforce contraction due to retirements in the coming years, which could worsen existing shortages unless New Mexico builds its pipeline.[cxciv]

Call Out Box 13. Stakeholder Input on Behavioral Health Workforce Challenges

During a December 9, 2025, public listening session attended by over 170 providers, MCOs and other stakeholders—including senior leaders from provider practices, social workers, case managers, brain injury rehabilitation physicians, residential rehabilitation facility administrators, hospitalists, MCO staff and local government representatives—workforce shortages were cited as a major barrier to access to behavioral health services. Stakeholders emphasized that limited provider availability undermines implementation of existing benefits, contributes to long wait times, and exacerbates geographic inequities—particularly in rural, frontier, and tribal areas.

Stakeholders also shared that administrative burden, including uncompensated time providers must spend collecting and reporting data and making referrals, and training limitations, especially for brain injury contribute to workforce gaps and limit the system's ability to deliver services at scale.

Following the public listening session, a survey was shared with participants to collect data on gaps, challenges, and opportunities to improve the state's behavioral health system. Key findings collected through the survey[76] included:

- 40% of respondents believe that the biggest barrier to delivering care to New Mexicans with SMI, SED and SUD is the need for capacity building funds to offer new services or build the workforce.
- 60% of respondents noted that the biggest barrier to delivering care to New Mexicans with brain injury is workforce related, including lack of training and the need to build the workforce.

For a full summary of stakeholder feedback collected during this public listening session and other stakeholder engagement activities, please see **Appendix E**.

Several major initiatives underway in New Mexico are using targeted strategies to build a sustainable pipeline of behavioral health professionals. These include specific initiatives like the New Mexico Higher Education Departments Health Professional Loan Repayment Program,[cxcv] provider training to increase capacity for evidence-based practices,[cxcvi] and telehealth adoption—as well as structural reforms to streamline the process of behavioral health licensing, reduce administrative burden for behavioral health professionals, and prioritize integrated care models.[cxcvii, cxcviii, cxcix]

[76] Fifty-three external stakeholders completed the post listening session survey.

As noted, new funding streams—including the federal RHTP, the state Behavioral Health Trust Fund,[cc] and the state Rural Health Care Delivery Fund (RHCDF)[cci] — are already supporting or are expected to advance major initiatives focused on building a more robust behavioral health workforce:

- **State BHRIA** – The passage of SB 3 established a regional approach to behavioral health care improvement. The legislative direction and funding from the BHRIA will address workforce challenges through multiple approaches including:
    - *Regional planning efforts that include creation of a behavioral health workforce pipeline* for the behavioral health services identified within regional plans, and making recommendations to the legislature to better address the behavioral health workforce needs of the region.
    - *Provider credentialing and licensing initiatives* that will establish a universal behavioral health provider enrollment and credentialing process for Medicaid and streamline the process of verifying provider licensing.
- **RHCDF** - The RHCDF is aimed at improving access to quality health care in rural New Mexico. With a total of $20 million available for the SFY 26-27 funding cycle, the RHCDF provides financial support to rural Medicaid providers, helping to offset operational costs in the expansion of essential health care services.[ccii] Funding from this program will help expand access to primary care and behavioral health services statewide.
- **Federal RHTP** – New RHTP application to CMS proposes a robust set of workforce initiatives aimed at strengthening the pipeline and retention of health professionals in rural, frontier, and tribal communities. The state's vision includes launching K-12 health career pathway programs to inspire and prepare students for future health care roles, expanding apprenticeships and rural clinical rotations, and developing residency tracks for high-need professions—including behavioral health providers. The application also invests in mentorship and tele-supervision networks, such as Project ECHO, to support ongoing professional development and accelerate licensure for clinicians in remote areas. New Mexico plans to offer paid training, certification support, and defined career ladders for licensed practical nurses, community health workers, peer support workers, and HCBS caregivers. Retention incentives, including five-year rural service commitments, housing stipends, and bonuses, are designed to attract and keep providers in underserved regions. On December 30, 2025, HCA announced[cciii] the state received $211.5 million in RHTP funding, which is expected to help fund these initiatives and build a sustainable, culturally responsive workforce equipped to meet the behavioral health and broader health needs of New Mexico's rural communities.[cciv]

Recommendations and Implementation Steps

The current and ongoing behavioral health workforce initiatives above reflect the state's commitment to strengthening provider capacity and ensuring access to behavioral health services across the state. Given the breadth of work underway, the primary strategy in the next several years should be to ensure limited state capacity is dedicated to advancing existing initiatives rather than creating entirely new frameworks to grow the workforce. This could look like:

- Continue implementing efforts underway through SB 3, the State Rural Health Care Delivery Fund and RHTP workforce initiatives.
- Fully fund the Health Professional Loan Repayment Program in 2026-2027.
- Consider removing the Health Professional Loan Repayment Program eligibility requirement for individuals to be a New Mexico resident for 12 consecutive months before applying, while maintaining the 3-year service obligation. This could help attract behavioral health professionals from other states, especially recent graduates, to move to New Mexico to begin their careers.

- Participate in healthcare licensing compacts for additional provider types, including psychologists, APRNs, social workers and counselors.
- Develop differential rates for CPSWs and CSWs who have more years of experience to incentivize retention and career growth.
- Establish formal career ladders for CPSWs by defining clear, statewide advancement pathways (e.g., entry-level, senior, specialist, supervisor, and leadership roles) tied to competencies, experience, and training. This could include standardized job titles, opportunities for certification and continuing education, mentorship and supervision roles, and commensurate increases in compensation and responsibility to improve retention, professional growth, and long-term workforce stability.
- Work with New Mexico's tribes to understand community-specific workforce gaps and consider feasibility of obtaining Medicaid authority to reimburse for new position(s) that can meet their needs. New Mexico can look to states like Alaska for an example of this approach (See Call Out Box 14).

Call Out Box 14. Alaska Behavioral Health Aide Program

Alaska's Behavioral Health Aide (BHA) program promotes behavioral health in Alaska Native communities through culturally relevant, community-based care. BHAs are local residents selected by their communities, allowing them to build trust, reduce stigma, and provide effective support. BHAs work within a tiered certification system, are employed by tribal or IHS organizations, supervised by licensed clinicians, and provide direct behavioral health services. The program is primarily funded by the IHS, with Medicaid reimbursement[77] for certified BHA services.[ccv]

Feasibility Criteria	Description
Impact	• Strategies are expected to significantly expand provider capacity across the state, which could increase access to care and ultimately improve behavioral health outcomes
Federal Authority Considerations	• Precedence exists for CMS approval of tribal-specific members of the workforce
State Administrative Complexity	• Implementation of RHTP funding will take significant state resources, but will come with significant funding; HCA has already committed to this undertaking • Potential new service definitions would require state resources to engage with Tribes to identify ways to grow their behavioral health workforce; develop new service definition and billing guidance; institute required technology changes; seek approval from CMS; implement new benefits/programs; and coordinate on an ongoing basis with Tribes • Legislation would be needed for the state to participate in additional licensing compacts

[77] Alaksa's Medicaid State Plan allows reimbursement of rehabilitative behavioral health disorder services by Behavioral Health Aides supervised by a mental health professional clinician when employed by a Community Behavioral Health Services Provider (see Alaska's Medicaid State Plan: https://health.alaska.gov/media/n04hpv3j/msp-section-31-attachment-a-sheets-benefits-31-62425.pdf).

Feasibility Criteria	Description
Workforce	• Efforts are expected to significantly grow the behavioral health workforce in the state

Recommendation 6.2: Create new tools to help consumers and providers navigate the behavioral health system.

Context

While New Mexico has a comprehensive behavioral health service array, there is a significant lack of awareness among individuals and families/caregivers, many behavioral health providers, and the general public about service availability and where and how to access care. Many New Mexicans do not know where to find information, how to navigate the system, and where to go for help. This knowledge gap is likely a major factor in delays in seeking treatment, underutilization of existing services and programs, and poor behavioral health outcomes across the state.[ccvi]

Lack of awareness and navigation challenges was one of the most common themes raised by external stakeholders during public forums, small group interviews, and one-on-one discussions. Individuals with complex behavioral health and brain injury needs and their family members stressed the need for clear resources on available services and help connecting with those services. Providers emphasized difficultly navigating a complex web of regulatory, policy and administrative requirements, with program oversight dispersed across many State departments and divisions.

Call Out Box 15. Stakeholder Input on Knowledge and Navigation Gaps

During a December 10, 2025 public listening session attended by 45 individuals with a diverse mix of backgrounds and experience—including individuals with complex behavioral health conditions; parents of children that have developmental disorders, behavioral health conditions and brain injury; patient advocates; behavioral health professionals; and non-profit organizations — stakeholders emphasized the complexity of New Mexico's behavioral health system and challenges they have experienced navigating services.

Families and individuals highlighted the burden of finding the programs and services to meet their needs, citing that there is not a central source of information for people with SMI, SED, SUD, and brain injury care needs. Family members of individuals with behavioral health needs summarized the issue by sharing:

- **"We have a tough system to navigate. Information is not easy to access."**
- **"The responsibility of finding a therapist and other services and supports often falls on the individual or family member. I try to help my son navigate the system, but it can be challenging."**
- **"There's ongoing need across the behavioral health system for providers to get the word out about what they're doing, and for users and clients and families to really get a sense of what is available and how to access."**

One-on-one interviews with individuals with lived experience and advocacy organizations reinforced the challenges that New Mexicans face in navigating the behavioral health system, noting difficulty identifying available providers, understanding eligibility requirements, and completing administrative processes. Even knowledgeable stakeholders lacked key information, such as that people with SMI

and SUD can qualify for the Community Benefit program as long as they otherwise would require NFLOC.

In addition to highlighting challenges and gaps, stakeholders shared recommendations, noting "[**what is needed is] a step-by-step process of where to go, what to do, what to expect and how to proceed**."

For a full summary of stakeholder feedback collected during this public listening session and other stakeholder engagement activities, please see **Appendix F**.

While the state has several important resources with information about Medicaid and other state-funded services - including the Behavioral Health Policy and Billing Manual, the Managed Care Policy Manual, and program-specific fact sheets, there is no single source of information to obtain information about both Medicaid- and state-funded services.

Recommendations and Implementation Steps

The state can take several steps to improve awareness of behavioral health services among individuals, families/caregivers, providers, and the general public. Relatively low-cost actions to conduct outreach, develop informational guides and navigation tools could help improve awareness among individuals, families and the general public and reduce administrative burden on providers.

Additionally, the state should leverage the regional planning process already underway to build awareness of New Mexico's current service array. Information sharing will help ensure that regional plans capitalize on existing coverage, identify regional-specific opportunities to increase access to covered services, and focus funding requests on filling gaps in coverage. This will help ensure the state maximizes federal Medicaid match funding for all eligible services and activities—and allocates state dollars to filling gaps that Medicaid cannot address.

- Create a centralized online hub for behavioral health and brain injury resources.
- Develop navigation tools in multiple languages.
- Develop a single state behavioral health provider manual that includes all Medicaid and state-funded services, with consistent services definitions, requirements, and billing guidance.
- Conduct information sessions as part of regional planning on already-covered resources and services.

Feasibility Criteria	Description
Impact	• Increasing public awareness of available services and how to access them could lead to greater utilization, which in turn could improve outcomes
Federal Authority Considerations	• No federal Medicaid authority required
State Administrative Complexity	• Requires staffing resources, including a combination of internal staff time and external contractor - to develop resources, update web pages, translate information, and conduct outreach. • Creating a new consolidated provider manual would require dedicated staff time
Workforce	• Does not impact workforce

Recommendation 6.3: Improve the state's transportation options.

Context

Reliable medical and non-medical transportation is essential for people with behavioral health issues because it directly supports access to care, stability, community integration, and recovery. Medical transportation ensures people can consistently attend appointments, adhere to medication regimens, and access emergency and hospital services when needed, while non-medical transportation enables access to community living and everyday needs such as employment, education, housing services, social support, and community activities.

Medical Transportation

New Mexico covers **medical transportation**—including both emergency transportation and non-emergency medical transportation (NEMT)—**through Medicaid**. Emergency transportation, which can include ground or air transportation, can be provided for a medical and/or behavioral health condition. NEMT provides transportation to medical and behavioral health services. Most NEMT in New Mexico is administered by Medicaid MCOs who are responsible for contracting with a network of transportation providers to ensure statewide access for Medicaid enrollees. Individuals who are enrolled in New Mexico's Medicaid FFS program also have access to NEMT.

As is the case with many other behavioral health services, New Mexico has adequate Medicaid coverage of medical transportation for the Medicaid population, though there are important access challenges that can inhibit access to NEMT in particular. First, given the state's rural landscape, there are a limited number of transportation vendors in certain areas of the state. With the 2023 passage of SB 485, the state added transportation network companies as eligible providers of NEMT, meaning that MCOs now have the ability to contract with companies like Uber and Lyft to expand access to transportation.

Additionally, stakeholder feedback indicated that Medicaid enrollees and their families have a hard time understanding who to contact to arrange NEMT services, what the requirements for NEMT are, who is allowed to accompany a member to an appointment, and what to do when out-of-state transportation is necessary.

A unique challenge for the population with complex behavioral health needs—not just in New Mexico, but nationwide—is ensuring the safety of both people receiving services and drivers providing NEMT. Drivers may encounter situations where a passenger experiences emotional distress, verbal escalation, or physical aggression, creating safety risks for both the provider and the individual being transported. These incidents can lead to fear, stress, and reluctance among drivers to accept future trips involving people with behavioral health needs. Balancing the need for compassionate access to transportation with appropriate safety training, support, and protocols for drivers remains a critical and ongoing concern. Other states like Colorado and Virginia have addressed this challenge by creating secure, non-law enforcement transportation programs.

Call Out Box 16. Colorado's Secure Transportation Services Program[ccvii]

Colorado's Secure Transportation Services program, established by HB 21-1085, provides safe, non-medical transportation for individuals experiencing a behavioral health crisis. Counties are required to license secure transportation providers and issue permits for vehicles, enforcing statewide minimum standards for staff training, vehicle safety, client rights, and quality management.

The program helps free up emergency medical and law enforcement resources, while ensuring people in crisis receive safe and less stigmatizing transportation. Licensed providers and certain exempt

agencies can be reimbursed through Colorado's Medicaid program. Two types of licenses (with or without physical restraint) and vehicle permits (with or without safety partitions) are available.

Finally, while NEMT is available through the state's Medicaid program, there is a gap in coverage for the uninsured/underinsurance population who are unable to access these services consistently.

Non-medical transportation

New Mexico currently covers non-medical transportation through Medicaid on a limited basis for individuals enrolled in the Community Benefit program (self-directed option), DD, and Mi Via 1915(c) waivers.

- **Community Benefit** (authorized by 1115 demonstration)—Individuals with behavioral health conditions that require a NFLOC can access non-medical transportation that enables them to travel to and from community services, activities and resources as specified in their care plan. These services are available only to individuals who are enrolled in the Self-Directed Community Benefit, and transportation is limited to a 75-mile radius of the enrollee's home. The total limit on transportation services may not exceed $1,000 per year[ccviii].
- **DD and Mi Via Waiver Programs** (authorized by 1915(c) waivers)—Individuals in these waiver programs have access to transportation services that enable them to get to waiver and other community services, activities and resources, as specified in their service plan. A person must be enrolled in a waiver program to access these services.

While the waiver programs above provide much needed access to people with co-occurring physical health needs or DD in addition to their behavioral health needs, there is no Medicaid non-medical transportation Medicaid benefit for people without co-occurring conditions, nor is there a State-funded program that provides non-medical transportation to the uninsured/underinsured population.

Recommendations and Implementation Steps

Together, medical and non-medical transportation options promote independence, reduce isolation, support treatment adherence, and help prevent crises by keeping individuals connected to the health care and broader support systems. To improve the state's transportation options, New Mexico could:

- Create a navigable website for NEMT that includes information for Medicaid managed care and FFS enrollees, frequently asked questions, and contact information for MCOs and state divisions that can support individuals and their families.
- Consolidate all Medicaid medical transportation program administration under a single division.
- Submit a 1915(i) SPA that includes coverage for non-medical transportation for people with complex behavioral health needs who do not have a co-occurring DD and do not meet NFLOC (see **Section V** for additional information on this recommendation).
- Add state-funded coverage of medical and non-medical transportation for the uninsured/underinsured population as resources permit.
- Explore pilot of a new Medicaid non law enforcement transportation service that provides an alternative to ambulance transport and/or law enforcement transport for individuals experiencing behavioral health crisis who need to get to crisis facilities or hospitals, or who need

to be transported from a hospital to another setting. New Mexico could look to Virginia[78]as an example of this approach.

Feasibility Criteria	Description
Impact	• Increasing public awareness of available services and how to access them could lead to greater utilization, which in turn could improve outcomes • Increasing access to medical and non-medical transportation could greatly improve access to care, improve outcomes and support people to remain in the community. It could also reduce utilization of emergency services, freeing up resources for other emergencies
Federal Authority Considerations	• Adding non-medical transportation as a Medicaid benefit for people with complex behavioral health needs who do not have a co-occurring DD and do not meet NFLOC would require a 1915(i) SPA (see Strategy #4)
State Administrative Complexity	• Requires significant new staffing resources to develop a 1915(i) SPA (see Strategy #4) • Requires some staffing or contracted resources to update websites; consolidating administration under a single division may require transferring positions but is not expected to require new staff • Requires staffing resources to pilot a new Medicaid non law enforcement transportation service, including a request for proposals for a transportation vendor
Workforce	• A new non-law enforcement transportation pilot program would require existing or new transportation providers to deliver a service • With existing shortages of NEMT transportation providers in rural areas, workforce challenges would need to be addressed

Section V. Does New Mexico Need a Waiver?

The New Mexico Legislature funded this work to "study the merits, feasibility, costs and likely enrollment in a proposed new Medicaid waiver for people with SMI or substance dependency leading to regular confinement in county jails or intensive overuse of hospital emergency rooms or other emergency or crisis services versus continuing with the current service array for people with SMI." HCA also directed that this study assess the need for a waiver among New Mexicans with brain injury given that the legislature had previously considered a bill (HB 70, 2025) that would extend additional HCBS to this population. Based on these directives, Manatt Health focused its specific assessment of the need for a waiver on adults who meet the criteria identified by the Legislature or with brain injury who might require additional HCBS (i.e., the "population of focus").

For the reasons described in this **Section**, Manatt Health does not recommend that New Mexico pursue a major new Medicaid waiver at this time. After a few years of experience implementing SB 3, the State

[78] In 2021, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) announced alternative transportation statewide for children and adults experiencing a mental health crisis.

may want to consider a 1915(i) SPA to address gaps in HCBS for people living with complex behavioral health issues or brain injury.

Assessing the Merits and Feasibility of a Waiver

To assess the merits and feasibility of a waiver, Manatt Health reviewed the result of its comprehensive assessment of New Mexico's covered services, gathered feedback from stakeholders, and considered data on the number of people in the population of focus and costs of potential services. We then reviewed how New Mexico could reasonably address those gaps, considering a Medicaid 1115 demonstration, a 1915(c) waiver, and other federal authorities such as the 1915(i) SPA that we ultimately recommend that New Mexico consider.

Relevant Findings from the Service Inventory

As described in **Section III**, New Mexico offers a robust array of behavioral health and brain injury services, but there are some gaps in covered services. (Access issues are distinct.) To review, New Mexico:

- **Covers a comprehensive set of rehabilitation-oriented community-based services and some habilitative supports,** such as through ACT teams, CCSS, psychosocial rehabilitation, peer supports, and recovery supports benefits.
- Covers a broader array of HCBS for individuals with co-occurring physical health needs at NFLOC through the Community Benefit program.
- Offers a variety of **navigational supports**, including through the MCO care coordination function, CCBHCs, CareLink Health Homes, CCSS, and ACT, which combines clinical services with elements of navigational supports.
- Covers **evidence-based housing interventions** for people with behavioral health needs, including both PSH and **short-term housing assistance**.

At the same time, New Mexico has some gaps in its current continuum of covered services.

- People wit**h needs less than an institutional LOC do not have access to a number of the habilitative services** recommended by SAMHSA's "good and modern" framework.
- The Community Benefit program does not cover some services of particular importance to people with brain injury-related needs that assist primarily with IADLs.
- While it offers some help with employment through CCSS and ACT, **the state does not explicitly cover the Individual Placement and Support (IPS) version of supported employment,** which is a recommended evidence-based practice from SAMHSA for people with behavioral health needs.[ccix]

Perspective of Stakeholders on a Waiver

While New Mexico's coverage of benefits is relatively strong on paper, stakeholders reported major gaps and often suggested that a waiver would be the best way to address them. A key theme from the stakeholder engagement process was that there are **insufficient step-down options and community-based supports to promote recovery and community inclusion for people who are ineligible for a waiver program:**

- Stakeholders discussed the difficulty of finding appropriate placements for individuals being discharged from inpatient psychiatric care, residential treatment, and incarceration.
- They expressed that there are not enough living environments where individuals with complex behavioral health needs or brain injury can obtain ongoing support with ADLs and IADLs

required to maintain recovery and live safely. Many identified that supportive housing is the top need for individuals with complex behavioral health needs.

- For people with brain injury, stakeholders indicated that there is substantial need for HCBS among people with significant functional needs that are less than NFLOC. Additionally, for both people eligible for the Community Benefit program and those with less intensive needs, there are gaps in supports that address IADLs, like skill building, and life coaching.
- Stakeholders also cited a lack of help in finding and retaining employment, the burden of social isolation, difficulty obtaining transport to community events and activities that foster maximum community inclusion, and insufficient support for caregivers.
- Finally, stakeholders expressed the view that the state's I/DD waivers and services are working well and could offer a model for what the state should make available to people with complex behavioral health needs and/or brain injury.

To address these gaps, stakeholders broadly agreed that there is a need for more PSH, such as that provided through the Linkages and SAHP programs. However, they disagreed about whether New Mexico should pursue Medicaid funding to cover services provided in group homes for people living with SMI and/or brain injury, recognizing that these settings largely do not exist today for these populations. The majority of stakeholders strongly advocated that group homes—similar to those offered under the DD waiver and the Community Benefit program—are needed for adults with SMI and to a lesser extent, people with brain injury. Others, however, raised concerns that these settings might not be conducive to recovery, could further silo people with complex behavioral health needs from the broader community, and could be difficult to implement consistent with the federal government's home- and community-based settings rule.

Quote: "I can provide people with psychiatric services, clinical services, case management, peer support, get them to medical appointments. But if I can't house them, it's hard to keep them stable." New Mexico provider, December 8, 2025.

Quote: "One of the biggest challenges that we're seeing is when people are discharged from a hospital or from a higher LOC, and then they go back into the community and are unhoused. They may be unable to be reached, meaning their condition isn't being managed, and then may stop taking their medications and following up with outpatient treatment. Then they cycle back into a hospital admission or the emergency department." New Mexico MCO representative, December 8, 2025.

Quote: "I am a parent of a 24-year-old daughter with SMI, SUD, and autism spectrum disorder. She is currently living in a "group home" which is really a boarding house—nothing therapeutic about it. She really needs a supportive living environment that offers therapy, daily living skills, etc."

Beneficiary Public Listening Session, December 10, 2025.

Additionally, stakeholders broadly agreed that navigational tools **are not working well** despite multiple programs and services that offer navigational supports. In New Mexico, individuals living with complex behavioral health needs and brain injury remain at risk of "falling through the cracks," particularly when transitioning between settings (e.g., hospital to residential treatment, hospital to home).

Recommendation to Consider a 1915(i) SPA

As directed by the legislature, Manatt Health considered whether a new waiver focused on these populations is the optimal approach to address these gaps. Ultimately, in lieu of pursuing a waiver,

Manatt Health **recommends that after gaining a few years of experience implementing SB 3, New Mexico consider pursuing a 1915(i) SPA if gaps remain in HCBS** for people living with complex behavioral health issues or brain injury**.** The SPA could provide services to people with SMI, severe SUD, and brain injury who have significant functional needs **below** an institutional LOC up to that required at an institutional LOC. People enrolled in Community Benefit program could access specialized services targeted to people with SMI, SUD, and brain injury through the 1915(i) SPA that go beyond those offered under Community Benefit. Filling these gaps would give New Mexicans with complex behavioral health needs and brain injury additional supports to maximize their ability to live stably in the community and avoid hospitalization, emergency department visits, crisis utilization, and incarceration.

Manatt Health's reasons for recommending that the state consider a 1915(i) SPA after assessing the early impacts of SB 3 planning efforts are based on the following:

- **Allows the State to offer new HCBS for people with needs less than NFLOC.** Different than a traditional 1915(c) waiver, a 1915(i) SPA would permit New Mexico to offer a specialized set of HCBS to individuals with needs less than an institutional LOC in addition to those at an institutional LOC. The State has significant flexibility in defining needs-based criteria for people eligible for the 1915(i) SPA and can tailor the criteria to provide services to key populations identified in the interviews (e.g., individuals with SMI SUD, or brain injury who need support with ADLs and IADLs, experience frequent psychiatric hospitalizations, have a history of incarceration and/or have experienced homelessness).
- **Avoids the complexity and uncertainty of a major Medicaid 1115 demonstration.** A Medicaid 1115 demonstration could be used to cover services for people with SMI, SUD, and brain injury with needs less than an institutional LOC, but it typically takes several years to negotiate and begin implementing a major new 1115 demonstration. (Amendments and renewals can take less time.) Moreover, the current Administration has rescinded guidance promoting the use of Medicaid 1115 demonstrations and other tools to address HRSN, suggesting it would prove difficult to impossible to secure federal Medicaid funding for some of the services—such as transitional rent for homeless people with SMI or SUD—that might have warranted the additional risk and work associated with securing approval of an 1115 demonstration.[ccx]
- **Fills gaps in the Community Benefit package.** As noted above, the Community Benefit program includes some enrollees with complex behavioral health issues or brain injury, but its benefits were designed primarily for the elderly and people with physical disabilities. As such, its robust benefit package does not include some HCBS that meet the specialized needs of the populations of focus (e.g., the IPS model of supported employment for people with SMI or services that assist with "cueing" for people with brain injury). The 1915(i) SPA could provide additional benefits to Community Benefit enrollees with complex behavioral health needs and brain injury.
- **Feasible for the state to obtain federal approval.** The 1915(i) SPA option is codified in federal statute and regulations.[ccxi] CMS regularly approves 1915(i) SPAs, regardless of the federal administration. While in some ways a 1915(i) is akin in complexity to pursuing a 1915(c) waiver, it is a SPA rather than a waiver, making it potentially more stable over time and avoiding the need to demonstrate cost neutrality. In addition, other states have reported that pursuing a 1915(i) SPA is less burdensome than pursuing a 1915(c) waiver.[ccxii]
- **Allows for a phase in over time.** It may take New Mexico several years to build provider and workforce capacity for these benefits. If the State decides to move forward with the 1915(i) SPA, federal flexibilities give states the ability to phase in benefits over a period of up to five years.[ccxiii]
- **Provides significant ability to control costs.** While eligibility for a 1915(i) must be based on functional needs-based criteria established by the state, the 1915(i) option additionally gives states

the ability to "target" benefits to individuals with specific diagnoses or disabilities (e.g., SMI, severe SUD, brain injury), eligibility groups, or ages. While a few of the services recommended below could be covered as a non-HCBS State Plan benefit (e.g., personal care), 1915(i) allows the state flexibility to limit these benefits to the populations of focus, controlling potential costs. Unlike with a waiver, New Mexico cannot use a 1915(i) SPA to cap enrollment, but the discretion to set eligibility standards provides the state with an important tool to contain costs and ensure services are reserved for those with the greatest need.

While Manatt Health recommends a 1915(i) SPA as the most suitable option to fill gaps in New Mexico's covered benefits, it also considered the alternatives displayed in **Table 3**. Note that New Mexico could also opt to pursue a "mix and match" type of approach, where it covers recommended benefits under different authorities (e.g., personal care as a "regular" State Plan benefit and other benefits under a 1915(i) SPA). For the purpose of simplicity, the **Table** below does not include all permutations that are possible.

Table 3. Alternatives Considered

	Pros	Cons
Traditional 1915(c) waiver	▪ Could cap enrollment to control costs and allow time to build provider capacity ▪ Planning funding available under HR 1	▪ Could not cover services for individuals with needs less than institutional LOC ▪ Services not an entitlement for eligible individuals ▪ More burdensome for state to apply for than 1915(i) SPA ▪ Requires cost neutrality
New 1915(c) waiver under H.R.1	▪ Could cap enrollment to control costs and allow time to build provider capacity ▪ Allows for coverage for people with less than institutional LOC ▪ Planning funding available under HR 1	▪ Services not an entitlement for eligible individuals because state has ability to cap enrollment ▪ CMS guidance does not yet exist; administrative burden unclear ▪ Requires cost neutrality
Turquoise Care 1115 demonstration amendment	▪ Would not need to pursue a distinct new waiver program/other authority ▪ Planning funding available under HR 1	▪ Significant risks to amending 1115 demonstration because of changing CMS priorities ▪ Most burdensome option for state to apply for and negotiate

Potential Design of a 1915(i) SPA

The key elements of a 1915(i) SPA designed for New Mexico's current needs are described below. If New Mexico implements SB 3 for a few years before determining if a 1915(i) SPA remains necessary, it would likely be necessary to re-evaluate this design prior to submittal.

Eligibility

Based on the New Mexico Legislature's population of focus and gaps identified during the interviews, Manatt Health recommends that if New Mexico pursues a 1915(i) SPA, it focus on adults with SMI, severe SUD, and brain injury with the needs and risk factors identified below:

- The individual needs assistance with at least one ADL or two IADLs to reside independently in the community; or

- The individual needs assistance with management and intervention of maladaptive or antisocial behaviors to ensure the safety of the individual and/or others AND needs assistance with at least one ADL or IADLs to reside independently in the community.

  AND

- The individual is age 18 and over with a diagnosis of SMI, severe SUD, and brain injury, as defined by New Mexico, and meets at least one of the following risk factors:
  - A history of hospitalization, emergency department visits, or crisis services for SMI, SUD, or brain injury, measured having at least three of any combination of these circumstances in the past 12 months; or
  - Has a history of involvement with the justice system (within the past three years) plus at least one hospitalization, emergency department visit, or use of crisis services related to SMI, SUD, or brain injury in the past 12 months; or
  - History of homelessness (any year) or is at risk of homelessness plus at least one hospitalization, emergency department visit, or use of crisis services related to SMI, SUD, or brain injury in the past 12 months.

These criteria are similar to those in other states' existing 1915(i) SPAs and are designed to be approvable by CMS. Based on an analysis of SFY 2025 Medicaid data provided by New Mexico Medicaid, it is estimated that 7,185 individuals with SMI, SUD or a brain injury would meet the risk factors above.

A functional assessment is required to determine whether individuals meet the proposed needs-based criteria; however, Manatt Health believes that it is reasonable to assume that individuals with the identified risk factors also have the proposed level of functional need. It is important to note that Medicaid claims data may not present an accurate sense of the number and service needs of Medicaid enrollees living with a brain injury and their functional needs because of inconsistencies in whether and how brain injury is documented.

Benefits

As summarized in **Table 4**, Manatt Health recommends that New Mexico consider covering the following benefits through a 1915(i) SPA based on gaps in New Mexico's current continuum of care and the services covered in other states. See **Appendix C** for a representative sample of what is covered by four of the states that have a 1915(i) SPA to provide services to adults with SMI, SUD, and/or brain injury.

i. Support with ADLs, IADLs, and other personal care needs to maintain stability in community-based settings.

- **Personal care.** Personal care provides people with hands-on assistance or cueing to perform ADLs (e.g., eating, personal hygiene, medication management) or IADLs (e.g., financial management, preparing meals). Today, only individuals in the Community Benefit program are able to access personal care services, meaning that the benefit is not available to individuals with less needs than NFLOC. Stakeholders emphasized that lack of support with ADLs and IADLs makes it challenging or even unsafe for many New Mexicans with SMI, severe SUD, and brain injury who have complex needs to live independently. The 1915(i) SPA could be used to extend personal care to people who struggle with ADLs and IADLs due to SMI, SUD, and/or brain injury, but whose needs are less than NFLOC.
- **Professional life skills coaching and organizer services.** This service, which currently is not covered in the Community Benefit program, assists individuals in learning or re-learning life skills that are required to function independently in their home environment, in their job, or in their

community. It may include assistance with home organization or management, time management, records management, and organization and management of finances, as well as coaching in appropriate social interactions; effective communication skills; anger management; self-care/health management; pursuit of education or employment; childcare and parenting skills; accessing and navigating community resources; mindfulness training and other skills identified in the individual's care plan. As compared to personal care, professional life skills coaching and organizer services focus more on supporting IADLs, while personal care focuses more on ADLs. This service could be extended via the 1915(i) SPA to people who already qualify for the Community Benefit program, as well as to people with SMI, severe SUD and brain injury who do not require NFLOC.

- **Assistive technology and remote supports (benefit would be limited to adults with brain injury).** Assistive technology and remote supports can be a cost-effective way for individuals with brain injury to obtain assistance with ADLs and IADLs without requiring in-person support.
    - **Assistive technology** includes the purchase or renting of items, devices, or systems to increase or maintain a person's functional status. It can include designing, fitting, adapting, and maintaining equipment, as well as training on how to use equipment.[ccxiv] The benefit may aid individuals living in community-based settings with reminders, pill organizers, memory apps, and computer access tools to address attention, planning, and physical challenges.
    - **Remote supports** pay for an attendant to remotely support a person with ADLs and IADLS such as cueing a person to eat, shower, get ready for work, shop, and pay bills. Today, neither benefit is available to individuals unless they are enrolled in the Community Benefit program, and assistive technology is only available on a limited basis to individuals enrolled in the Community Benefit program.

The 1915(i) SPA can be used to extend remote supports and assistive technology to people with brain injury, both at and below NFLOC.

ii. More robust support during transitions between settings (e.g., hospital to home).

- **Community transition services.** Community transition services are supports for one-time costs that help people establish a basic household, including things like security deposits, essential household furnishings, set-up fees or deposits for utility or service access, pest eradication and one-time cleaning and moving expenses. Transitioning from an institutional setting back to the community is often a significant challenge for individuals with SMI, severe SUD, and brain injury. For these populations, these supports can help ensure safe and stable transitions and prevent relapses, crisis, homelessness, or re-institutionalization. While community transition services already are available to people enrolled in the Community Benefit program, the 1915(i) could be used to extend them to people with SMI, severe SUD and brain injury who do not need NFLOC.

iii. Focused assistance in finding and retaining employment that would promote recovery.

- **Supported employment.** This service helps a person obtain or maintain paid employment or self-employment (e.g., through job development, job seeking and job coaching supports).[ccxv, ccxvi] New Mexico currently incorporates aspects of supported employment into its psychosocial rehabilitation and CCSS benefits for people with SMI and SUD. However, best practice is to implement the IPS supported employment model for people with SMI and severe SUD, which New Mexico is currently piloting through a SAMHSA grant (referred to as New Mexico SUCCESS).

The 1915(i) SPA could be used to provide the IPS model of supported employment to people in the Community Benefit program for whom it is appropriate, along with people with SMI or severe SUD who fall short of NFLOC.

iv. Supports to prevent social isolation and assistance obtaining transport to settings that foster community inclusion.

- **Non-medical transportation.** Beyond transportation to medical appointments, individuals with complex behavioral health conditions and brain injury can benefit from transportation to services and supports that promote community inclusion. For example, these populations may benefit from transportation to and from employment, an educational program, or support groups, all of which can be critical components of rehabilitation.
- **Related goods.** Related goods are equipment, supplies or fees, and memberships that help improve and maintain an individual's opportunities for full membership in the community. Related goods must be responsive to an individual's condition and must help with managing their household, facilitating ADLs, or promoting personal safety and health.

  Currently, neither of these benefits are available to people in the Community Benefit program, with the exception of non-medical transportation for people who direct their own HCBS. The 1915(i) could be used to add them for people in the Community Benefit program with SMI, severe SUD and/or brain injury who do not direct their own services, as well as for those who do not need NFLOC.

v. Additional support for caregivers

- **Respite.** This service aids caregivers who provide ongoing support to people with a disability.[ccxvii] Respite services are furnished on a short-term basis to allow the primary caregiver of individuals unable to care for themselves a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. Respite care is furnished at home or in approved alternative settings (e.g., private residence of a respite care provider, specialized foster care home, in a hospital or NF).[ccxviii] Today, New Mexico covers behavioral health respite for parents and other caregivers of youth with SED and for Community Benefit participants. The 1915(i) SPA could be used to extend respite care to caregivers of adults with SMI, severe SUD, and brain injury with needs at less than an institutional LOC.

Table 4 below summarizes recommended benefits to include in a 1915(i) SPA, and the proposed population that would be eligible for each benefit. In addition, the table displays benefits that would be new for individuals who are currently enrolled in the Community Benefit program.

Table 4. Summary of Proposed 1915(i) Benefits by Need and Population

	Proposed Target Populations Eligible for Benefit (Note all Individuals Obtaining 1915(i) Benefits Must Meet Needs-Based Eligibility Criteria and Risk Factors)			Services Beyond Those Currently Available to Community Benefit Participants
	SMI	Severe SUD	Brain Injury	
Support with ADLs, IADLs, and other personal care needs to live safely in community-based settings				

	Proposed Target Populations Eligible for Benefit (Note all Individuals Obtaining 1915(i) Benefits Must Meet Needs-Based Eligibility Criteria and Risk Factors)			Services Beyond Those Currently Available to Community Benefit Participants
	SMI	Severe SUD	Brain Injury	
Personal care	X	X	X	
Professional life skills coaching	X	X	X	X
Assistive technology			X	X (current benefit is limited)
Remote supports			X	X
More robust support during transitions between living arrangements				
Community transition services	X	X	X	
Focused assistance in finding and retaining employment that would promote recovery				
Supported employment/ employment supports	X (IPS)	X (IPS)	X	X (IPS not offered today)
Supports to prevent social isolation and assistance obtaining transport to settings that foster maximum community inclusion				
Related goods	X	X	X	
Non-medical transportation	X	X	X	X (not offered as part of agency model today)
Additional support for caregivers				
Respite	X	X	X	

Call Out Box 17: Note on Group Homes

There was considerable support among stakeholders—predominantly among advocates and families—for New Mexico to establish group homes for people living SMI and brain injury. Despite the support from stakeholders, Manatt Health is **not** recommending that New Mexico establish new group homes for people with complex behavioral health needs and brain injury for several reasons:

- **There is no clear agreement among people with lived experience, advocacy organizations, provider organizations, and researchers about whether groups homes are a preferred living environment for people with SMI.** Some experts argue that PSH where clients have significant autonomy should be the primary model for housing people with SMI, while others assert that a full range of housing options, including group settings should be available.[ccxix, ccxx, ccxxi , ccxxii, ccxxiii]
- **Most states do not use Medicaid to cover residential habilitation services in group homes for people with SMI.** While some states do use waivers or other vehicles to cover a defined package of residential habilitation services offered in group homes for people with SMI, it is not the majority of states. Moreover, those states that cover residential habilitation services in group homes often appear to have done so primarily to re-finance existing state and local dollars invested in these settings, rather than as part of innovative efforts to strengthen care for people with SMI.
- **Medicaid funding cannot be used for room and board or capital expenses.** Medicaid dollars can only be used to pay for Medicaid-coverable services provided to people in group homes—and

even then, only if the group home can meet "home and community-based setting" rule standards. They cannot be used to cover room and board expenses. As such, if New Mexico were to establish new group homes for people living with complex behavioral health needs, considerable state funds would be required to finance room and board on an ongoing basis in addition to capital expenses.

- **Compliance with HCBS rules requires extensive state oversight.** Group homes must comply with Medicaid home- and community-based settings requirements to obtain Medicaid-funded HCBS. In their role as regulators, states are required to oversee group homes' compliance with these rules,[ccxxiv] and most importantly, the safety of the people living in these settings. Conducting sufficient oversight requires substantial state resources. New Mexico has previously experienced challenges overseeing boarding homes—which are not being regulated as home- and community-based settings today. Seeking Medicaid reimbursement for services delivered in group homes substantially increases the regulatory burden.
- **Some states, such as New York, North Carolina, and South Carolina have faced *Olmstead* litigation related to group homes or similar settings for people with SMI.**[ccxxvi,ccxxvii] *Olmstead v. L.C.* was a 1999 Supreme Court decision that prevents states and other public entities from unnecessarily segregating people with mental illness. Under *Olmstead*, states are required to serve people with mental illness in the most integrated setting possible.
- **The State likely would need to spend considerable resources engaging with stakeholders on "siting" issues if it were to establish new group homes.** Group homes often face considerable community opposition because of "siting," or an attitude of "not in my backyard." While this factor alone should not prevent New Mexico from establishing group homes, it adds state financial and administrative burden onto the factors named above.

While Manatt Health does not recommend at this time pursuing a waiver or using the proposed 1915(i) to cover residential habilitation services in group homes, a group home strategy may be of interest to some of the regional entities charged with behavioral health reform under SB 3.

Implementation Considerations

As described in **Section II**, 1915(i) SPAs are subject to an extensive set of rules, including around determining eligibility for HCBS, person-centered planning, conflict-free case management, quality, program oversight, and provision of services in home- and community-based settings.[ccxxx] Manatt Health assumes that New Mexico would implement a 1915(i) SPA similar to how it administers the Community Benefit program, with the benefits included in managed care for individuals enrolled in MCOs. This would mean that while the state would determine a person's eligibility for 1915(i) services, the MCO would assess the person's need for specific benefits and conduct ongoing care coordination and person-centered planning. MCOs would also need to establish provider networks to ensure statewide availability of the services. Other state administrative considerations are discussed in Recommendation 4.1.

Cost of a 1915(i) SPA

The total estimated yearly cost of a 1915(i) SPA as outlined above would be **$33.7 million** per year **($9.7 million state share**), depending on the actual take-up rate and utilization of services. In developing the estimate, a 50% take-up rate of services is assumed, given this is a difficult-to-reach population. In practice, the take-up rate could be even lower, which would reduce total costs. The estimate assumes service delivery would begin in 2030.

The cost estimate for the proposed 1915(i) SPA was developed by first identifying populations with behavioral health and brain injury diagnoses, then categorizing these individuals into targeted populations for the 1915(i) services and lastly attributing estimated costs for each proposed 1915(i) service to the targeted population.

The key assumptions used to inform the cost estimate are summarized in **Table 5** below. See **Appendix F** for a full description of the methodology used for the cost estimate.

Table 5. Key Assumptions and Cost Estimates for 1915(i) SPA

Category	Assumption
Total estimated eligible population	7,185
Take-up rate (i.e., total percentage of eligible population that would utilize services)	50%
Federal Medical Assistance Percentage (FMAP) [79]	71.66% for service costs / 50% for administrative costs
Year service delivery begins	2030
Inflation rate	3%
Total HCA full-time equivalent (FTE) staff required to administer SPA	4 (2 MAD staff; 2 BHSD staff)

Section VI. Feasibility Study

At the request of HCA, this analysis addresses the core question of whether the state should pursue a waiver to help people with complex behavioral health issues and/or brain injury but also includes a broader set of recommendations on ways to address gaps in the behavioral health system for this population of focus. By design, the recommendations are comprehensive, but it would be unrealistic for the state to implement all of them, especially at this moment in time. New Mexico already is in the midst of a major overhaul of its behavioral health system via regional planning mandated by SB 3. Moreover, it is in the process of implementing HR 1, which will require unprecedented levels of work by HCA and impose a steep new financial burden on the state.

Throughout the report, Manatt Health shares an assessment of the feasibility of implementing the recommendations, taking into account the level of effort required by state staff, impact on New Mexico's stretched behavioral health workforce, likelihood of approval by the federal government (if required), and, when available, estimated cost impact.

It will be New Mexico's decision-makers who determine which, if any, of the recommendations the state opts to pursue. To assist in this process, Manatt Health offers its own perspective on which recommendations the state may want to prioritize in the short-term versus over a longer period of time, focusing on which changes could make the biggest difference for the New Mexican residents living with complex behavioral health issues and/or brain injury.

Recommended Short-Term Priorities

In the short-term—over the next two years, Manatt Health recommends that the state focus on expanding access to already-covered services, namely ACT, PSH available through Linkages and SAHP, and HCBS that already should be available to individuals via the Community Benefit program. For the

[79] The State would receive a higher FMAP for children up to age 19 and adults in the Medicaid expansion eligibility group.

ACT recommendation, in particular, it will be important to coordinate with the regional planning process since ACT teams may already be a priority for some regions. While not trivial, each of these recommendations builds on the state's already existing infrastructure and primarily requires extending the reach of providers and offering consumers information on already covered services.

In addition, Manatt Health recommends ramping up quickly the medical respite model. It could play a life-saving role in providing people who otherwise would be homeless with a safe place to heal after a hospitalization. Plus, New Mexico has a unique and time-limited opportunity to secure federal Medicaid matching funds at a 50/50 rate to cover some of the infrastructure costs needed to extend the service beyond Albuquerque.

Finally, Manatt Health recommends quickly pursuing the recommendations aimed at providing consumers with more information on where to go for services and what already is covered. The level of confusion and misinformation about what already is available to New Mexican residents warrants an investment in outreach and clear communication.

Recommended Medium-Term Priorities

In the medium-term—the next two to three years— we recommend that HCA address some of the more significant and more structural changes required to address some of the gaps identified in this analysis. Most notably, we recommend that in two to three years, the state consider pursuing the 1915(i) SPA discussed in **Section V,** based on its decision on whether the needs of individuals living with complex behavioral health issues have been sufficiently addressed by the SB 3 planning process. Although we are not recommending an 1115 demonstration—which is not required given New Mexico's particular needs and the potential difficulty of securing CMS approval of 1115 demonstrations at this point in time—it still requires significant staff time (~4 FTEs) to develop and properly implement and oversee a 1915(i) SPA. Moreover, Milliman estimates that the cost of the new 1915(i) SPA would be **$33.7 million ($9.7 million state share**) each year, depending on the take-up rate and utilization of services.

In the medium term, we also encourage HCA to address the recommendations related to re-vamping the state's navigational supports infrastructure. These changes require more time to implement, largely because they require a reorganization that affects the work of each of the major players in New Mexico's behavioral health system—MAD, CYFD, BHSD, Medicaid MCOs, CCBHCs, Health Homes, OTPs, and providers that offer CCSS, ACT and HFW.

Finally, we recommend that the state pursue the recommendations aimed at special populations such as building out residential treatment options for pregnant women and for young people in the state who are female. These are major initiatives that potentially require significant fiscal resources, as well as complex implementation and oversight. For new residential capacity, in particular, it will be critical to provide adequate oversight and monitoring given the heightened vulnerability of people who require a residential LOC and history around the country of abuses.

Recommended Ongoing Priorities

The final set of recommendations is aimed at perennial issues including the status of New Mexico's behavioral health workforce and strategies to improve transportation. While they are urgent, they also interact closely with numerous other efforts already underway. As such, it is especially important that any consideration of whether to adopt one or more of them be done in close coordination with the other workforce and transportation initiatives already happening in the state.

Section VII. Conclusion

In conclusion, the New Mexico Behavioral Health Assessment and Feasibility Study finds that the path forward for the state lies in strengthening and optimizing its existing behavioral health infrastructure rather than pursuing a major new Medicaid waiver. New Mexico has made significant progress in expanding services, increasing provider rates, and launching innovative initiatives, but persistent gaps remain—especially in access to care in rural and frontier areas, housing, navigational supports, and tailored supports for populations with the most complex needs. By focusing on expanding access to already-covered services, enhancing outreach and navigation, streamlining and strengthening navigational supports, and leveraging targeted federal authorities such as a 1915(i) SPA if still needed over time, New Mexico can make meaningful improvements for individuals with complex behavioral health conditions and brain injuries. And, continued investment in workforce, housing, transportation, and consumer tools will be critical to achieving a more integrated, equitable, and effective behavioral health system for all New Mexicans.

Appendix

Appendix A - SAMHSA "Good and Modern" and ASAM Frameworks

As discussed in the body of the report, Manatt Health based its behavioral health service inventory analysis on SAMHSA's "good and modern addictions and mental health service framework." SAMHSA presents its vision for a "good and modern" system as follows:

> *The vision for a good and modern mental health and addiction system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. The goal of a "good" and "modern" system of care is to provide a full range of high-quality services to meet the range of age, gender, cultural and other needs presented. The interventions that are used in a good system should reflect the knowledge and technology that are available as part of modern medicine and include evidenced-informed practice; the system should recognize the critical connection between primary and specialty care and the key role of community supports with linkage to housing, employment, etc. A good system should also promote healthy behaviors and lifestyles, a primary driver of health outcomes.*[ccxxxi]

While the SAMHSA "good and modern" framework incorporates both mental health and SUD services, the SAMHSA framework is not as granular in key SUD service areas as the ASAM continuum. The ASAM continuum is the most widely used and comprehensive set of standards for placement, continued service, and transfer of patients with addiction and co-occurring conditions. It provides a framework for organizing addiction treatment systems and helps professionals determine the appropriate level of care based on an individual's needs.

As such, in consultation with national experts, Manatt Health substituted ASAM levels of care (3rd Edition, which is the version currently used by New Mexico) for other SUD services reflected in the "good and modern" framework, where appropriate.[ccxxxii] The 4th Edition of the ASAM Continuum was released in 2023, and New Mexico intends to transition to this edition in 2026. Manatt Health also made some other minor updates to the framework based on input from these experts.

Table 1 below displays the modified framework used for this report. Note that certain components of the framework were out of scope for Manatt Health (e.g., because they address physical health, are a public health program and not a coverable service) and are noted as such below with an asterisk (*). **Table 2** presents an analysis of New Mexico's Medicaid and state-funded coverage of mental health and SUD services as compared to the adapted SAMHSA "good and modern" framework. The analysis does not include New Mexico-covered services that are not part of the "good and modern" framework (e.g., applied behavior analysis, Treat First Clinical Model).

Appendix Table 1. Modified "Good and Modern" Framework

Healthcare Home / Physical Health	Prevention and Wellness	Engagement Services	Outpatient and Medication Services	Community and Recovery Supports (Rehabilitative)	Other Supports (Habilitative)	Intensive Support Services	Out-of-Home Residential Services	Acute Intensive Services
• Behavioral health screenings • Comprehensive care management • Care coordination and health promotion • Individual and family support • Referral to community services • Comprehensive transitional care • Generalized and specialized outpatient medical services* • Acute primary care* • General health screens, tests, and immunization*	• Screening, brief intervention and referral to treatment (ASAM .5) • Screening and brief intervention for tobacco cessation • Brief motivational interviews* • Relapse prevention/wellness recovery support* • Parent training* • Facilitated referrals* • Health promotion* • Warm line*	• Assessment • Specialized evaluations (psycho-logical, neurological) • Service planning (including crisis planning) • Consumer /family education* • Outreach*	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy* • Consultation to caregivers* • Laboratory services* • Medication management (MH only) *SUD only:* • Opioid treatment program (ASAM 1) • Outpatient services (ASAM 1) • Ambulatory withdrawal management without extended on-site monitoring (ASAM Level 1-WM) • SUD pharmacotherapy (including office-based opioid treatment)	• Parent/ caregiver support • Skill building (social, daily living, cognitive) • Case management • Behavioral management • Supported employment • Permanent supportive housing • Recovery housing • Therapeutic mentoring • Traditional healing services* • Peer supports • Recovery support coaching • Recovery support center services • Relapse prevention	• Personal care • Homemaker • Respite • Supported Education • Recreational services • Transportation • Assisted living services • Interactive communication technology devices* • Trained behavioral health interpreters*	• Intensive outpatient treatment • Partial hospitalization • Coordinated specialty care for first episode psychosis • Intensive case management • Assertive community treatment • Intensive home-based treatment • Multi-systemic therapy *SUD only*: • Intensive outpatient services (ASAM Level 2.1) • Partial hospitalization (ASAM Level 2.5) • Ambulatory withdrawal management with extended on-site monitoring (Level 2-WM)	• Adult mental health residential services • Children's mental health residential services • Crisis residential/ stabilization services • Therapeutic foster care *SUD only:* • Clinically managed low-intensity residential services (ASAM 3.1) • Clinically managed population-specific high-intensity residential services (ASAM 3.3) • Clinically managed high-intensity residential	• Mobile crisis services • Urgent care services • 23-hour crisis stabilization service • 24/7 crisis hotline services • Psychiatric inpatient services *SUD only:* • Medically managed intensive inpatient services (ASAM 4.0) • Medically managed intensive inpatient withdrawal management (ASAM 4.0-WM)

Healthcare Home / Physical Health	Prevention and Wellness	Engagement Services	Outpatient and Medication Services	Community and Recovery Supports (Rehabilitative)	Other Supports (Habilitative)	Intensive Support Services	Out-of-Home Residential Services	Acute Intensive Services
			• Contingency management[80]	• Wellness recovery support* • Continuing care for SUD • Supports for self-directed care*			services (ASAM 3.5) • Medically monitored intensive inpatient services (ASAM 3.7) • Clinically managed residential withdrawal management (ASAM 3.2-WM) • Medically monitored inpatient withdrawal management (ASAM 3.7-WM) • Residential treatment specific to	

[80] While this service is not included in ASAM continuum, ASAM recommends, "Contingency management has demonstrated the best effectiveness in the treatment of stimulant use disorders compared to any other intervention studied and represents the current standard of care.," See the ASAM/AAAP Clinical Practice Guideline on the Management of Stimulant Use Disorder, available at https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/quality-science/stud_guideline_document_final.pdf#:~:text=Contingency%20Management%20....%2044&text=Contingency%20Management%20Benefit%20Program%20Manual.,https%3A%2F%2Fwww.uclaisap.org%2Frecoveryincentives%2Fdocs%2Ftraining%2FProgram-Manual-with-

Healthcare Home / Physical Health	Prevention and Wellness	Engagement Services	Outpatient and Medication Services	Community and Recovery Supports (Rehabilitative)	Other Supports (Habilitative)	Intensive Support Services	Out-of-Home Residential Services	Acute Intensive Services
							perinatal population[81]	

[81] While this service is not included in the ASAM continuum, ASAM recommends, "Residential treatment and recovery housing facilities should provide affordable, family housing that permits children to live on the premises with a parent receiving treatment or who is in recovery." See ASAM's 2022 "Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People," available at https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/public-policy-statements/2022-sud-pregnant-postpartum.pdf?sfvrsn=61e2c93a_7.

Appendix Table 2. New Mexico's Medicaid and State-Funded Coverage of Mental Health Services and SUD Services as Compared to Adapted SAMHSA "Good and Modern" Framework

Population	Optimal Services *Services are for Individuals with Either Mental Health or SUD-Related Needs Unless Otherwise Noted*	New Mexico's Service Offerings		Meaningful Gaps
		Medicaid-Covered *Services Authorized Under the State Plan[82] and ABP Unless Otherwise Noted*	**State-Funded**	
Healthcare Home, Physical Health, Prevention and Wellness *(Most services in this category are outside of the scope of this report and are not included below)*				
Adults and youth	• Behavioral health screenings[83] • Screening, Brief Intervention and Referral to Treatment *(ASAM 0.5)* • Comprehensive care management • Care coordination and health promotion • Individual and family support • Referral to community services • Comprehensive transitional care	• Behavioral health professional services for screenings, evaluations, assessments, and therapy • Screening, Brief Intervention and Referral to Treatment (SBIRT) • CCSS • CareLink New Mexico Health Home • Targeted case management through CCBHCs[84] • HFW (youth only)[85] • MCO care coordination[86]	• Psychiatric diagnostic evaluation with or without medical services • SBIRT • CCSS • Targeted case management through CCBHCs	• **No state-funded coverage:** CareLink New Mexico Health Home, HFW *Note: CYFD is in process of adding HFW to the CYFD Fee Schedule in alignment with the current Medicaid rate for each*
Engagement Services *(Most services in this category are outside of the scope of this report and are not included below)*				

[82] Includes services covered under EPSDT. Services only covered for the EPSDT population are denoted by an asterisk. Youth ages 19 – 20 are able to access the benefit under EPSDT.
[83] "Youth only" indicates up to 21 in most cases.
[84] Authorized under the CCBHC demonstration.
[85] Authorized under 1115 demonstration.
[86] MCO care coordination, Health Homes, and CCBHC targeted case management includes referrals to community services and comprehensive transitional care.

Population	Optimal Services *Services are for Individuals with Either Mental Health or SUD-Related Needs Unless Otherwise Noted*	New Mexico's Service Offerings **Medicaid-Covered** *Services Authorized Under the State Plan[82] and ABP Unless Otherwise Noted*	New Mexico's Service Offerings **State-Funded**	**Meaningful Gaps**
Adults and youth	• Assessment • Service planning • Specialized evaluations (E.g., psychological, neurological)	• Comprehensive multidisciplinary assessment and treatment planning • Behavioral health professional services for screenings, evaluations, assessments, and therapy • **Only covered for Community Benefit participants:** Behavior support consultation	• Psychiatric diagnostic evaluation with or without medical services • Comprehensive multidisciplinary assessment and treatment planning	**None**
Outpatient and Medication Services				
Adults and youth	• Individual evidence-based therapies • Group therapy	• Electroconvulsive therapy (ECT) (only covered under ABP and EPSDT) • Evidence-based therapeutic interventions: DBT, EMDR • Behavioral health professional services for screenings, evaluations, assessments, and therapy • Group therapy also covered as part of other services (e.g., mental health IOP)	• Group therapy • Multiple family psychotherapy • Group psychotherapy *Note: CYFD is in process of adding DBT and EMDR to the CYFD Fee Schedule in alignment with the current Medicaid rate for each service.*	• **No State Plan coverage for adults:** ECT (covered by EPSDT for youth younger than 21) • **No state-funded coverage:** ECT
	<u>MH only:</u> • Medication management	• Component as component of other covered services (e.g., intensive outpatient program for mental health conditions (mental health IOP), multi-systemic therapy, etc.)	• Covered as component of intensive outpatient program for mental health conditions for youth (Mental health IOP)	• **No state-funded coverage**
	<u>SUD only:</u> • Opioid treatment program (ASAM 1)	• Medications for opioid use disorder / opioid treatment program • Smoking cessation counseling	• Methadone maintenance / opioid use disorder treatment • Contingency management	• **No Medicaid coverage:** Contingency management *(Note: CMS approved 1115*

Population	Optimal Services ***Services are for Individuals with Either Mental Health or SUD-Related Needs Unless Otherwise Noted***	New Mexico's Service Offerings **Medicaid-Covered** *Services Authorized Under the State Plan[82] and ABP Unless Otherwise Noted*	New Mexico's Service Offerings **State-Funded**	**Meaningful Gaps**
	• Outpatient SUD services (ASAM 1) • Ambulatory withdrawal management without extended on-site monitoring (ASAM 1-WM) • Contingency management • SUD pharmacotherapy (including Office-Based Opioid Treatment)	• Outpatient SUD services (ASAM 1 and 1-WM) • Contingency management	• Outpatient SUD services (ASAM 1 and 1-WM)	*demonstrations authorizing contingency management under the previous administration; unclear whether current administration would approve)* • **No state-funded coverage:** Smoking cessation counseling
Adults Only	• Individual evidence-based therapies	• Cognitive enhancement therapy (CET)	None	**No state-funded coverage:** CET
Youth only	• Individual evidence-based therapies • Family therapy	• Evidence-based therapeutic interventions: trauma-focused cognitive behavioral therapy (TF-CBT) • FFT	*CYFD is in process of adding TF-CBT and FFT to the CYFD Fee Schedule in alignment with the current Medicaid rate for each service.*	**None**
Community and Recovery Supports (Rehabilitative)				
Adults and youth	• Peer support • Recovery support coaching • Parent/caregiver support • Skill building (social, daily living, cognitive) • Case management • Supported employment	• Peer support services (includes family peer support services and youth peer support services) • Recovery services • CCSS • Psychosocial rehabilitation • CareLink New Mexico Health Home	• Peer support-self help • Recovery services • CCSS • Psychosocial rehabilitation • CCBHC	• **No Medicaid/state-funded coverage for adults:** Respite, IPS model of supported employment, traditional healing • **No state-funded coverage:** Respite (for adults)

Population	Optimal Services *Services are for Individuals with Either Mental Health or SUD-Related Needs Unless Otherwise Noted*	New Mexico's Service Offerings		Meaningful Gaps
		Medicaid-Covered *Services Authorized Under the State Plan[82] and ABP Unless Otherwise Noted*	**State-Funded**	
	• Traditional healing services • Continuing care for SUD • Relapse prevention • Wellness recovery support • Therapeutic mentoring • Recovery support center services	• CCBHC[87] • HFW[88]		
Youth only	• Behavioral management	• Behavioral management services (BMS)	• BMS	**None**
Adults only	• Permanent supported housing • Recovery housing	• Pre-tenancy and tenancy services[89] • Short-term post-hospitalization housing[90]	• Linkages and SAHP programs (permanent supportive housing) • Recovery housing program	• **Medicaid-funded** pre-tenancy and tenancy services are capped • *Note: Room and board for permanent supportive housing and recovery housing are not coverable by Medicaid even with a waiver*
Other Supports (Habilitative)				
Adults and youth	• Personal care • Homemaker • Respite • Supported education	• Behavioral health respite care • CCSS	• Behavioral health respite care • CCSS	• **No Medicaid coverage:** Homemaker, supported education

[87] Authorized under the CCBHC demonstration.
[88] Authorized under 1115 demonstration.
[89] Authorized through the state's Section 1115 demonstration.
[90] Authorized through the state's Section 1115 demonstration.

Population	Optimal Services *Services are for Individuals with Either Mental Health or SUD-Related Needs Unless Otherwise Noted*	New Mexico's Service Offerings **Medicaid-Covered** *Services Authorized Under the State Plan[82] and ABP Unless Otherwise Noted*	New Mexico's Service Offerings **State-Funded**	**Meaningful Gaps**
	• Transportation • Assisted living services • Recreational services • Interactive communication technology devices	• Some services covered as a component of other services (e.g., day treatment, recovery services) • NEMT • **Only covered for Community Benefit participants:** Personal care, non-medical transportation (self-directed participants only), assisted living (agency-based participants only), recreational services, respite for adults, assistive technology (limited coverage)[91]		• **No Medicaid coverage for individuals not enrolled in Community Benefit program:** Personal care, respite (adults only), non-medical transportation, assisted living services, assistive technology • **No state-funded coverage:** Personal care, homemaker, respite (adults only), educational services, NEMT, assisted living services
Intensive Support Services				
Adults and youth	MH only: • Intensive outpatient treatment • Partial hospitalization • Coordinated specialty care for first episode psychosis • Intensive Case Management	• Intensive outpatient program for mental health conditions (mental health IOP) • Partial hospitalization program • Day treatment services (youth only) • ACT (coordinated specialty care for first episode psychosis is a component of service) • **Only covered for Community Benefit participants:** Adult day health (agency-based participants only) • CareLink New Mexico Health Home • CCBHC Targeted Case Management	• ACT (coordinated specialty care for first episode psychosis is a component of service) • Intensive outpatient program for mental health conditions (mental health IOP) (for youth only)	• **No state-funded coverage:** Mental health IOP for adults, partial hospitalization

[91] Authorized through the state's Section 1115 demonstration.

Population	Optimal Services *Services are for Individuals with Either Mental Health or SUD-Related Needs Unless Otherwise Noted*	New Mexico's Service Offerings		Meaningful Gaps
		Medicaid-Covered *Services Authorized Under the State Plan[82] and ABP Unless Otherwise Noted*	**State-Funded**	
	SUD only: • Intensive outpatient services (ASAM 2.1) • Partial hospitalization (ASAM 2.5) • Ambulatory withdrawal management with extended on-site monitoring (Level 2-WM)	• Intensive outpatient program for SUD (SUD IOP) (ASAM 2.1) • Partial hospitalization program (ASAM 2.5) • ASAM Level 2-WM (Ambulatory withdrawal management with extended on-site monitoring)	• Intensive outpatient program for SUD (SUD IOP) (ASAM 2.1) • ASAM Level 2-WM (Ambulatory Withdrawal Management with Extended On-Site Monitoring)	• **No state-funded coverage:** Partial hospitalization (ASAM 2.5)
Youth only	• Intensive Case Management • Intensive home-based treatment • Multi-systemic therapy	• HFW[92] • FFT • Multi-systemic therapy	• FFT • Multi-systemic therapy	• **Gaps in state-funded coverage:** HFW *Note: CYFD is in process of adding HFW to the CYFD Fee Schedule in alignment with the current Medicaid rate for each service. HFW is currently only authorized for a few providers.*
Adults only	MH only: • ACT	• ACT	• ACT	None
Out-of-Home Residential Services				
Adults and youth	SUD only: • Clinically managed low-intensity residential services (ASAM 3.1) • Clinically managed population specific high-	• Adult Accredited Residential Treatment Center (AARTC) for Adults with SUD (covers ASAM 3.1, 3.2-WM, 3.3, 3.5, 3.7-WM) • All ASAM levels of care covered for youth under EPSDT benefit	• Short-term residential • Long-term residential-transitional living services • Alcohol and/or drug services—residential—med. monitored	• **No Medicaid coverage:** Residential services specific to perinatal population

[92] Authorized through the state's Section 1115 demonstration.

Population	Optimal Services *Services are for Individuals with Either Mental Health or SUD-Related Needs Unless Otherwise Noted*	New Mexico's Service Offerings		Meaningful Gaps
		Medicaid-Covered *Services Authorized Under the State Plan[82] and ABP Unless Otherwise Noted*	**State-Funded**	
	intensity residential services (ASAM 3.3) • Clinically managed high-intensity residential services (ASAM 3.5) • Medically monitored intensive inpatient services (ASAM 3.7) • Clinically managed residential withdrawal management (ASAM 3.2-WM) • Medically monitored inpatient withdrawal management (ASAM 3.7-WM) • Residential treatment specific to perinatal population[93]		detoxification/social detoxification) • Residential pregnant women/parenting	
Adults only	MH only: • Adult mental health residential services • Crisis residential/stabilization services	• None	• None	• **No Medicaid/state-funded coverage:** Residential treatment and crisis residential treatment • *Note: In 2026, the State intends to submit a SPA to*

[93] While this service is not included in ASAM continuum, ASAM recommends, "Residential treatment and recovery housing facilities should provide affordable, family housing that permits children to live on the premises with a parent receiving treatment or who is in recovery." See ASAM's 2022 "Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People," available at https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/public-policy-statements/2022-sud-pregnant-postpartum.pdf?sfvrsn=61e2c93a_7.

Population	Optimal Services *Services are for Individuals with Either Mental Health or SUD-Related Needs Unless Otherwise Noted*	New Mexico's Service Offerings **Medicaid-Covered** *Services Authorized Under the State Plan[82] and ABP Unless Otherwise Noted*	New Mexico's Service Offerings **State-Funded**	**Meaningful Gaps**
				cover AARTC for mental health, which will include several levels of residential services, including crisis
Youth only	• Children's mental health residential services • Therapeutic foster care	• Accredited Residential Treatment Center (ARTC) for youth • Non- ARTCs and group home services • Treatment foster care (TFC) I and II	• ARTC for youth	• **No state-funded coverage:** Non- ARTCs and group home services, TFC I and II
Acute Intensive Services				
Adults and youth	• Mobile crisis services • Urgent care services • 23-hour crisis stabilization service • Psychiatric inpatient services • 24/7 crisis hotline services	• Telephone crisis services • Face-to-face outpatient clinic crisis services • Crisis stabilization services • Crisis triage centers[94] • Mobile crisis intervention services • Mobile response and stabilization service (MRSS) (youth) • Inpatient psychiatric care in psychiatric units of acute care hospitals • Inpatient psychiatric care in freestanding psychiatric hospitals (youth)	• Crisis call centers • Mental health urgent care/outpatient crisis programs • Face-to-face outpatient clinic crisis services • Crisis stabilization services • Psychiatric emergency room services • Psychiatric admission—staying less than 24 hours • Inpatient psychiatric hospitalization • Crisis intervention-mobile	• **No state-funded coverage:** Crisis triage centers, MRSS *Note: CYFD is in process of adding MRSS as a state-funded service*
	<u>SUD only:</u> • Medically managed intensive inpatient services (ASAM 4.0)	• ASAM Level 4 (Medically managed intensive inpatient services) • ASAM Level 4-WM (Medically managed intensive inpatient	**None**	• **No state-funded coverage:** ASAM Level 4 and ASAM Level 4-WM

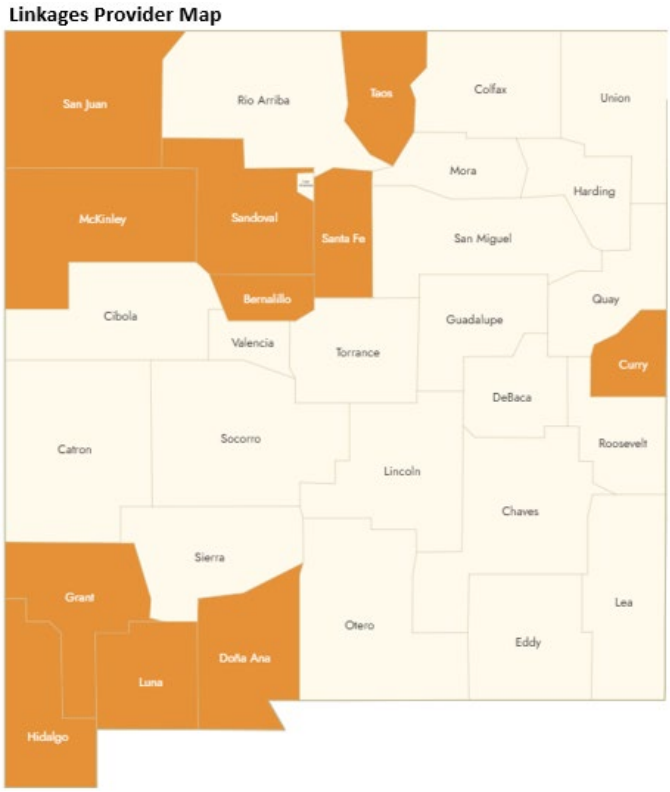
[94] Ages 14+

Population	Optimal Services ***Services are for Individuals with Either Mental Health or SUD-Related Needs Unless Otherwise Noted***	New Mexico's Service Offerings		Meaningful Gaps
		Medicaid-Covered *Services Authorized Under the State Plan[82] and ABP Unless Otherwise Noted*	**State-Funded**	
	• Medically managed intensive inpatient withdrawal management (ASAM 4.0-WM)	withdrawal management in a hospital)		

Appendix B - New Mexico's Continuum of Supportive Housing Services

New Mexico currently implements a broad continuum of evidence-based housing interventions for people with behavioral health and brain injury needs, including permanent and short-term housing assistance and outreach and navigation programs. Through Linkages and SAHP, the state operates a coordinated permanent supportive housing delivery system that provides rental assistance and tenancy-sustaining services to New Mexicans with behavioral health needs experiencing homelessness or housing instability. BHSD and the MFA also implement an array of short-term housing programs and outreach and housing navigation support services that serve individuals with behavioral health needs.

Permanent Supportive Housing



BHSD administers two permanent supportive housing programs in partnership with the MFA (also known as 'Housing New Mexico') for adults with behavioral health needs, including SMI and SUD, who are experiencing homelessness or housing instability:[95]

Linkages: Linkages is a permanent supportive housing program that provides state-funded long-term rental assistance and basic tenancy supports to adults with incomes at or under 30% of area median income (AMI) who are homeless or at risk of homelessness and diagnosed with SMI.[ccxxxiii] BHSD and MFA partner with 11 supportive services administrators (SSAs) to screen individuals for program eligibility, provide pre-tenancy services to assist with their housing search, and navigate applicants to rental subsidies. A set of eight housing administrators are contracted by MFA to review and approve rental subsidy applications, ensure that housing units meet quality standards and rent limits, and make rental assistance payments to landlords.[ccxxxiv] Today, there are over 550 participants in select counties. Once enrollees are housed, SSAs provide tenancy-sustaining and case management services and also connect them to mental health services.

Linkages is funded through a combination of state general funds—which cover rental assistance and a baseline set of tenancy-sustaining services, including monthly case management visits to enrollees' units—and Medicaid funds. SSAs can obtain Medicaid payment for providing pre-tenancy and tenancy services under the Turquoise Care 1115 demonstration, which authorizes New Mexico to provide these services to up to 450 individuals. HCA implements this enrollment cap to ensure that the number of people receiving Turquoise Care pre-tenancy and tenancy services matches the number of people

[95] New Mexico also implements local permanent supportive housing, short-term housing assistance, and outreach and navigation programs through Continuum of Care and Youth Homeless Demonstration Project funds, though these funds are not exclusively geared towards individuals with behavioral health or brain injury needs.

receiving Linkages rental subsidies. Linkages SSAs do not appear to be fully utilizing these services; stakeholders engaged indicated that only 130 Linkages enrollees are using Medicaid-funded pre-tenancy and tenancy services, leaving 320 of the allowable 450 slots unused. BHSD is working to expand the number of enrollees who receive these supports, including by encouraging Linkages providers to bill Medicaid.[ccxxxv]

Call Out Box 1. What are Pre-Tenancy and Tenancy Services?

Pre-tenancy services (often referred to as 'housing navigation' services) are case management services that assist enrollees in preparing for transitions to and acquiring community-based housing. Examples include support in searching for available housing; completing housing or rental subsidy applications and landlord interviews; conducting household budgeting, moving coordination, and utility setup; and obtaining household items.

Tenancy or *tenancy-sustaining* services refer to case management and other services to help enrollees maintain ongoing tenancy in a designated apartment, home, or other unit. Examples include support in understanding and complying with lease terms and obligations; avoiding and troubleshooting lease violations; performing activities of daily living; and connecting to other clinical and non-clinical services in order to maintain stable housing.

SAHP: SAHP is a project-based housing program in which units within new affordable housing developments subsidized by LIHTCs are designated (set aside) for low-income individuals and households ages 18-61 with a diagnosis of SMI, SUD, or a physical, sensory, or cognitive disability; eligible for Medicaid; and with incomes at or under 30% AMI. A set of 12 local lead agencies (LLAs) overseen by MFA screen individuals for program eligibility, navigate eligible individuals to designated housing units, provide tenant advocacy services, and arrange supportive services through the tenant's selected provider.

There are currently over 370 units set aside for SAHP enrollees within 43 LIHTC-subsidized properties across 19 counties. Some of these units receive project-based rental assistance through HUD's Section 811 program for individuals with disabilities. Like in the Linkages program, SAHP plans to leverage Medicaid funds to expand managed care enrollees' supportive service array through Turquoise Care's pre-tenancy and tenancy services benefit. These services will go live for SAHP enrollees after the benefit is embedded in LLA provider manuals and providers are trained on billing Medicaid.[96]

Short-Term Housing Assistance

BHSD and MFA also administer various transitional and interim housing assistance programs supported by state and federal funds, offering a range of rental assistance and supportive services for New Mexicans with behavioral health needs in select counties. None of these programs rely on federal Medicaid funds and/or waiver authority for implementation, and, relative to the permanent supportive housing services outlined above, their implementation is largely limited to a small number of enrollees in select counties statewide. These include:

[96] Howley, Lisa. New Mexico's Special Needs / Set aside Housing Program. Human Services Department, State of New Mexico, July 2019, housingnm.org/uploads/documents/New_Mexico_Special_Needs_Program_Operations_Manual_%28LIHTC%29.pdf.

- **Crisis Housing Program:** This program provides temporary, transitional housing for up to 120 days with tenancy-sustaining services (e.g., life skills, income entitlements reinstatement assistance, and support with finding permanent housing) for adults with SMI being discharged from psychiatric centers, hospitals, jails, or other institutional settings who would otherwise be homeless. This program currently operates in Doña Ana County.[ccxxxvi]
- **Fresh Start Rental Assistance:** This program provides state-funded and National Opioids Settlement-funded move-in assistance and eviction prevention assistance for up to six months (or up to $10,000) for adults diagnosed with SUD who are homeless, precariously housed, or at risk of homelessness and receiving behavioral health services, including recovery services or MAT. It currently operates in 17 counties.[ccxxxvii]
- **Move-in Assistance and Eviction Program (MIAEP):** MIAEP provides state-funded assistance for rent, damage deposit, utilities, or other approved costs directly related to housing to adults and households who are diagnosed with SMI or co-occurring SUD, homeless or at risk of homelessness, and receiving behavioral health services. The program provides $1,000 grants to approximately 544 households in all counties across the state and is available once every three years to eligible individuals.[ccxxxviii] [ccxxxix]
- **Substance Use Transitional Housing (Oxford House):** Substance Abuse Transitional Housing provides state-funded and National Opioids Settlement-funded support to Oxford Houses, which are self-run, congregate living homes for individuals who are diagnosed with and recovering from SUD and/or co-occurring SMI and participating in MAT services. Oxford Houses provides a structured living environment for participants to achieve the behavior change necessary to avoid relapsing and for long-term recovery. There are 17 sites for men, women, and children across the state.[ccxl]
- **Recovery Housing Program (RHP):** RHP provides HUD-funded stable, independent housing and recovery services for low- to middle-income adults who are diagnosed with SUD. The RHP was authorized under Section 8071 of the federal Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. MFA administers funds received from HUD's Community Development Block Grant statewide and oversees the development, implementation, distribution, and reporting of RHP activities. Between October 2024 through September 2025, MFA awarded five Recovery Housing projects that served 107 individuals, 38 of whom transitioned to permanent supportive housing.[ccxli, ccxlii, ccxliii]
- **Emergency Solutions Grant (ESG) and HOME-American Rescue Plan (HOME-ARP) Rapid Rehousing and Homeless Prevention Program:** MFA draws upon two federal funding sources—ESG and HOME-ARP—to provide short- and medium-term rental assistance and supportive services for low-income individuals and families who are homeless or at risk of homelessness to regain housing stability. Funds may be used for housing development, rental, utility, and housing deposit assistance, supportive services, and non-congregate shelter. Program participants must also meet with a case manager at least once per month for assistance in navigating to long-term supportive housing.[ccxliv, ccxlv, ccxlvi] Dollars are currently allocated as follows:
    - Albuquerque (Bernalillo County): $7,412,150
    - Las Cruces (Doña Ana County): $1,778,071
    - Statewide: $19,577,257

- **Gateway Recovery:** In Albuquerque, the Albuquerque Gateway Center covers 46 state-funded recovery pallet homes for individuals in need of SUD services for up to 24 months or until they are connected to longer-term recovery housing.[ccxlvii]

- **Emergency Homeless Assistance Program (EHAP):** MFA combines ESG and state funding to deliver EHAP, which provides certain essential services within emergency shelters for individuals and families experiencing homelessness, including access to safe and sanitary shelter and supportive services.[ccxlviii, ccxlix]
- **Homeless Shelters:** BHSD funds the following shelter providers:[ccl, ccli]
    - Battered Families Services, Inc.
    - Interfaith Community Shelter Group, Inc.
    - Saint Elizabeth Shelter Corporation
    - Valencia Shelter Services
- **BISF Program Initial and Emergency Housing Costs:** BISF provides state-funded assistance to cover initial or emergency rent, security deposit, utility start-of-service, or one-month maintenance of service charges for individuals of all ages who are diagnosed with brain injury (either ABI or TBI) and residents of New Mexico. This assistance may be provided just once in one's lifetime unless an exception is made in writing by the BISF program manager at HCA.[cclii]

Outreach and Housing Navigation Support Services

New Mexico also administers various outreach and navigation services providing case management and pre-tenancy supports for individuals with behavioral health needs. Like the transitional and interim housing assistance programs identified above, none of these programs rely on federal Medicaid matching funds and/or waiver authority for implementation but are supported by state and federal funds. These include:

- **Almost Home Case Management:** This program provides state-funded case management services for individuals ages 18 and over in Bernalillo County (Alburquerque) who are diagnosed with SMI and homeless or precariously housed.[ccliii]
- **Projects for Assistance in Transition from Homelessness (PATH):** PATH provides federally funded supportive services, including screening, diagnostic treatment, rehabilitation, housing, and case management, for adults who are diagnosed with SMI and/or co-occurring SUD and experiencing homelessness.[ccliv]
- **Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) Outreach, Access and Recovery (SOAR):** SOAR provides state-funded navigation support in obtaining approval for disability income benefits administered by the SSA for individuals ages 18 and over in Bernalillo, Grant, and Santa Fe counties who are diagnosed with SMI, medical impairment, and/or co-occurring SUD and homeless or at risk of homelessness. This program previously received federal training funds administered by SAMHSA, which were recently cut.[cclv]

Appendix C - Summary of Select Other States' 1915(i) State Plan Amendments (SPAs) for People with Complex Behavioral Health Conditions and Brain Injury

In developing recommendations for a proposed 1915(i) SPA for New Mexico, Manatt reviewed a sample of other states' 1915(i) SPAs targeted toward individuals with significant behavioral health needs and brain injury. **Table 3** below includes the need-based eligibility criteria and target groups for four states—North Carolina, Ohio, Oregon, and Texas. **Table 4** displays the benefits covered by each of these states. Manatt Health referenced this group of states because they have elected to pursue varying approaches to the 1915(i) eligibility criteria and benefit package.

Appendix Table 3. 1915(i) Eligibility Criteria in Select States

NC[cclvi, 97]	OH[cclvii]	OR[cclviii]	TX[cclix]
Needs-based Eligibility Criteria			
Individuals must have a need for support in acquiring, maintaining, and retaining skills needed to live and work in the community, as evidenced by at least one functional deficit in ADLs, IADLs, social and/or work skills.	Individuals must: 1. Have been assessed using the Adult Needs and Strengths Assessment (ANSA) and scored a 2 or higher on the "Behavioral/Emotional Needs" or "Risk Behaviors" domains or scored a 3 on the 'Life Functioning' domain. 2. Demonstrate needs related to the management of his or her behavioral health or diagnosed chronic condition as documented in the ANSA. 3. Demonstrate a need for HCBS outlined in the State Plan 1915(i) application and would not otherwise receive that service. 4. Have at least one of the following risk factors prior to enrollment in the program: (a) One or more psychiatric inpatient admissions at an inpatient psychiatric hospital; or (b) A discharge from a correctional facility with a history of inpatient or outpatient behavioral health treatment; or (c) Two or more emergency department visits with a	Individuals must have a need for assistance in two IADLs due to the symptoms of behavioral health condition. IADLs include but are not limited to housekeeping, including laundry, shopping, transportation, medication management, and meal preparation. Assistance is defined as hands-on supervision, and/or cueing.	Individual has a functional need demonstrated by an ANSA score of 2 or higher, which indicates the need for hands-on assistance, in at least one of the following 6 items in the Life Domain: physical/medical, family functioning, employment, social functioning, living skills, residential stability. In addition, the individual must meet one of the following: 1. A history of extended or repeated stays(s) in an inpatient psychiatric hospital (i.e., three years or more of consecutive or cumulative inpatient psychiatric hospitalization during the

[97] Some of North Carolina's benefits are only offered to certain age or disability groups.

NC[cclvi, 97]	OH[cclvii]	OR[cclviii]	TX[cclix]
	psychiatric diagnosis or diagnosed chronic condition; or (d) A history of treatment in an intensive outpatient rehabilitation program for greater than ninety days; or (e) One or more inpatient/outpatient admissions due to a diagnosed chronic condition. And either 5. Have one of the following needs based risk factors: requires the HCBS level of service to maintain stability, improve functioning, prevent relapse, maintain residence in the community, AND who is assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning). Or 6. Previously have met the needs-based criteria above AND who is assessed and found that, but for the provision of HCBS for stabilization and maintenance purposes, would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).		five years prior to initial enrollment in program). 2. In the three years prior to initial enrollment in the program, two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and four or more repeated arrests or discharges from correctional facilities. 3. In the three years prior to the initial enrollment in the program two or more psychiatric crises (crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and fifteen or more total emergency department visits.
Target Groups			
Persons ages 3 and older with I/DD, TBI, SMI (including severe and persistent mental illness (SPMI)), SED, or severe SUD.	SPMI target group: Persons who have been determined to meet the Social Security Administration's definition of disability who are age 21 and over and who are diagnosed with SPMI. *State also includes a chronic condition target group.*	Persons who are twenty-one years of age or older with a chronic mental illness (i.e., chronic schizophrenia, a chronic major affective disorder, a chronic paranoid disorder, or another chronic psychotic mental disorder	People over the age of 18 who meet the criteria for SMI.

NC[cclvi, 97]	OH[cclvii]	OR[cclviii]	TX[cclix]
		other than those caused by substance abuse).	

Appendix Table 4. 1915(i) Benefits in Select States

Service Category	NC[cclx, cclxi]	OH[cclxii]	OR[cclxiii]	TX[cclxiv]
Personal care in person's own residence/non-provider-owned setting	Community living and support	---	In-home personal care	Host home/companion care, supported home living
Skills training/development in non-provider owned setting	Individual and transitional support	---	Community-based integrated supports, psychosocial rehabilitation	Psychosocial rehabilitation
Residential habilitation in provider-owned settings	---	---	Residential habilitation	Supervised living services, assisted living services
Rehabilitative services	---	---	Psychosocial rehabilitation	Community psychiatric supports and treatment, peer supports, SUD services beyond State Plan
Home health care	---	---	---	Nursing
Respite	Respite	---	---	Respite
Equipment, technology, & modifications	---	---	---	Adaptive aids, minor home modifications
Non-medical transportation	---	---	Community transportation	Transportation
Supported employment	Individual Placement Supports	Individualized Placement and Support-Supported Employment	---	Employment services
Home-delivered meals	---	---	Home-delivered meals	Home-delivered meals
Community transition services	Community transition	---	Transition services	Transition assistance services
Tenancy supports	---	---	Housing support services, pest eradication services	---
Case management *Note: 1915(i) rules require an independent assessment of need and development and implementation of a person-centered service plan. Often, these functions are referred to as case management. Some states cover case management as a 1915(i) benefit, while others use a different approach.*[cclxv]	Provided via separate Health Home benefit by a community-based provider or health plan	Approved as a 1915(i) service, "Recovery Management," and provided by a Recovery Management Entity/Provider	Approved as an administrative function under the 1915(i) SPA; state contracts with "Independent and Qualified Agent" that performs needs-based assessments and supports development and implementation of service plan	Approved as a 1915(i) service, "Recovery Management" and provided by a Recovery Management Entity/Provider

Appendix D - Stakeholder Engagement Approach

The findings and recommendations in this report were informed by input from a diverse range of stakeholders, including through 40 interviews, three public listening sessions, and 26 written comments.

Interviews. Manatt Health conducted 16 interviews with a broad cross-section of stakeholders, including advocates, behavioral health providers, managed care organizations, state provider associations, and representatives from other state agencies, such as CYFD, the Department of Corrections, and the Office of Housing within the New Mexico Department of Workforce Solutions. Manatt also conducted 17 interviews with officials from the New Mexico HCA, including experts from New Mexico Medicaid and BHSD. To ensure the perspectives of individuals with lived experience were reflected, Manatt partnered with KAI, an American Indian- and woman-owned firm specializing in culturally responsive research and evaluation, to conduct seven key informant interviews with individuals and families who access behavioral health services across New Mexico. (*See **Appendix Table 5**: List of Organizations/Individuals Interviewed.)*

Public listening sessions. Manatt and KAI hosted three public listening sessions —for providers and other stakeholders; individuals, families, and caregivers; and Tribal partners— to gather broader input from communities across the state. In advance of the listening sessions, Manatt and HCA developed and distributed materials publicizing the event, including notification of the public forums for providers and stakeholders; individuals, families and caregivers; and Tribal partners. The notifications were distributed via email, a provider blast, and published in the *Albuquerque Journal* and *Las Cruces Sun News.* In total, 254 individuals participated in the listening sessions (170 individuals attended public forum for providers and stakeholders; 45 individuals attended public forum for individuals, families, and caregivers; and 39 individuals attended public forum for Tribal partners). *(See **Appendix E** for Listening Session Key Takeaways)*

Written comments. Twenty-four individuals submitted 26 written comments, representing feedback from advocacy groups, providers, individuals with lived experience, and family members. Written public comments were accepted from November 26 through December 12, 2025.

Appendix Table 5: List of Organizations/Individuals Interviewed

Organization	Interviewees
BH Providers Association of New Mexico	• Phillip Huston, Secretary • David Ley, President of the Board of Directors • Maggie McCowen, Executive Director
Brain Injury Providers	• LouElla Tafoya, Brain Injury Alliance of NM • Miquela Ortiz Upston, Brain Injury Alliance of NM • Fallon Wentzel, Care Network Resource Group • Christina Gomez, Care Network Resource Group • Linsey Neal, Care Network Resource Group • Ed Gellis, HelpNet LLC • Michelle Harmon, ARCA
Brain Injury Alliance of New Mexico	• Margot Feldvebel, President • Other consumers and advocates brought to the meeting by the Brain Injury Alliance of New Mexico
CCBHC: Carlsbad Life House	• Phillip Huston, Executive Director and Founder • Pennie Morton, Regional Director

Organization	Interviewees
CCBHC: Families & Youth Innovations Plus	• Dr. Mara Muraven, Chief Medical Officer and Medical Director • Kathryn Schmidt, LCSW, CCBHC Program Director
CCBHC: Mental Health Resources	• Lacy Keith, CEO
CCBHC: Presbyterian Medical Services	• Stacey Romero, Director of Behavioral Health • Doug Smith, Executive VP
CCBHC: Santa Fe Recovery Center	• Donna Magnuson, Chief Strategy Officer • William Becker, Vice President of Community-Based Services • Heather King, Chief Strategy Officer
CCBHC: University of New Mexico Health System	• Rodney McNease, Executive Director of Government Affairs
Coalition for a Safer Albuquerque	• Javier Benavidez, Organizer • Jerry Ortiz y Pino, Social Worker, and former New Mexico State Senator
Housing New Mexico	• Donna Maestras-De Vries, Chief Housing Officer • Robyn Powell, Director of Policy and Planning • Kellie Tillerson, Director of Community Development • Axton Nichols, Program Manager
Key Informant Interviews	• 7 interviews, representing individuals with lived experience navigating Medicaid-funded services, family members of individuals with behavioral health conditions, Tribal leaders, and program administrators, IHS and Tribal 638 facility staff and professionals with expertise in justice system transitions and tribal law.
MCO: Blue Cross Blue Shield of New Mexico	• Amber Lawrence, Utilization Management team • Jennifer Patton, Project Manager, Behavioral Health team
MCO: Molina Healthcare of NM	• Valerie Corral, Government Contracts team • Charlene Espinoza, Supervisor of Care Coordination • Victoria Perez, Provider Relations team
MCO: Presbyterian Health Plan (PHP)	• Amber Grewal, BH Services Representative • Dr. Ranota Hall, Complex Discharges Representative • Amy Hallquist, Claims Representative • Dr. Robin Napoleone, Medicaid CMO • Samantha Satriana, Clinical Operations Representative • Gabe Sena, BH Services Representative
MCO: United Healthcare Community Plan of New Mexico (UHC)	• Anneke Frankel, Chief Operating Officer • William Palmer, Clinical Program Manager • Quanah Walker, Behavioral Health Executive Director

Organization	Interviewees
New Mexico Behavioral Health Institute	• Tim Shields, Executive Director
New Mexico Brain Injury Advisory Council (BIAC)	• Adrienne Bratcher, BIAC Chairman • Mirella Galvan-De La Cruz, BIAC Vice Chair • Angelia Velarde-Logsdon, BIAC Program Manager • Additional BIAC members
New Mexico Children, Youth and Families Department	• Kristin Doellinger • Elizabeth Hamilton • Jolene Mondragon (BHSD/CYFD)
New Mexico Coalition to End Homelessness	• Monet Silva, Executive Director • Mark Oldknow, Associate Director
New Mexico Department of Corrections (NMDC)	• Wenceslaus Asonganyi, Health Services Administrator • Wendy Price, Behavioral Health Bureau Chief • Pamela Smith, Deputy Programming NMDC
New Mexico Health Care Authority	• Jonathan Baskin (BHSD) • Richard Bell (HCA) • Kristen Borderswood (MAD) • Margaret Bost (MAD) • Nick Boukas (BHSD) • Melanie Buenviaje (DDSD) • Crystal Cantu (BHSD) • Heidi Capriotti (MAD) • Teri Cotter (DHI) • Christopher Futey (DDSD) • Scott Gagnon (BHSD) • Russel Grayson (HCA) • Jennifer Guhl (BHSD) • Alexandra Herrera (MAD) • Lisa Howley (BHSD) • Ashli Jackson (HCA) • Jennifer Jones (MAD) • Christina Kupferschmidt (MAD) • Nancy Laster (DHI) • Erica Leyba (MAD) • Kathy Leyba (MAD) • Patricia Lopez (MAD) • LeeAnn Lopez (BHSD) • Annabelle Martinez (BHSD) • Jason Martinez (BHSD) • Joseph Mirabal (MAD) • Jackie Nielsen (BHSD)

Organization	Interviewees
	• Kresta Opperman (MAD) • Michael Padilla (BHSD) • Nicholas Palmisano (BHSD) • Lori Pena (MAD) • Jennifer Rodriguez (DDSD) • Jeanelle Romero (MAD) • Elena Sanchez (HCA) • Bianca Schultz (MAD) • Maurella Sooh (DHI) • Tami Spellbring (BHSD) • Valerie Tapia (MAD) • Tallie Tolen (MAD) • Prescillas Torres (MAD) • Jason Trujillo (MAD) • Prescilla Torres (MAD)
New Mexico Hospital Association (NMHA) and Invited Members	• Amy Alexander, NMHA member • Erika Campos, President, Hospital Services Corporation • Brad Cherry, NMHA member • Troy Clark, President and CEO • Kathleen Dostalik, NMHA member • Sandy Emanuel, NMHA member • Brandon Estrada, NMHA member • Manon Gouse, Senior Director, Quality & Patient Safety • Mario Guzman, NMHA member • Rodney McNease, NMHA member • Jeanette Rodgers, NMHA member • Julia Ruetten, Senior Director, Government Affairs
New Mexico Medicaid Advisory Committee	• Larry Martinez, Committee Chair
New Mexico Society for Addiction Medicine	• Kurt Lebneck, Executive Director
Office of Housing in New Mexico Department of Workforce Solutions	• Maria Wolfe, Manager of Homeless Initiatives • Dudek Forrest, Project Manager • Roslynn Gallegos, Senior Project Manager
Primary Care Council (PCC)	• John Andazola, Member • Jon Helm, Member • Matt Probst, Member • Valory Wangler, PCC Chair
Serenity Mesa	• Jennifer Burke, Executive Director

Organization	Interviewees
UNM Center for Health Policy	• Dr. Annette Crisanti, Vice Chair • Margaret Greenwood Ericksen, Associate Professor of Emergency Medicine

Appendix E - Listening Session Key Takeaways Provider and Other Stakeholders

Overall, 170 individuals registered and attended the three public listening session, representing a diverse mix of roles and expertise from across the state—including senior leaders from provider practices (e.g., CEOs and executive directors), social workers, case managers, brain injury rehabilitation physicians, residential rehabilitation facility administrators, hospitalists, and other stakeholders (e.g., MCOs, NAMI representatives, and local governments such as the City of Santa Fe, Otero County, and Bernalillo County). 149 out of 170 attendees disclosed the county they represent when registering for the webinar, representing 21 of New Mexico's 33 counties: Bernalillo, Chaves, Cibola, Colfax, Curry, Doña Ana, Guadalupe, Hidalgo, Lincoln, Los Alamos, Luna, McKinley, Otero, Rio Arriba, San Juan, San Miguel, Sandoval, Santa Fe, Sierra, Taos, Valencia. It is unclear the extent to which the 21 individuals who did not disclose their county represent the other 12 counties in New Mexico.

Summary of Key Themes

1. Supportive Housing and Supervised Living Arrangements

Stakeholders voiced a need for supportive housing and supervised living arrangements for individuals with SMI or brain injury, highlighting gaps such as the absence of small, trauma-informed group homes for people with SMI.

1.1 Gaps in providing stable housing and supervised living arrangements: Several stakeholders urged the development of supportive housing and supervised living environments for those with SMI or brain injury. Concerns were raised that the lack of housing support leaves many individuals without a safe supportive place to live while receiving care. In particular, a key gap that was raised was the lack of "small, trauma-informed group homes."

- One stakeholder raised that part of the need for supportive housing is to have "places [for people] to spend time with other people and develop relationships with [others]."
- Another stakeholder highlighted, "several gaps in care that are not Medicaid or private insurance eligible [include] … respite services, supportive housing and employment, long-term group homes, day programs, etc."

2. Gaps in Case Management and Care Navigation

Stakeholders voiced widespread support for stronger and greater availability of high-quality intensive case management for individuals with SMI, SED, and SUD, especially during transitions and in rural areas where services are limited.

2.1 SUD, SMI, SED patients falling through the cracks: There were concerns that not all individuals across the state with SMI, SED, SUD have access to intensive case management. In particular stakeholders stressed the need for intensive care coordination and better case management to ensure they do not fall through the cracks, including during transitions of care. Stakeholders highlighted that one area where there is a more acute need for case management is in rural communities where behavioral health and brain injury services are more limited and challenging to access.

2.2 Establishment of a knowledge hub: Several stakeholders voiced the desire for a centralized hub (e.g., online platform) that lists available resources and services for people with SMI, SED, SUD, and brain injury. Some counties/providers already use such a system, and stakeholders believe there is an opportunity to expand these resources statewide.

3. **Input on Merits of a New Medicaid Waiver**

Several stakeholders voiced support for a waiver to serve people with SMI, SUD, SED, and brain injury. They pointed to New Mexico's existing 1915(c) DD waiver as a potential model, recommending that something similar be made available for people living with SMI, SED, SUD, and/or brain injury.

- **3.1 Strong support for a new waiver with a few cautionary notes**: Several stakeholders voiced their strong support for a new waiver that would cover services for people with SMI, SUD, SED, or brain injury. Many indicated that they believe the state's current 1915(c) DD waiver works effectively to provide people with intensive case management, supportive housing, and wraparound services in the community. They suggested it could be leveraged as a model to provide similar services to high-need individuals with SMI, SED, SUD, and/or brain injury. Of particular interest is "supportive housing, improved access to services, family respite services, and assisted case management." Among supporters of a new waiver, some noted that if a new waiver is to work well, New Mexico would need to expand its workforce.

4. **Workforce Shortages, Provider Capacity Constraints and Geographic Inequities**

Many stakeholders reported that New Mexico struggles with workforce shortages and suggested that provider capacity issues serve as the major barrier to improving care for people with SMI, SUD, SED, and brain injury.

- **4.1 Workforce shortages are a system-wide constraint:** Overall, stakeholders highlighted that the current system is constrained in its ability to meet the needs of individuals living with complex behavioral health issues or brain injury due to a shortage of qualified providers. Among other things, there is a particular need for additional occupational, speech, and behavioral therapists, along with direct support care workers.
- **4.2 Rural and frontier areas experience the most severe shortages:** Stakeholders indicated that rural and frontier communities face the sharpest shortages. Several stakeholders offered ways to mitigate the issue, such as by expanding the use of telehealth, although they also suggested that such a strategy would require the state to revisit licensure reciprocity laws.
- **4.3 Provider caseloads and burnout compound workforce shortage challenges:** Stakeholders cited that a core issue driving provider shortages is unrealistic caseloads, which result in providers "burning out" and moving to new careers or positions. They also suggested that higher wages could help to incentivize providers to remain in practice.

5. **Supply of Treatment Options and Access Points**

Stakeholders highlighted the importance of providing high-need people with SMI, SED, SUD, and/or brain injury with more access to "step-down" care, detox beds, and in-state residential treatment.

- **5.1 Timely access to step-down care:** Stakeholders reported struggles with finding residential treatment programs for individuals with SUD and/or severe mental health needs who need to be discharged from a hospital, resulting in them getting stuck in the hospital or rapidly returning to homelessness.
- **5.2 Lack of detox beds:** Stakeholders suggested that there is a lack of detox beds available to people enrolled in Medicaid or receiving BHSD-funded services. Even though such treatment is available for private-pay patients, many public facilities are over capacity, leaving low-income individuals without an affordable option.
- **5.3 Limited capacity for individuals needing intensive treatment or specialized care:** Stakeholders cited challenges finding intensive treatment, including residential treatment, for individuals with more specialized needs (e.g., co-occurring disorder programs, brain injury rehab, long-term psychiatric care). Individuals in need of such services may have to go out of state to receive care.

For example, a stakeholder indicated that their organization had to send multiple clients with dual diagnoses out of state for treatment because there were no appropriate options open within the state of New Mexico.

6. Provider Reimbursement and Related Concerns

Providers voiced broad concerns over a lack of resources and appropriate reimbursement rates available for services provided to individuals living with SMI, SED, SUD, and/or brain injury**.**

6.1 Provider reimbursement constraints: In general, stakeholders raised concerns about reimbursement rates, noting that high no-show rates add to the financial burden associated with serving Medicaid enrollees. They also suggested that extensive travel distances in rural and frontier areas make it financially challenging to offer some services – such as Comprehensive Community Support Services (CCSS) in these regions.

6.2 Lack of provider supports and funding: Providers also cited a lack of reimbursement or funding to support their efforts to conduct outreach and enrollment to engage people in services. For example, they suggested that they must spend considerable unbilled time marketing, assisting patients with care navigation, and helping them identify what services are available to them.

7. Unique Tribal Population Considerations

Stakeholders voiced the need for the state to consider the unique needs and challenges that tribal populations have as it relates to where they receive care – often in rural communities – and the services that are available on tribal lands.

7.1 Tribal populations have a disproportionate need for services: In general, stakeholders reported that tribal populations face especially high rates of SUD, SMI, SED, and brain injury. One stakeholder, for example, cited a recent community health survey that found that substance use disorder is the top issue of concern for their tribe, but, even so, there is a lack of public detox facilities available to tribal members.

7.2 Lack of services on tribal lands: Stakeholders also described challenges with being discharged from Emergency Rooms and hospitals before they are stable and then having to return to reservations where outpatient services are insufficient.

8. Continuity of Care and Care Transitions

Overall, providers face challenges helping people to move from higher-acuity settings to lower acuity settings, reflecting a lack of treatment options per Item #5, but also a lack of knowledge about how to make linkages from one setting to the next.

8.1 Poor continuity of care: Providers report patients getting "lost" in transitions of care as they step down from high acuity settings to the next level. In particular, providers face challenges getting patients directly into residential and outpatient rehab programs because they lack knowledge of available options or simply cannot make the hand offs work as intended. One stakeholder described the linkages that should be in place to help people move from the hospital into community-based care settings as "broken."

9. Transportation

Low-income individuals and those with complex behavioral needs require better and more reliable transportation systems to help them remain in the community while receiving treatment.

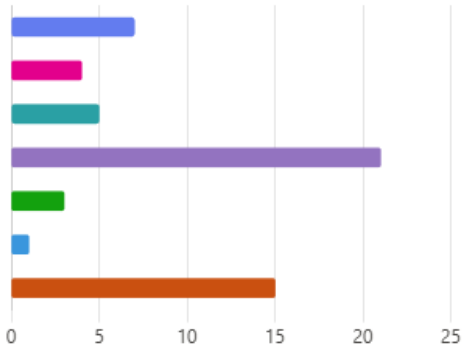
9.1 Breakdowns in transportation: Several stakeholders cited challenges with the current system of transportation including no-shows and late rides as being key barriers to patients receiving timely treatment. In order for patients to consistently receive treatment in the community, stakeholders suggested that improvements in non-emergency medical transportation are needed to ensure patients are receiving care and not falling through the cracks.

Post-Listening Session Survey Results

Overall, fifty-three people participated in the post-listening session survey. Questions 1 – 4 collected demographic information of respondents and are therefore not included.

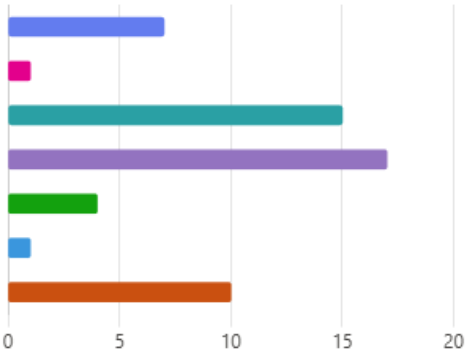
5. What is the biggest barrier to delivering care to New Mexicans with SMI, SED, and SUD?

a) Medicaid reimbursement rates / rate changes	7
b) Administrative barriers to Medicaid enrollment	4
c) Lack of training to serve these populations	5
d) Need for capacity building funds to offer new services or build the workforce	21
e) Difficulty addressing transportation barriers	3
f) Confusion around what is covered by Medicaid or state funds	1
Other	15



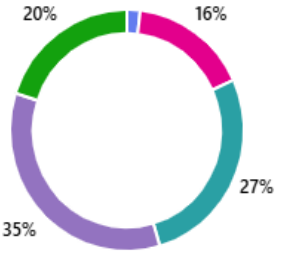
6. What is the biggest barrier to delivering care to New Mexicans with BI?

a) Medicaid reimbursement rates / rate changes	7
b) Administrative barriers to Medicaid enrollment	1
c) Lack of training to serve these populations	15
d) Need for capacity building funds to offer new services or build the workforce	17
e) Difficulty addressing transportation barriers	4
f) Confusion around what is covered by Medicaid or state funds	1
Other	10



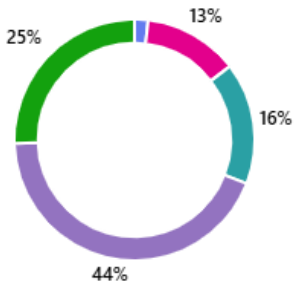
7. How confident do you feel that New Mexicans with SMI, SED, or SUD can access Medicaid-covered behavioral health services wh en needed (e.g., therapy, substance use treatment)?

a) Very confident	1
b) Somewhat confident	9
c) Neutral	15
d) Somewhat unconfident	19
e) Not confident	11



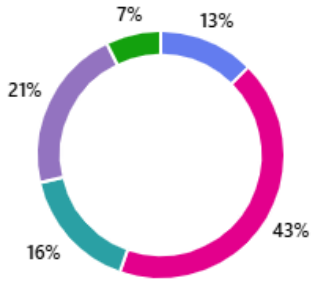
8. How confident do you feel that New Mexicans with BI can access Medicaid-covered brain injury services when needed (e.g., hom e and community-based services, including help with daily activities, home modifications)?

a) Very confident	1
b) Somewhat confident	7
c) Neutral	9
d) Somewhat unconfident	24
e) Not confident	14



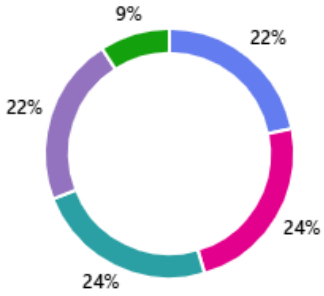
9. What is the biggest barrier for individuals to receive behavioral health services?

a) No access to a provider	7
b) Wait list/provider capacity	24
c) Services not available in region	9
d) Limitations on covered services	12
Other	4



10. What is the biggest barrier for individuals to receive brain injury services?

a) No access to a provider	12
b) Wait list/provider capacity	13
c) Services not available in region	13
d) Limitations on covered services	12
Other	5



11. In a few words, what is one change that would make the biggest impact for New Mexicans who use behavioral or brain injury services?

Forty-nine stakeholders had varying responses that largely covered the following themes that would make the biggest impact: increase provider capacity and access, enhance Medicaid reimbursement and funding, expand and clarify covered services, address administrative and systemic barriers, invest in workforce training and development, improve transportation and social supports, and policy and system innovations.

Individuals, Families, Caregivers and Other Stakeholders

Overall, 45 individuals registered and attended the listening session for individuals, families and caregivers, representing a diverse mix of backgrounds and experience—including individuals with complex behavioral health (BH) conditions, parents with children that have I/DD, SMI, SUD, SED and brain injury, patient advocates, behavioral health professionals, and representatives of non-profit organizations. 40 out of 45 attendees disclosed the county they represent when registering for the webinar, representing 8 of New Mexico's 33 Counties: Bernalillo, Dona Ana, Hidalgo, Luna, Otero, Sandoval, Santa Fe, and Taos. It is unclear the extent to which the 5 individuals who did not disclose their county represent one of the other 25 counties in New Mexico.

Summary of Key Themes

1. Inputs on Case Management and Navigation

Stakeholders voiced a broad-based need for improved case management and navigation services to help families and individuals navigate the system as they are typically not well-equipped to do so on their own.

1.1 System is complex and hard to navigate: Families and individuals highlighted the burden of finding the programs and services that are available – citing that there is not a central source of information for people with SMI, SED, SUD and brain injury care needs – "we have a tough system to navigate. Information is not easy to access. It is easier to navigate the DD waiver than find BH services."

1.2 Improved case management: Stakeholders were broadly aligned with the need for better case management, noting that the burden of finding services usually falls on the individual seeking help even if they are not in a position to self-advocate due to their cognitive or behavioral health challenges. In particular, one individual raised the need for a new targeted case management benefit to better manage the unique needs of complex behavioral health populations. Another stakeholder suggested that there is little awareness of CareLink – New Mexico's Health Home program that has 12 sites throughout the state. Finally, a stakeholder said that Assertive Community Treatment (ACT) Teams are helpful, but they need to provide more follow up and support to patients and their families.

1.3 Breakdowns in transitions of care: Stakeholders cited major breakdowns in care coordination at the point of discharge. Among other issues, members with lived experience and family members described problems with ensuring that essential medications are maintained when someone must change facilities or care settings.

2. Inputs on Housing Supports, Group Homes and Adult Foster Care

Many stakeholders highlighted that a key need for people is stable housing, adult foster care and programs that give individuals with complex behavioral health issues a safe and supportive environment in which to recover.

2.1 Need for stable housing services: When they are available, family caregivers reported that housing vouchers are extremely helpful, but they also said that they do not think there are enough of them. They pointed to group homes for people living with I/DD as a potential model; as one stakeholder put it, "we need waiver-type supported living for children / youth with SED who are not safe at home. Numerous stakeholders reported that when their family members do not have a safe place to live, they are constantly worried and not sure when or how to intervene.

2.2 Current housing supports, including group homes, are not providing sufficient treatment for people with complex behavioral health issues. Stakeholders reported that even when their family members have a housing spot, they still may lack the treatment services needed to maintain stability when living with a complex behavioral health issue. For example, one stakeholder described their daughter's living situation as "she is in a 'group home' which is really a boarding house – nothing therapeutic about it. She needs a supportive living environment with therapy, daily living skills, etc."

2.3 Specific callouts for a waiver to address housing: A number of family members said that providing people with the type of supportive living available to people enrolled in the DD waiver would be helpful. They suggested that this level of care is vital for people with complex behavioral health conditions. As one member put it, "supported living arrangements [are key] so people [won't] be unhoused, institutionalized or jailed."

3. Inputs on New Waiver

Stakeholders raised the need for a new waiver, similar to the DD waiver.

3.1 Broader waiver authorities are needed to service these populations: Several participants highlighted the strengths of the current DD waiver; however, they expressed frustration with its narrow eligibility criteria. They noted that many of the services available in the DD waiver are needed by people living with complex BH conditions. One family member, for example, shared that "I have an adult child with schizophrenia and another adult child with autism. My daughter with autism is on the DD Waiver. My son is on Medicaid. My daughter has better access to care than my son. The difference between DDW case management and Turquoise Care care coordination is big. My son would benefit from DDW type case management."

4. Access Challenges

Access issues are a major barrier for many individuals seeking treatment, which can ultimately lead to individuals either never or inconsistently receiving care.

4.1 Challenges accessing outpatient care: Participants indicated that it can be difficult to gain access to outpatient care. One stakeholder described that the only way to access outpatient care from a major provider is to show up in-person during its limited walk-in counseling hours. Even so, the provider may have very limited capacity even if you can arrive during the narrow window during which it takes new patients.

4.2 Long wait-times. Other participants agreed that wait times pose meaningful barriers to accessing care in a timely manner – voicing a need for more convenient service hours to avoid inpatient admissions. As one stakeholder raised, "I don't know how things can change in order to make it more accessible for an individual to walk into a place and say, I need help with my meds or finding a therapist. A lot of times when you walk into the Medicaid office, there is a long line. Maybe there is a way to separate some of those services so that … you're not going into the same [physical place or line] that [people going on Medicaid for the first time are," so that those currently enrolled in Medicaid needing resources can be better attended to.

5. Workforce Shortages

Workforce shortages continue to add strain to the system, which stakeholders voiced as a concern that needs to be addressed in order for any future efforts to be successful.

5.1 Acute need for additional practitioners including paraprofessionals: Stakeholders raised the need for additional providers including psychiatrists, psychologists, counselors, and other providers to meet demand. In addition, it was suggested that there be more of a focus on recruiting paraprofessionals – especially peer support specialist – to address the workforce shortage because many clients are more comfortable knowing the person guiding them is a peer who has shared experience.

5.2 Cultural and bilingual gaps exist in current workforce: Stakeholders also stressed an urgent need for "bilingual/bicultural professionals" and services in all areas of behavioral health. One stakeholder suggested that the state may want to establish an alternative licensing system to allow people trained in other countries (e.g., "Mexico or Central America"), easing the burden of getting these individuals licensed to practice in New Mexico.

5.4 Lack of providers specializing in acute BH needs: Stakeholders cited that many practitioners today specialize in the treatment of generalized anxiety or moderate depression, but there is a significant need for practitioners who specialize in treating people with complex needs (i.e., SMI, SED, SUD, and brain injury).

6. Care Delivery

Stakeholders also voiced a need for better care that takes a holistic approach with a lens toward long-term recovery. In particular, there is a need for better integration of mental health and SUD services, as well as more of a focus on whole-person care that addresses the root causes of complex behavioral health needs. Stakeholders reported that often services feel disjointed and at some acuity levels – particularly inpatient – there is little integration of mental health and substance use disorder treatment services.

6.1 Need for more high-quality clinical services in residential and inpatient settings: Participants noted a lack of integrated SUD and mental health treatment in facilities and inpatient settings, as well as that "inpatient settings appear more like correctional facilities targeted toward introducing meds and then discharge, rather than working with clients in individual and group sessions or connecting them to community resources."

6.2 Need for more integrated, whole-person care: Stakeholders shared the need for more dual-diagnosis facilities that are equipped to handle patients with complex behavioral needs that integrate an array of services to better meet the whole-person needs of SMI, SED, SUD, and brain injury patients.

6.3 Lack of emphasis on more balanced and comprehensive treatment approaches: Stakeholders voiced concerns that current treatment plans do not prioritize the combination of therapy and psychosocial support that would be most effective. Participants also suggest that inpatient stays are not long enough – they should be at least 12 days instead of 5 or 7 days – and there is a missed opportunity to also provide therapeutic care during these stays.

Once patients are discharged from higher acuity settings, stakeholders also raised a need for more of a focus on treatment plans that prioritize step-down services such as intensive outpatient programs (IOP).

7. Inputs on (Health Insurance Portability and Accountability Act (HIPAA) and Privacy

Family members indicated that privacy laws make it uniquely challenging to advocate for their loved ones, creating barriers to their involvement in care decisions and overall management. In particular,

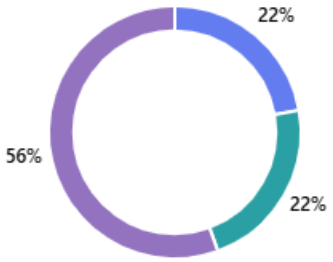
stakeholders raised the tension between the intentions of HIPAA privacy rules keeping patient information confidential and the need for caregiver involvement. For example, they noted it Is not uncommon for an adult family member in treatment to refuse to sign a release of information that would enable family members to assist in the management of their care.

Post Listening Session Survey Results

Overall, nine people participated in the post-listening session survey. Questions 1 – 4 collected demographic information of respondents and are therefore not included.

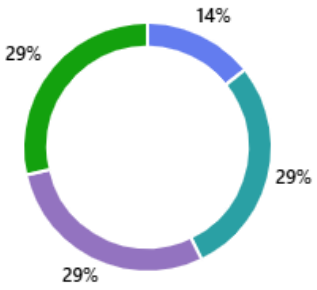
5. How easy or hard is it for you to find out what behavioral health services are available?

a) Easy	2
b) Somewhat Easy	0
c) Neutral	2
d) Somewhat Hard	5
e) Hard	0



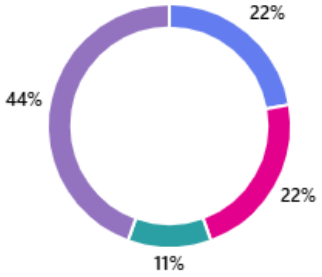
6. How easy or hard is it for you to find out what brain injury services are available?

a) Easy	1
b) Somewhat Easy	0
c) Neutral	2
d) Somewhat Hard	2
e) Hard	2



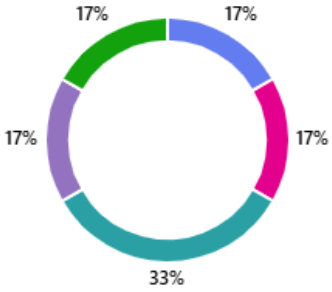
7. How confident do you feel that you or your family can access the behavioral health services you need, when you need them?

a) Very confident	2
b) Somewhat confident	2
c) Neutral	1
d) Somewhat unconfident	4
e) Not confident	0



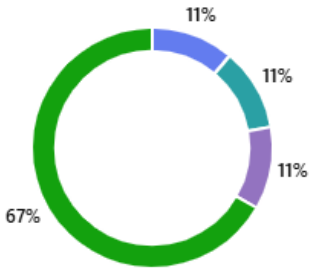
8. How confident do you feel that you or your family can access the brain injury services you need, when you need them?

a) Very confident	1
b) Somewhat confident	1
c) Neutral	2
d) Somewhat unconfident	1
e) Not confident	1



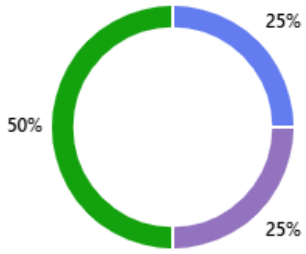
9. What is the biggest barrier to receiving behavioral health services?

a) I don't have access to a provider	1
b) Services are too expensive	0
c) It takes a long time to get an appointment for the service I need	1
d) The service I need is not available where I live	1
Other	6



10. What is the biggest barrier to receiving brain injury services?

a) I don't have access to a provider	1
b) Services are too expensive	0
c) It takes a long time to get an appointment for the service I need	0
d) The service I need is not available where I live	1
Other	2



11. In a few words, what is one change that would make the biggest impact on your ability to get the mental health, substance use or brain injury services you need?

- There really needs to be more providers, better coordination, and integration with medical issues.
- A step-by-step process of where to go, what to do, what to expect and how to proceed. It was scary and daunting in the beginning.
- More providers are needed.
- Programs for long-term care and treatment for SMI.
- Compassion, caring, respect, and dignity to those searching help instead of exacerbating situations. Communication between networks so patients are not over medicated.
- Improved access to information and additional behavioral health providers.
- We need paraprofessionals that are vetted and have the capacity to work with our communities. My time at the Hawthorn also exposed the lack of services in the family shelters.

Tribal Partners

Overall, 39 individuals attended the Tribal Partner Listening Session, which convened Tribal behavioral health leaders, clinicians, and community representatives to share perspectives on strengths, gaps, and priorities related to behavioral health and brain injury services in New Mexico. Participants brought experience working across Tribal behavioral health programs, clinical settings, youth, adult and elder services, and community-based systems of care. The discussion reflected diverse Tribal contexts, including rural and remote communities, and highlighted the importance of culturally-grounded approaches, service accessibility, and meaningful state–Tribal partnership in shaping future behavioral health policy and system improvements. 32 out of 39 attendees disclosed the county in which they reside when registering for the webinar, representing 8 of New Mexico's 33 counties: Bernalillo, Cibola, Doña Ana, Hidalgo, McKinley, San Juan, Sandoval, Santa Fe. It is unclear the extent to which the 7 individuals who did not disclose their county represent the other 25 counties in New Mexico.

Summary of Key Themes

1. Social Determinants of Health and Basic Needs

Stakeholders emphasized that behavioral health access and outcomes are deeply intertwined with unmet basic needs and infrastructure gaps in Tribal and rural communities. Participants consistently described food security, housing stability, transportation, employment, and access to clean water as foundational to effective behavioral health care.

1.1 Behavioral health is inseparable from basic needs: Several stakeholders noted that Tribal members are often forced to make difficult financial trade-offs, e.g., choosing between food, transportation, or attending appointments, which limits consistent engagement in care. Participants stressed that without addressing these underlying needs, behavioral health interventions alone are insufficient.

1.2 Rural and infrastructure barriers exacerbate access challenges: Stakeholders highlighted that rural geography and limited infrastructure significantly impact their ability to access services. Transportation gaps, long travel distances, and limited broadband access were cited as persistent barriers, particularly for individuals with SMI, SED, SUD, and brain injury who require frequent or coordinated services.

2. Service Availability, Capacity, and Continuum of Care

Participants raised that the current behavioral health and brain injury service array is insufficient to meet community needs, especially for youth, crisis services, and ongoing treatment in Tribal communities.

2.1 Gaps across prevention, crisis, and treatment services: Stakeholders described gaps across the full continuum of care—from prevention and early intervention to crisis response and long-term treatment. Several participants noted that crisis services are limited or entirely absent in many Tribal communities. Youth were identified as a particularly underserved population, with limited local supports contributing to isolation.

2.2 Out-of-state placements disrupt families and communities: Participants reported that limited in-state capacity often forces families to seek residential or specialized services far from home, including out-of-state placements for youth and individuals requiring intensive treatment. Stakeholders emphasized that these disruptions strain families, weaken continuity of care, and disconnect individuals from their cultural and community supports.

3. Cultural Relevance and Traditional Healing

Stakeholders strongly emphasized that culturally responsive, Tribal-led approaches are essential to effective behavioral health care for tribal communities. Participants noted that many existing services and treatment models do not align with Tribal worldviews or traditional healing practices.

3.1 Misalignment of existing models with Tribal cultures: Several stakeholders raised concerns that commonly used behavioral health models, such as standardized treatment frameworks or 12-step programs, do not reflect Tribal values or approaches to healing. Participants stressed that one-size-fits-all service models are ineffective given the diversity across Tribes.

3.2 Need to expand culturally grounded and traditional services: Stakeholders voiced strong support for expanding access to culturally grounded services, including traditional healing practices, and ensuring these services are recognized and supported within the broader behavioral health system. Participants also highlighted the importance of culturally compatible care environments, particularly for elders in group homes or residential settings.

4. Workforce Shortages, Training, and Provider Network Integration

Participants consistently identified workforce shortages and provider capacity constraints as major barriers to service access in Tribal communities.

4.1 Workforce shortages limit access across service types: Stakeholders noted significant shortages of trained professionals with expertise in substance use disorders, mental health treatment, and historical trauma.

4.2 Importance of integrating Tribal providers into networks: Stakeholders expressed a desire for stronger integration of Tribal programs into provider networks and closer partnerships with the State and managed care organizations. Participants highlighted nurse practitioners as a critical part of the workforce that should be fully integrated into service delivery models.

5. Care Coordination and System Navigation

Participants described persistent challenges related to navigating complex systems of care and referral pathways, which hinder continuity of care for Tribal members.

5.1 Fragmented care coordination and referral processes: Stakeholders noted that while managed care organizations are responsible for care coordination, individuals face challenges, including delays, in obtaining support. These delays contribute to gaps in care, particularly during transitions between service settings.

5.2 Need for dedicated navigators and better data access: Participants emphasized the value of dedicated navigators who can help Tribal members understand eligibility criteria, access services, and move through complex systems. Stakeholders also noted that limited access to comprehensive data constrains the ability of Tribal leaders to plan, advocate for, and ensure continuity of care.

6. Transportation and Infrastructure Barriers

Transportation was consistently cited as a critical barrier to accessing behavioral health and brain injury services in Tribal communities.

6.1 Inconsistent transportation limits service utilization: Stakeholders reported that unreliable transportation frequently prevents individuals from attending appointments or maintaining consistent engagement in care, particularly in rural and remote areas.

6.2 Need to expand behavioral health infrastructure: Participants highlighted the need for significant investment in behavioral health infrastructure, including clinics, crisis services, and treatment facilities, to support community-based care and reduce reliance on distant or inappropriate settings.

7. Stigma, Structural Factors, and Historical Trauma

Stakeholders emphasized that stigma, labeling, and historical trauma continue to shape behavioral health experiences and outcomes in Tribal communities.

7.1 Stigma and labeling can undermine engagement: Participants noted that diagnostic labels, particularly for children, can be discouraging or unhelpful, and may deter individuals from seeking support. Stakeholders also raised concerns that linking behavioral health issues with the justice system in legislation can reinforce stigma rather than promote healing.

7.2 Historical trauma and border-town dynamics: Stakeholders underscored the lasting impact of historical trauma on mental health, substance use, and alcohol misuse within Tribal communities. Participants also highlighted border-town dynamics as exacerbating challenges and requiring additional oversight and policy attention.

8. Funding, Sustainability, and Tribal-Led Solutions

Participants voiced concerns about the sustainability of behavioral health programs and the need for more stable funding mechanisms.

8.1 Reliance on grants limits long-term planning: Stakeholders noted that many Tribal behavioral health programs rely heavily on grants, which restrict long-term sustainability and service expansion. Additional funding was identified as necessary to build and maintain services in underserved rural communities.

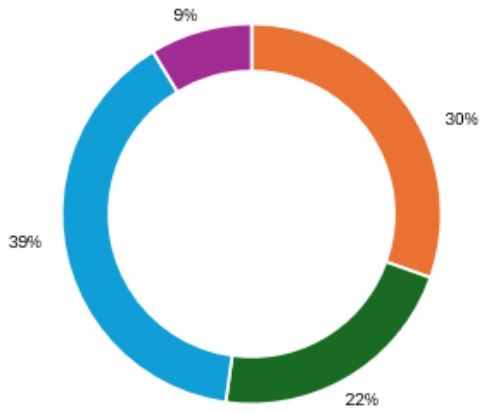
8.2 Interest in Tribal-led and community-based innovations: Several participants suggested exploring Tribal-led solutions, including street medicine and outreach-based models, to reach individuals where they live and better align services with community needs.

Post-Listening Session Survey Results

Overall, 24 people participated in completing the survey. To increase participation, select questions were administered during the listening session, while additional questions (questions 8 to 12) were included in a post-session survey. Of the 24 participants, six completed the post-listening session survey; responses from all respondents are reflected below. Survey Questions 1 – 5 collected demographic information of respondents and are therefore not included.

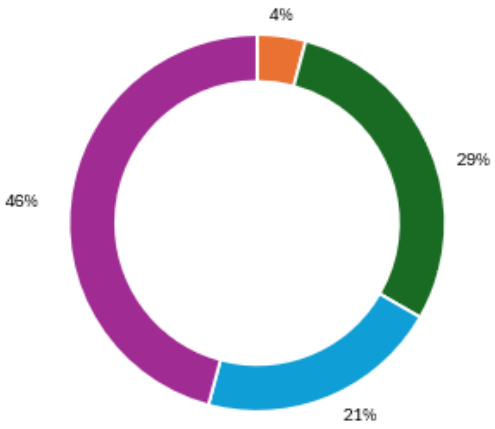
6. How easy or hard is it for you or your family to find out what behavioral health services are available?

a) Easy	0
b) Somewhat Easy	7
c) Neutral	5
d) Somewhat Hard	9
e) Hard	2



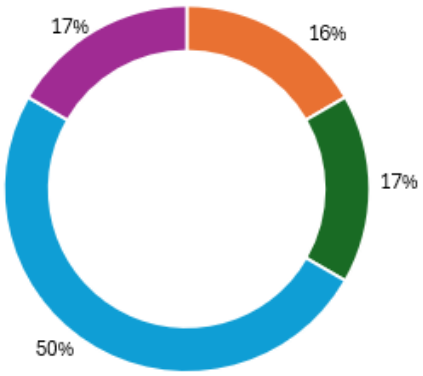
7. How easy or hard is it for you or your family to find out what brain injury services are available?

a) Easy	0
b) Somewhat Easy	1
c) Neutral	7
d) Somewhat Hard	5
e) Hard	11



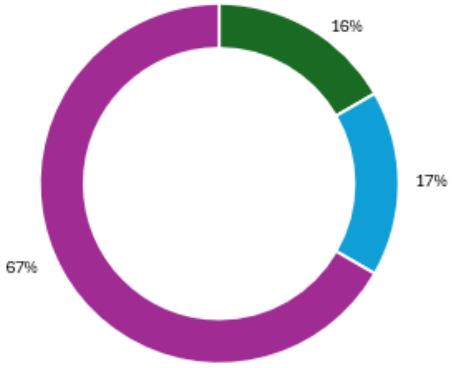
8. How confident do you feel that you or your family can access the behavioral health services you need, when you need them?

a) Very Confident	0
b) Somewhat confident	1
c) Neutral	1
d) Somewhat unconfident	3
e) Not confident	1



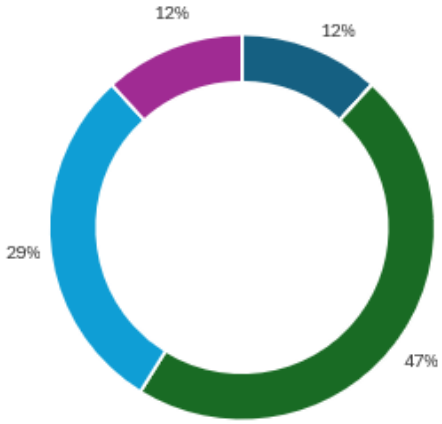
9. How confident do you feel that you or your family can access the behavioral health services you need, when you need them?

a) Very Confident	0
b) Somewhat confident	0
c) Neutral	1
d) Somewhat unconfident	1
e) Not confident	4



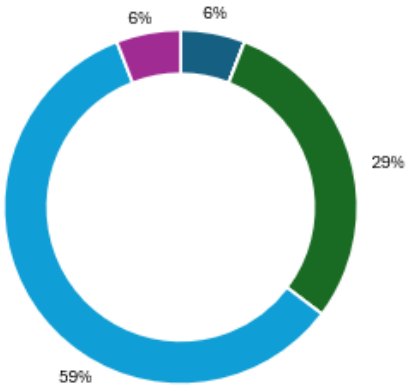
10. What is the biggest barrier to receiving behavioral health services?

a) I don't have access to a provider	2
b) Services are too expensive	0
c) It takes a long time to get an appointment for the service I need	8
d) The service I need is not available where I live	5
e) Other	2



11. What is the biggest barrier to receiving brain injury services?

a) I don't have access to a provider	1
b) Services are too expensive	0
c) It takes a long time to get an appointment for the service I need	5
d) The service I need is not available where I live	10
e) Other	1



12. In a few words, what is one change that would make the biggest impact for New Mexicans who use behavioral or brain injury services?
    Four stakeholders provided a response to this question. They highlighted gaps in adult brain injury services, workforce capacity, and system navigation, and called for expanded culturally responsive, wrap-around supports (e.g., therapy, peer mentorship, and rehabilitative services) accessible to all individuals, including those in Tribal communities.

Appendix F - Methodology for Estimating Cost of 1915(i) SPA

Summary of Methodology

The cost estimate for the potential 1915(i) SPA was developed by first identifying populations with behavioral health and brain injury diagnoses, then categorizing these individuals into targeted populations for the 1915(i) services and lastly attributing estimated costs for each proposed 1915(i) service to the targeted population. Each step is described in detail below.

Behavioral Health and Brain Injury Flags

Using July 2024 to June 2025 (SFY 2025) Medicaid services claims and enrollment data provided by the New Mexico Health Care Authority (HCA), Milliman identified the beneficiaries with behavioral health and brain injury diagnoses.

Beneficiaries were assigned a flag for SMI, SED, and/or SUD using the ICD-10 criteria included in HCA's SMI and SED Criteria checklists as outlined beginning on pg. 418 in the 2024 HCA Managed Care Policy Manual. In addition, Milliman applied the logic that an individual must also have at least one psychiatric inpatient stay or three emergency department visits in the given year. The flagging logic potentially over-flags individuals as Milliman was not able to apply some of the more subjective criteria included in the algorithm outside of the diagnostic and utilization information noted above. Milliman identified individuals with brain injury through diagnosis codes for moderate-to-severe brain injury.

To identify individuals with a history of incarceration, Milliman used a data file provided by HCA to flag individuals that were incarcerated at any point in SFY 2025. To identify individuals with a history of homelessness, Milliman used ICD-10 diagnosis codes to flag individuals with a homeless indicator (codes included Z59.0, Z59.1, Z59.81, Z59.89, or Z59.9).

Targeted Population

Milliman grouped SMI, SED, SUD, and brain injury beneficiaries into sub-populations from the Medicaid data to define a targeted population for the proposed 1915(i) services. These sub-populations include adults that meet one of the following criteria:

- Criterion 1: Adults with SMI or SUD with a history of incarceration in SFY 2025 and a psychiatric inpatient, emergency room, or crisis service utilization in SFY 2025.
- Criterion 2: Adults with SMI or SUD with a history of homelessness in SFY 2025 and a psychiatric inpatient, emergency room, or crisis service utilization in SFY 2025
- Criterion 4: Adults with SMI or SUD and a Community Benefit waiver claim in SFY 2025
- Criterion 5: Adults with SMI or SUD that had at least 3 psychiatric or SUD related inpatient stays or a combination of 3 psychiatric or SUD related ER or crisis services in SFY 2025
- Criterion 6: Adults with a brain injury diagnosis code that includes "sequela"

Individuals with any nursing home utilization during SFY 2025 were excluded from the populations above.

1915(i) Service Cost Estimates

Using the target population beneficiary counts Milliman estimated the potential cost if the 1915(i) services shown in **Table 6** below were added to the current benefit package.

Appendix Table 6: Potential 1915(i) SPA Services

Services	Codes
Personal care services	T1019, T1020
Professional life skills coaching and organizer services	H2014
Assistive technology and remote supports (adults with brain injury only)	T1999, T1031
Respite	S5150, S5151
Community transition services	T2038
Supported employment	H2023
Related goods	Up to $2,000 per year
Non-medical transportation	A1030

Milliman summarized per-member-per-month (PMPM) costs from their proprietary Consolidated Health Cost Guidelines Sources Database (CHSD) database, limited to Medicaid beneficiaries who use the identified procedure codes for the services outlined in **Table 6**. There is a range of costs for each service type in the underlying data that represents a full Medicaid population, and the average cost may not be reflective of the target population. Therefore, for all services except personal care services and respite, Milliman summarized the PMPM costs at the median percentile and selected one PMPM for each claim type by population type. For personal care services and respite, Milliman summarized the PMPM cost at the 25th percentile and then dampened the PMPM further – by 50% for personal care services and 75% for respite services – as utilization of these services in the CHSD database may reflect a Medicaid population that is likely older and/or disabled, with higher costs for these services, in particular, than what would be expected from the target population for the 1915(i) SPA.

The estimated PMPM cost for managed care organizations to administer the 1915(i) benefits was based on the projected care coordination cost from the calendar year 2026 capitation rates for the LTSS-Dual population, as provided by HCA. Milliman then reduced this projected PMPM to reflect that a portion of the target population already participates in the Community Benefit program and therefore already receives a set of HCBS services.

Next, Milliman applied an estimated 50% take-up rate to reflect anticipated lower utilization of these services than a general Medicaid population, as they may either be difficult to locate or not necessarily want to use the full set of potential new services. For individuals in the Community Benefit Wavier, this take-up rate is set to 0% for duplicative services that are already provided to these individuals.

Lastly, the adjusted PMPM was multiplied by the targeted beneficiary count, annualized to estimate the total expenditures of the proposed 1915(i) services, and trended forward at an average annual rate of 3 percent to reflect estimated costs in 2030.

Caveats and Limitations

Milliman prepared this information for the specific purpose of summarizing SMI, SED, SUD and brain injury populations and target populations and cost estimates for the services in the potential 1915(i) SPA design as part of the Behavioral Health Assessment and Feasibility Study. This information may not be appropriate, and should not be used, for any other purpose.

In preparing the cost estimate, Milliman relied on information retrieved from the New Mexico HCA website, Manatt Health, Milliman's proprietary CHSD database, and detailed claims and enrollment data from HCA. Milliman did not audit any of the data sources or other information but did assess the data

and information for reasonableness. If the data or other information used is inadequate or incomplete, the results will be likewise inadequate or incomplete. Milliman performed a limited review of the data used directly in the analysis for reasonableness and consistency and did not find material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of these data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this analysis.

Costs are estimates. Actual costs of these services will vary due to the actual population enrolled, service utilization, and program definitions.

Milliman developed certain models to estimate the values included in the cost estimate. The intent of these models was to flag individuals with behavioral health conditions. Milliman reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs). The models, including all inputs, calculations, and output, may not be appropriate for any other purpose.

Appendix G – About Manatt Health, Milliman and Kauffman and Associates, Inc.

About Manatt Health

Health Manatt Health integrates legal and consulting services to better meet the complex needs of clients across the health care system. Combining legal excellence, firsthand experience in shaping public policy, sophisticated strategy insight, and deep analytic capabilities, Manatt provides uniquely valuable professional services to the full range of health industry players. Manatt's diverse team of more than 200 attorneys and consultants from Manatt, Phelps & Phillips, LLP, and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping clients advance their business interests, fulfill their missions, and lead health care into the future.

About Milliman

The cost estimate for the potential 1915(i) SPA services was developed by Milliman, the largest provider of health care actuarial services in the United States. Milliman has a longstanding and extensive history of providing actuarial and economic expertise in healthcare, with a particular focus on Medicaid programs. They have been a national leader in consulting to state Medicaid agencies for over 20 years, serving as the primary actuary certifying sound capitation rates in 19 states and maintaining consistent relationships with these agencies for at least the last two decades.

About Kauffman and Associates, Inc.

Founded in 1990, Kauffman and Associates, Inc., is an American Indian– and woman-owned management consulting firm dedicated to uplifting American Indian and Alaska Native people, tribal and urban Indian communities, and social sector programs. They value Indigenous Knowledge and believe in the inherent strength, resilience, and sovereignty of tribal nations to find community-led solutions for intergenerational healing, wellness, and growth. Their expertise spans diverse specialty areas, including behavioral health, public health, education, and tribal affairs. They work closely with diverse stakeholders, combining stories of lived experiences with data-driven insights, to drive positive change across Indian Country.

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