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David R. Scrase, M.D., Secretary

HUMAN SERVICES DEPARTMENT

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Behavioral Health Services Division

February 25, 2021

In October 2019, The Pew Charitable Trust's Substance Use Prevention and Treatment Initiative was invited by Governor Lujan Grisham, Speaker Egolf, and Senate President Pro Tempore Papen to provide technical assistance to increase access to medications for opioid use disorder and reduce opioid deaths. Since then, SUPTI met with over 100 stakeholders in New Mexico and provided the state with 11 recommendations for consideration to increase access to evidence-based substance use disorder treatment and reduce opioid overdose deaths.

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December 17, 2020

The Honorable Michelle Lujan Grisham
Governor of New Mexico

The Honorable Mary Kay Papen
President Pro Tempore of the New Mexico Senate

The Honorable Brian Egolf
Speaker of the New Mexico House of Representatives

Governor Grisham, President Papen, and Speaker Egolf,

In October 2019, The Pew Charitable Trusts (Pew) was invited to provide the State of New Mexico with technical assistance on its substance use disorder (SUD) programs and policies and provide recommendations. To better understand the strengths and gaps in New Mexico's treatment system, Pew held over 100 meetings with key stakeholders, analyzed available federal and state data, and reviewed the current legal and regulatory landscape.

The scope of this memo is treatment for opioid use disorder (OUD), including expanding access to medications for opioid use disorders (MOUD) and behavioral therapy. Each recommendation is grounded in evidence-based best practices and informed by evaluations of innovative models from other jurisdictions. During Pew's system assessment, other SUDs and polysubstance use were highlighted frequently in stakeholder interviews and data. Though Pew's recommendations are focused on OUD, the policies in this memo aim to increase access points into the treatment system and encourage integration of services – changes that would be beneficial to any patient, regardless of the kind of SUD they have.

By way of this memo, Pew provides 11 recommendations categorized by six domains that will build on New Mexico's efforts to address the opioid crisis and may result in measurable improvements in access to MOUD:

Increasing the adoption of best practices for OUD treatment in the state's hospital system;

1. The Governor's Office should direct the Department of Health (DOH) to require hospitals, as a condition of state licensure, to have protocols for initiating MOUD, distributing naloxone, and transitioning patients treated for a drug overdose.
2. DOH should use State Opioid Response (SOR) funds to support practice facilitation.

Improving the quality and quantity of residential treatment for Medicaid patients;

3. The Children, Youth, and Families Department (CYFD), the Behavioral Health Service Division of the Human Services Department (BHSD/HSD), and DOH should create an inter-departmental council that coordinates regulation and compliance for residential treatment facilities.
4. BHSD/HSD should coordinate with the Regulation and Licensing Department (RLD) and DOH to phase in service requirements that expand the use of MOUD in residential treatment facilities using state licensure regulations.
5. BHSD/HSD should coordinate with RLD and DOH to require residential treatment facilities, as a condition of licensure, to provide treatment to public-insurance recipients on a non-discriminatory basis and report the facility's payer mix.

Aligning Opioid Treatment Program regulations with federal directives;

6. The Governor should appoint a workgroup tasked with revising DOH and Board of Pharmacy regulations, as needed, to better align the state's Opioid Treatment Program (OTP) workforce regulations with federal requirements on the types of providers permitted to dispense methadone.

Increasing buprenorphine prescribing capacity and strengthen care coordination services;

7. The Human Services Department (HSD) should pursue a Centennial Care 2.0 managed care contract amendment to pay for care coordination services at the point-of-care to facilitate team-based care, with the goal of increasing the number of providers offering buprenorphine.

Reducing preventable deaths from OUD;

8. The New Mexico Legislature should consider amending the 911 Good Samaritan Law to ensure legal protections for overdose bystanders.
9. DOH should allocate funding to purchase and distribute fentanyl test strips through the Hepatitis and Harm Reduction Program.
10. To support the distribution of fentanyl testing strips, the New Mexico Legislature should consider introducing legislation to exempt drug testing materials from the Controlled Substances Act.

Expanding access to underserved populations, including individuals in criminal justice facilities.

11. The Governor's office should direct DOH to develop a plan with the New Mexico Corrections Department (NMDC) and BHSD/HSD to initiate MOUD programs in state prisons.

Attachment 1 provides a set of metrics the state could use to track the progress and implementation of these 11 recommendations. Some of these metrics are being tracked as part of New Mexico's 1115 Medicaid waiver, while others have been used to track similar policies in other states. The Behavioral Health Collaborative (BHC) could similarly track and publicly report these metrics to keep the public informed about the state's progress towards addressing the opioid crisis and identify further opportunities for improvement. Attachment 6 discusses Pew's work with Tribal, Pueblo, and Nations governments.

The Opioid Crisis in the Context of COVID-19

Since Pew began work in New Mexico, the COVID-19 pandemic has disrupted OUD treatment service and led to delivery innovations. The federal coronavirus public health emergency declaration sparked temporary changes to federal regulations that have allowed providers to alter their service delivery models to minimize risk of coronavirus transmission and reduce potential harm to both patients and staff. The recommendations in this report do not address approaches made possible by these temporary regulatory relaxations.

As the fiscal impacts of the COVID-19 pandemic continue to unfold, state governments are facing the unanticipated cost of the responding to the pandemic while also being forced to make significant budget cuts. Studies show, however, that untreated OUD is also a significant drain on scarce public resources., The Council of Economic Advisers estimated that in 2015, opioid overdose, misuse and dependence nationally accounted for $504 billion in economic costs, $72.7 billion in non-fatality costs and $431.7 billion in fatality costs. Expanding access to MOUD has been consistently shown to be a cost-effective investment, especially in reducing costly emergency and hospital visits.

Increasing the adoption of best practices for OUD treatment in the state's hospital system

Recommended Action 1: The Governor's Office should direct DOH to require hospitals, as a condition of state licensure, to have protocols for initiating MOUD, distributing naloxone, and transitioning patients treated for a drug overdose. DOH should coordinate with the New Mexico Hospital Association (NMHA) to determine uniform protocols, conduct outreach to relevant stakeholders, and allocate responsibility for data collection and reporting, including rates of screening, medication initiation, and naloxone distribution. For the sub-set of patients enrolled in Medicaid, DOH should conduct additional analysis on whether patients receive follow up care in the community (see Table 1 in Attachment 1 for more detail).

State Examples:

- **Maryland**: In 2017, the Maryland Legislature passed the HOPE Act, requiring hospitals to have discharge protocols in place for patients treated for an overdose or identified as having an SUD. The Maryland Hospital Association held a series of forums with hospital leadership and emergency department physicians to develop core protocols, including:
    - Universal screening for SUD;
    - Naloxone provision by prescription or direct dispensation from the emergency department;
    - Facilitated referral to community-based providers; and
    - Incorporating Peer Recovery Services.

- **Massachusetts**: In 2018, the Massachusetts Legislature required the Executive Office for Health and Human Services to develop a commission that would ensure hospitals adopt uniform SUD discharge practices. The Massachusetts Health and Hospital Association played an important role in the rollout of this law by convening its members and providing:
    - Clinical and operational recommendations;
    - Prescribing guidelines, including information for practitioners on how to obtain a waiver to prescribe buprenorphine for OUD;
    - Information on the laws and regulations in place to allow hospitals to discharge patients with a take-home kit of buprenorphine;

- Template/customizable patient fact sheets; and
- A provider directed Q & A fact sheet.

Recommended Action 2: DOH should use SOR funds to support practice facilitation. The goal of practice facilitation is to help health facilities develop the internal capacity to achieve certain standards of care by incorporating clinical or administrative methods. This support may be provided (onsite, virtually, or both) by teams of clinical and administrative experts that are familiar with the desired protocol. In participating hospitals, these teams could help to integrate clinical protocols, train clinical and non-clinical staff, create partnerships with community behavioral health providers, and other important elements to integrate services into the provider workflow.

According to state agency stakeholders, the state has set aside federal SOR grant funding to provide practice facilitation to two interested hospitals. The state should consider offering practice facilitation to support the adoption of best practices for OUD treatment in additional hospitals.

State Examples:

- **West Virginia**: Through CDC's Overdose Data to Action Grant, West Virginia is partnering with the Mosaic Group and 10 hospitals across the state to initiate buprenorphine and provide peer recovery support services in their emergency departments.

Rationale

There is not widespread adoption of MOUD initiation and referral to community-based treatment in hospitals across New Mexico, even though the state's Medicaid program, Centennial Care 2.0, reimburses hospitals for this service. In New Mexico, opioid-related emergency room visits have increased 60% between 2012 and 2018. It is important for the state to take additional steps to encourage hospital system adoption of MOUD initiation and referral to treatment.

Despite the increase in opioid-related emergency room visits, a University of New Mexico (UNM) medical survey found that 45% of hospitals in the state did not carry buprenorphine. During Pew's stakeholder conversations, emergency physicians noted that the primary reasons why hospitals were not adopting these practices were unfamiliarity with MOUD treatment protocols and a lack of community-based providers to refer patients to following discharge.

Given the rise in opioid-related emergency room visits in New Mexico, hospitals play an important role in reducing relapse, overdose, and death by adopting protocols to initiate MOUD and refer to community-based treatment providers. Federal regulations allow the administration of methadone and buprenorphine in emergency situations for up to three days to treat withdrawal symptoms and arrange for treatment. Initiating treatment with buprenorphine in the emergency department increases rates of treatment retention, reduces reported illicit opioid use, and is cost-effective compared to other approaches, including referrals to treatment alone.

Improving the quality and quantity of residential treatment for Medicaid patients

There are three recommended actions the state should consider taking to improve the availability and quality of residential treatment in New Mexico: expand the state's oversight of residential treatment providers; increase the use of MOUD by facilities, and; ensure all licensed providers accept New Mexicans with public insurance.

Expanding the state's oversight of residential treatment providers

Recommended Action 3: CYFD, BHSD/HSD, and DOH should create an inter-departmental council that coordinates regulation and compliance for residential treatment facilities. During Pew's system assessment, state agency stakeholders mentioned the success of cross-agency collaboration during the rollout of intensive outpatient programs.

BHSD/HSD's role on this council should focus on the regulation of behavioral health programming within these facilities, as the department contains the relevant programmatic expertise. The Department of Health Improvement (DHI) within DOH is responsible for licensing health facilities and performing safety inspections. CYFD has taken an active role in licensing and regulating children's residential treatment facilities and could serve in an advisory role to help BHSD/HSD and DHI coordinate.

The council should be responsible for:

- Increasing fidelity to the American Society of Addiction Medicine (ASAM) criteria in residential treatment facilities.
- Improving care transitions between residential treatment facilities and other providers. This step is crucial, as many people leaving withdrawal management and residential facilities receive no follow-up care, leaving them vulnerable to relapse.
- Increasing the use of MOUD in residential treatment facilities (see recommendation 4); and
- Improving access to residential treatment for people with public insurance (see recommendation 5).

To ensure accountability, the council should report on its activities to the BHC and the Legislature on an annual basis. It should also track and report on a quarterly basis metrics related to the implementation of the ASAM criteria, transitions of care, the use of MOUD in residential facilities, and access among people with public insurance (see Table 2 in Attachment 1 for more detail).

Rationale

In 2019, New Mexico submitted an 1115 Medicaid waiver to the U.S. Centers for Medicare & Medicaid Services (CMS) to expand Centennial Care 2.0 to cover adult residential treatment for SUDs to make it more accessible to Medicaid patients and financially sustainable for providers. CMS accepted the waiver request on the condition that the state play a more active role in regulating residential treatment. In 2018, prior to adding Medicaid coverage of residential treatment facilities, BHSD/HSD spent $13.9 million of state non-Medicaid funding on adult residential care. However, despite this expenditure, BHSD/HSD didn't provide sufficient programmatic oversight or track patient health outcomes from residential facilities. According to stakeholder interviews, the state's managed care organizations (MCOs) didn't perform that role either.

The state has begun implementing the CMS required measures by directing residential treatment facilities to gain accreditation from one of three national accrediting bodies and to follow ASAM guidelines on clinical treatment, including the provision of MOUD.

However, as of July 2019, only six of New Mexico's 18 residential treatment facilities had become accredited. Systematizing the regulation of residential facilities will help the state to ensure compliance with evidence-based clinical guidelines and improve treatment quality. To help residential treatment providers meet new requirements, the state should consider providing technical support and funding to providers where necessary.

Increasing the use of MOUD in residential treatment facilities

Recommended Action 4: BHSD/HSD should coordinate with the RLD and DOH to phase in service requirements that expand the use of MOUD in residential treatment facilities using state licensure regulations. BHSD/HSD should consider that these requirements go into effect starting January 1st, 2022. In order to strengthen the state's role in ensuring residential treatment quality, any facility approved to provide ASAM level 3.1 or higher should be required to:

- Initiate and maintain patients on buprenorphine and naltrexone on-site, either by clinicians directly employed by the facility or in partnership with another provider;
- Enter an agreement with at least one OTP to offer methadone initiation and dosing provided through transportation or other arrangements;
- Establish facility policies that allow patients to bring previously prescribed buprenorphine to the residential facilities and allow patients to obtain refills;
- Establish facility policies against tapering medication, unless determined to be medically necessary or desired by the patient; and
- Submit annual reports on facility compliance with these regulations to BHC, including copies of their MOUD policies and data on the number and percentage of patients receiving MOUD by medication (see Table 2 in Appendix 1 for more detail).

State Examples:

- **Virginia**: In 2018, Virginia's Medicaid program required all residential treatment facilities that accept Medicaid to provide MOUD. The state also required residential providers through established benchmarks to demonstrate that patients are receiving MOUD and are connected with outpatient providers who can continue medications.
- **Louisiana**: In 2019, the Louisiana Legislature passed Act 425, requiring all state residential treatment facilities to offer buprenorphine and naltrexone onsite by January 1, 2021 as a condition of licensure.

Rationale

Medications are crucial to ensuring quality OUD treatment in residential facilities. Quality OUD treatment requires the availability of more than one form of MOUD, as each has different mechanisms of action and methods of administration. All three forms of MOUD reduce opioid use, the likelihood of infectious disease transmission, and criminal activity involved with illicit drug use. They also increase the likelihood of treatment retention regardless of counseling frequency, leading to decreased OUD-related morbidity, mortality, and criminal justice involvement as well as increased employment.

Despite the evidence, many residential treatment facilities nationwide rely upon abstinence-based treatment protocols, which have higher rates of relapse in patients upon release. According to Pew analysis of the 2020 National Survey of Substance Abuse Treatment Services, only four of the sixteen adult residential treatment facilities in New Mexico offer both buprenorphine and naltrexone, while none initiate patients on methadone. Access to all three medications is a critical component of quality care regardless of treatment setting. There is a higher risk of relapse, overdose, and death for patients without access to MOUD in residential treatment facilities.

Increasing residential treatment capacity for patients with public insurance

Recommended Action 5: BHSD/HSD should coordinate with RLD and DOH to require residential treatment facilities, as a condition of licensure, to provide treatment to public-insurance recipients on a non-discriminatory basis and report the facility's payer mix. Facilities should also be required to report quarterly to DOH on their payer mix (see Table 2 in Attachment 1 for more detail).

State Examples:

- **Massachusetts**: Massachusetts requires all SUD treatment providers to accept patients on public insurance as a condition of licensure. Additionally, facilities must report their payer mix to the Department of Health on a quarterly basis.

Rationale

In October 2019, the state reported that 39.5% of New Mexico residents were enrolled in Medicaid. Stakeholders indicated a pressing need for Medicaid-eligible residential treatment slots for patients with OUD. Focus groups of people who use drugs (PWUD) and interviews with treatment staff show that lack of available treatment slots and related wait times dissuade potential patients from seeking treatment for SUD.

Residential treatment is a vital component of ASAM's continuum of care and it is crucial to have all clinically appropriate levels of treatment available for OUD patients, regardless of their insurance status. However, according to Pew analysis of the 2020 National Survey of Substance Abuse Treatment Services, only nine of the sixteen adult residential treatment facilities in New Mexico accept Medicaid. Of these nine, three provide buprenorphine, four provide naltrexone, and only two provide both. Attachment 4 is a map of these facilities distributed across the state, which illustrates the difficulty of accessing evidence-based treatment for Medicaid enrollees seeking care in adult residential facilities.

Aligning Opioid Treatment Program regulations with federal directives

Recommended Action 6: The Governor should appoint a workgroup tasked with revising DOH and Board of Pharmacy regulations, as needed, to better align the state's OTP regulations with federal requirements. This should include expanding the types of practitioners who can dispense methadone at OTPs.

Example Policies:

- **Ohio:** Ohio's administrative code mandates that OTPs have a physician and one of the following medical professionals onsite during administration hours: a physician assistant, a registered nurse, a licensed practical nurse or a pharmacist. These providers are able to administer methadone with the appropriate credentialing from their respective licensing boards.

Rationale

OTPs are state- and federally-regulated facilities that are the only site where methadone is available for OUD treatment. Therefore, OTPs can readily make all forms of MOUD available to patients. Access to all three medications gives patients and providers flexibility in choosing the treatment regimen that meets their needs.

Patient access to OTPs is inadequate in New Mexico. Although New Mexico ranked 9th in the nation for OTPs per capita in 2018 according to Pew analysis of the 2020 National Survey of Substance Abuse Treatment Services, most of the state's OTPs are in the Albuquerque area. As of 2018, over 164,000

Medicaid beneficiaries—roughly 1 in 4—had limited or no reasonable access to methadone. See Attachment 3 for a map of OTP distribution in New Mexico.

According to Substance Abuse and Mental Health Services Administration (SAMHSA), practitioners who can dispense methadone are "required to be a pharmacist, registered nurse, or licensed practical nurse, or any other healthcare professional authorized by Federal and State law to administer or dispense opioid drugs." This provides states flexibility to authorize a range of providers to dispense methadone in OTPs based on their availability and distribution. However, in New Mexico, OTPs must be staffed by a pharmacist, an uncommon OTP workforce requirements– as of 2017, only nine states required pharmacists to be onsite.

Workforce requirements complicate the operation of existing OTPs and could make expansion of OTP services to underserved areas difficult, due to a shortage of pharmacists in New Mexico. In October 2020, New Mexico's Health Care Workforce Committee found that 27 New Mexico counties were below the national benchmark of 7.8 pharmacists per 10,000 population. The availability and distribution of these providers impacts the decision of where OTPs operate, contributing to the concentration of OTPs in the Albuquerque area. Please refer to Attachment 2 to see a map of pharmacist distribution by county.

Increasing buprenorphine prescribing capacity and strengthening care coordination services

Recommended Action 7: HSD should pursue a Centennial Care 2.0 managed care contract amendment to pay for care coordination services at the point-of-care to facilitate team-based care, with the goal of increasing the number of providers offering buprenorphine.

State Examples:

- **Virginia:** In 2016, Virginia's Medicaid program began a process to improve the state's community-based SUD services. Attachment 5 discusses a model in the state that has been successful in increasing the number of buprenorphine prescribers in different settings, in part by reimbursing for care coordination services offered at the point-of-care.
- **Pennsylvania:** In 2016, Pennsylvania awarded grants to 45 Medicaid-enrolled providers to establish centers of excellence meeting specific requirements. In 2020, the state expanded this program to allow any Medicaid-enrolled provider to meet this designation for providing OUD treatment.

Rationale

While the number of buprenorphine prescribers in New Mexico has increased in recent years, patients still have difficulty accessing the medication. Newly waivered prescribers have a 30-patient prescribing cap in the first year. However, in 2018, 57% of waivered providers in New Mexico treated fewer than 10 patients and 30% treated a single patient.

In 2018, New Mexico's three MCOs reported that 19,000 members had "few or zero" buprenorphine providers within a reasonable distance of their homes. During Pew's system assessment, stakeholders revealed that the number of waivered providers in different locations of the same provider organization varied greatly, contributing to inconsistent access for patients.

Providers, patients, and peers told Pew that there were challenges performing care coordination services, which help facilitate activities among various providers involved in a patient's continuous care. Care coordination can decrease the use of substances, overdoses, police contacts, and visits to the emergency

department for OUD patients. Given these benefits, care coordination is one of four components identified in effective models of OUD treatment.

New Mexico state officials realize the value of care coordination and are in the process of integrating it into treatment. First, the Legislative Finance Committee is analyzing the effectiveness of New Mexico's total Medicaid expenditure on care coordination (for all medical conditions), which is managed by MCOs.

Second, Centennial Care 2.0 received a federal planning grant to increase SUD provider capacity. Planned activities include improving Medicaid reimbursement for SUD treatment providers and developing sustainable alternative payment mechanisms to encourage delivery of SUD treatment services. These activities could inform efforts to expand team-based care in New Mexico.

Paying for care coordination services facilitates the provision of team-based care. Team-based care for OUD patients involves different types of medical professionals (such as nurses, counselors, case managers, and others) providing treatment necessary for a complex medical condition. At the point-of-care, these providers can meet various patient needs and supplement buprenorphine treatment with other forms of care, such as developing individualized treatment plans, monitoring patient outcomes, and facilitating behavioral health services.

Reducing preventable deaths from OUD

Recommended Action 8: The New Mexico Legislature should consider amending the 911 Good Samaritan Law to ensure legal protections for overdose bystanders.

State Examples:

- **Vermont:** Vermont's 911 Good Samaritan Law provides legal immunity "for being at the scene of the drug overdose or for being within close proximity to any person at the scene of the drug overdose."

Recommended Action 9: DOH should allocate funding to purchase and distribute fentanyl test strips through its Hepatitis and Harm Reduction Program. To track whether these supplies are successfully reaching PWUD, the state's harm reduction programs should report to DOH the number of test strips distributed. This recommendation closely matches the New Mexico Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council's 2019 recommendation on fentanyl test strips.

State Examples:

- **Maryland:** Maryland's Department of Health allocated $66,000 on fentanyl test strip kits to be distributed to county health departments and local organizations. The kits include fentanyl test strips, resource guides, and instructions on how to test drugs for fentanyl.
- **Washington:** In 2019, the Washington legislature allocated $101,000 for syringe service programs to distribute fentanyl test strips.
- **Massachusetts:** In 2020, the Massachusetts Department of Health provided police departments and their community partner agencies with a $150,000 grant to distribute fentanyl test strip kits.

Recommended Action 10: To support the distribution of drug testing materials, the New Mexico Legislature should consider introducing legislation to exempt fentanyl testing strips from the Controlled Substances Act. The Legislature has realized the importance of statutory exceptions before – to successfully distribute syringes as part of the state's harm reduction programs, the Legislature amended the Harm Reduction Act so that it would not apply to syringes.

Rationale

New Mexico has seen a 26.3% increase in drug overdose deaths from March 2019 to March 2020, according to provisional data from the Centers for Disease Control and Prevention. Opioid-overdose deaths involving fentanyl, a synthetic opioid that is 50 to 100 times more potent than morphine, have also increased, both in New Mexico and across the country. In conversations with Pew, stakeholders expressed the need to address this mounting public health concern by making fentanyl test strips more widely available to PWUD.

Fentanyl test strips can alert people to the presence of fentanyl, so they can take precautions to prevent an overdose death. A Johns Hopkins study found that most PWUD are willing to use test strips and, if fentanyl is detected, would modify their drug use accordingly. Based on the rising trend of fentanyl-related overdoses across the country, New Mexico should be prepared for fentanyl to become more prevalent in its opioid and non-opioid drug supply.

Some stakeholders expressed concern that the legal status of fentanyl test strips may present a barrier to purchasing them with public funding and distributing them to the state's harm reduction programs. New Mexico's Controlled Substances Act considers any "testing equipment… intended for use or designed for use in identifying or in analyzing the strength, effectiveness, or purity of controlled substances or controlled substance analogs" to be drug paraphernalia.

A common concern among PWUD is that they will experience legal consequences when police arrive on the scene of an overdose. A 2005 Baltimore study found that fear of arrest was associated with not calling 911, even though arrest was uncommon. A more recent study in Baltimore found that PWUD remain widely fearful of arrest for drug or paraphernalia possession, outstanding warrants, and/or trespassing. In an effort to allay these concerns, 46 states and the District of Columbia had passed 911 Good Samaritan laws as of January 2019. These laws encourage PWUD to call for help in the event of a suspected overdose by protecting them from drug-related charges, and they are associated with reductions in opioid overdose mortality.

In its current state, New Mexico's 911 Good Samaritan Law waives legal penalties for controlled substance possession, drug paraphernalia possession, violation of probation or parole, or restraining order violations for individuals at the scene of an overdose who seek or provide medical care, as well as victims of overdose. However, its protections do not extend to bystanders.

The CDC recommends offering protection from criminal charges, supervision violation, warrant searches and property seizure to all individuals at the scene of an overdose, including the overdose victim, the person that seeks care, the person administering naloxone, and all other bystanders. By removing the legal risks to bystanders, they are no longer "forced to weigh their own wellbeing against the wellbeing of the person who is in crisis in front of them". Prominent harm reduction organizations, such as the Drug Policy Alliance, also recommend that 911 Good Samaritan laws be as broadly applied as possible with respect to what immunity they provide and to whom.

Expanding access to medications for OUD in criminal justice settings

Recommended Action 11: The Governor's office should direct DOH to develop a plan with NMDC and BHSD/HSD to initiate MOUD programs in state prisons.

This plan should include a systematic review of each prison (state-run and privately operated) to document the current capacity for providing OUD treatment, such as the availability of OTPs for methadone provision and the number of health staff certified to provide buprenorphine. Within one year, the plan should be submitted to relevant legislative committees and should:

- Identify a facility that could pilot a MOUD program or identify facilities that would be ready to operate MOUD programs; and
- Request statutory amendments or funding necessary to implement the program.

The Executive Branch should consider working with the Legislature to secure authorization and funding for these programs after this plan is submitted.

Whether the state chooses to operate an MOUD program pilot in a single facility or in multiple prisons, the pilot should include use of a validated screening and assessment tool, access to all three forms of MOUD, and a protocol for a transition to community-based providers to ensure access to MOUD prior to release. This recommendation should be viewed as an intermediary step to having comprehensive MOUD programs in its state facilities, including privately-operated facilities.

The implementation team created by DOH, NMCD, and BHSD/HSD should include representatives from Medicaid, local jail wardens, private facilities, medical vendors, local and county government officials, and OUD providers. In addition to authoring the plan, this team can help to identify appropriate program models for different facilities. Similarly, the implementation team should take action on other preliminary steps from the toolkit, such as developing and distributing anti-stigma and protocol training for each facility's correctional and medical staff.

For recommendations about metrics that should be reported on, please refer to Attachment 1, Table 6.

Example Policy: In 2019, Wisconsin passed Act 119, which called for the Department of Health and the Department of Corrections to assess its local jails and state prisons for the availability of behavioral health counseling on premises, the number of rooms available for inpatient withdrawal management, and the availability of MOUD. The law then directs the Departments to identify a facility for a pilot and submit a proposal that contains any needed statutory changes or funding necessary to the budget and appropriations committee.

Rationale

During Pew's system assessment, stakeholders raised the lack of MOUD access in correctional facilities as a significant gap in New Mexico's OUD treatment system. Nationally, rates of substance use are high among people incarcerated in state prisons and individuals with jail sentences. The high rates of SUD and opioid use among people in state prisons and individuals with jail sentences show correctional facilities have an important role in treating people with OUD. While MOUD is the standard of care for OUD, regardless of treatment setting, most patients with OUD in New Mexico's correctional settings do not receive MOUD.

Studies show that patients that receive MOUD in correctional facilities are less likely to be arrested and more likely to continue treatment upon release. A study of OUD patients after release from Washington State Department of Corrections found that this population is over 10 times more likely to overdose

compared to the general OUD population, and a seamless transition to community care can mitigate heightened overdose risks during reentry.

The methadone maintenance program at the Metropolitan Detention Center (MDC) in Bernalillo County is the largest correctional MOUD program in New Mexico. In 2005, the facility began the program for patients that had been in treatment prior to incarceration. In 2018, the program expanded to initiate methadone treatment for patients that screened positive for OUD upon incarceration and were unlikely to be transferred to a state prison, as according to stakeholders, there are currently no MOUD programs in state correctional facilities. The MDC plans to expand their services for people with OUD to include buprenorphine maintenance and initiation; once this is completed, it can serve as a model for other county-run facilities in New Mexico.

Thank you for the opportunity to assist New Mexico in improving access to quality SUD treatment. We look forward to our continued partnership and further supporting New Mexico's efforts to address SUD. Should you have any questions or need additional information, please contact Saman Rouhani, Senior Associate, at srouhani@pewtrusts.org.

Sincerely,

Beth Connolly
Project Director, Substance Use Prevention and Treatment Initiative
The Pew Charitable Trusts

Attachment 1: Suggested Metrics

The tables in this appendix provide relevant metrics for each recommendation in this report. Where available, metrics draw from ongoing measurement activities in the state, particularly the 1115 SUD Waiver evaluation. All claims-based measures draw on Medicaid data, which is readily available to the state, unlike claims made through commercial insurance.

Final measurement should be made through consultation with state data experts within DOH, BHSD/HSD, NMCD, and other agencies who can determine data availability and measurement specifications.

Once final measures are adopted, they should be reported on a regular basis to the legislature and the BHC. The BHC should consider developing an opioid performance dashboard to display these metrics and keep New Mexicans updated on the progress the state is making toward addressing the opioid crisis.

Table 1: Metrics for increasing the adoption of best practices for OUD treatment in the state's hospital system

Outcome	How to measure progress - Relevant measure(s)	NQF[1] # (if applicable)	Current Use (if applicable)	Data source	Interpretation
Number of hospitals providing emergency department (ED) initiation increases	Count of hospitals initiating MOUD			Hospital reporting	Higher is better
Peer support is available in EDs	Count of peers working in hospitals			Hospital reporting	Higher is better
More patients are screened for OUD in hospitals	Percentage of patients in the ED screened for OUD			Hospital reporting	Higher is better
More patients are initiated in treatment	Percentage of patients screening positive for OUD initiated on MOUD			Hospital reporting	Higher is better
People at risk for overdose receive naloxone in the ED	Number of kits distributed			Hospital reporting	Higher is better
More patients connect to treatment following ED visit	Follow-up after ED visit for mental illness or alcohol and other drug abuse or dependence (with sub-analysis of OUD)	3488	1115 SUD Waiver, CMS 2018 Adult Core Set (New Mexico reporting)	Medicaid claims	Higher is better

[1] National Quality Forum number. The National Quality Forum sets standards for healthcare measurement through evaluation by expert stakeholders.

Table 2: Metrics for improving the quality and quantity of residential treatment for Medicaid patients

Outcome	How to measure progress - Relevant measure(s)	NQF # (if applicable)	Current Use (if applicable)	Data source	Interpretation
CYFD, BHSD/HSD, and DOH should create an inter-departmental council that coordinates regulation and compliance for residential treatment facilities.					
Residential treatment facilities provide the standard of care	Count of facilities in compliance with the ASAM criteria			BHSD reporting	Higher is better
Fewer patients return to residential treatment	Readmissions among beneficiaries with SUD		1115 SUD Waiver	Medicaid claims	Lower is better
BHSD/HSD should coordinate with RLD and DOH to phase in service requirements that expand the use of MOUD in residential treatment facilities using state licensure regulations.					
Residential treatment facilities have MOUD policies	Count of facilities with MOUD policies in compliance with MOUD licensure regulations			Facility reporting	Higher is better
	SUD provider availability - MAT (sub-analysis of ARTCs)		1115 SUD Waiver	Provider enrollment database; Medicaid claims	Higher is better
Patients in residential treatment receive MOUD	Number and percentage of patients with OUD receiving MOUD by medication			Facility reporting	Higher is better

Outcome	How to measure progress - Relevant measure(s)	NQF # (if applicable)	Current Use (if applicable)	Data source	Interpretation
	Use of pharmacotherapy for OUD	3400	CMS 2020 Adult Core Set (required reporting in 2024)	Medicaid claims	Higher is better
BHSD/HSD should coordinate with RLD and DOH to require residential treatment facilities, as a condition of licensure, to provide treatment to public-insurance recipients on a non-discriminatory basis and report the facility's payer mix.					
More patients with public insurance can access residential treatment	Percentage of each facility accepting each payer			Facility reporting	Higher is better
	Percentage of admissions for patients with public insurance			Facility reporting	Higher is better
	Medicaid beneficiaries treated in an IMD for SUD		1115 SUD Waiver	Medicaid claims	Higher is better

Table 3: Metrics for aligning Opioid Treatment Program regulations with federal directives

Outcome	How to measure progress - Relevant measure(s)	NQF # (if applicable)	Current Use (if applicable)	Data source	Interpretation
Patients have more access to treatment in OTPs	Number of OTPs outside of the Albuquerque region			Provider enrollment database	Higher is better
More patients receive MOUD	Use of pharmacotherapy for OUD	3400	CMS 2020 Adult Core Set (required reporting in 2024)	Medicaid claims	Higher is better
More people are retained on MOUD	Continuity of pharmacotherapy for OUD	3175	1115 SUD Waiver	Medicaid claims	Higher is better

Table 4: Metrics for strengthening care coordination and transition services

Outcome	How to measure progress - Relevant measure(s)	NQF # (if applicable)	Current Use (if applicable)	Data source	Interpretation
People with OUD receive medical care	Access to preventive/ambulatory health services for adult Medicaid beneficiaries with SUD (with sub-analysis of OUD)		1115 Waiver	Medicaid claims	Higher is better
People with OUD have seamless care transitions from higher levels of care	Follow-up after ED visit for mental illness or alcohol and other drug abuse or dependence (with sub-analysis of OUD)	3488	1115 SUD Waiver, CMS 2018 Adult Core Set (New Mexico reporting)	Medicaid claims	Higher is better
	SUB-3 alcohol and other drug use disorder treatment provided or offered at discharge and SUB-3a alcohol and other drug use disorder treatment at discharge	1664	1115 SUD Waiver	Medical record review or claims	
People with OUD stay engaged in treatment	Continuity of pharmacotherapy for OUD	3175	1115 SUD Waiver	Medicaid claims	Higher is better

Outcome	How to measure progress - Relevant measure(s)	NQF # (if applicable)	Current Use (if applicable)	Data source	Interpretation
People with OUD manage their health in community settings	Inpatient stays for SUD per 1,000 Medicaid beneficiaries (sub-analysis of OUD)		1115 SUD Waiver	Medicaid claims	Lower is better
	ED utilization for SUD per 1,000 Medicaid beneficiaries (sub-analysis of OUD)		1115 SUD Waiver	Medicaid claims	Lower is better
	Readmissions among beneficiaries with SUD (sub-analysis of OUD)		1115 SUD Waiver	Medicaid claims	Lower is better
More providers offer buprenorphine prescriptions	Buprenorphine waivered providers per 1,000 Medicaid enrollees diagnosed with OUD* (sub-analysis by county)				
	Proportion of waivered providers who have prescribed buprenorphine in the past 2 years* (sub-analysis by county)				

*Adapted from the Washington State Health Care Authority Accountable Communities of Health OUD Treatment Dashboard, available at https://hca-tableau.watech.wa.gov/t/51/views/OUDTreatment/Dashboard?:isGuestRedirectFromVizportal=y&:embed=y. For specifications for each metric, select "Providers: Buprenorphine waivered providers per 1,000 Medicaid enrollees diagnosed with OUD" or "Providers: Proportion of active Buprenorphine waivered providers" and click the "Spec." button in the top right. Repeat for the other measure.

Table 5: Metrics for reducing preventable deaths from OUD

Outcome	How to measure progress - Relevant measure(s)	Data source	Interpretation
The New Mexico Legislature should consider amending the 911 Good Samaritan Law to ensure legal protections for overdose bystanders.			

More people receive help from EMS when they may have overdosed	Number of EMS calls to suspected overdoses	EMS Tracking & Reporting System	Higher is better
DOH should allocate funding to purchase and distribute fentanyl test strips through the Hepatitis and Harm Reduction Program.			
PWUD receive fentanyl test strips	Number of test strip kits distributed	Distribution site reporting	Higher is better

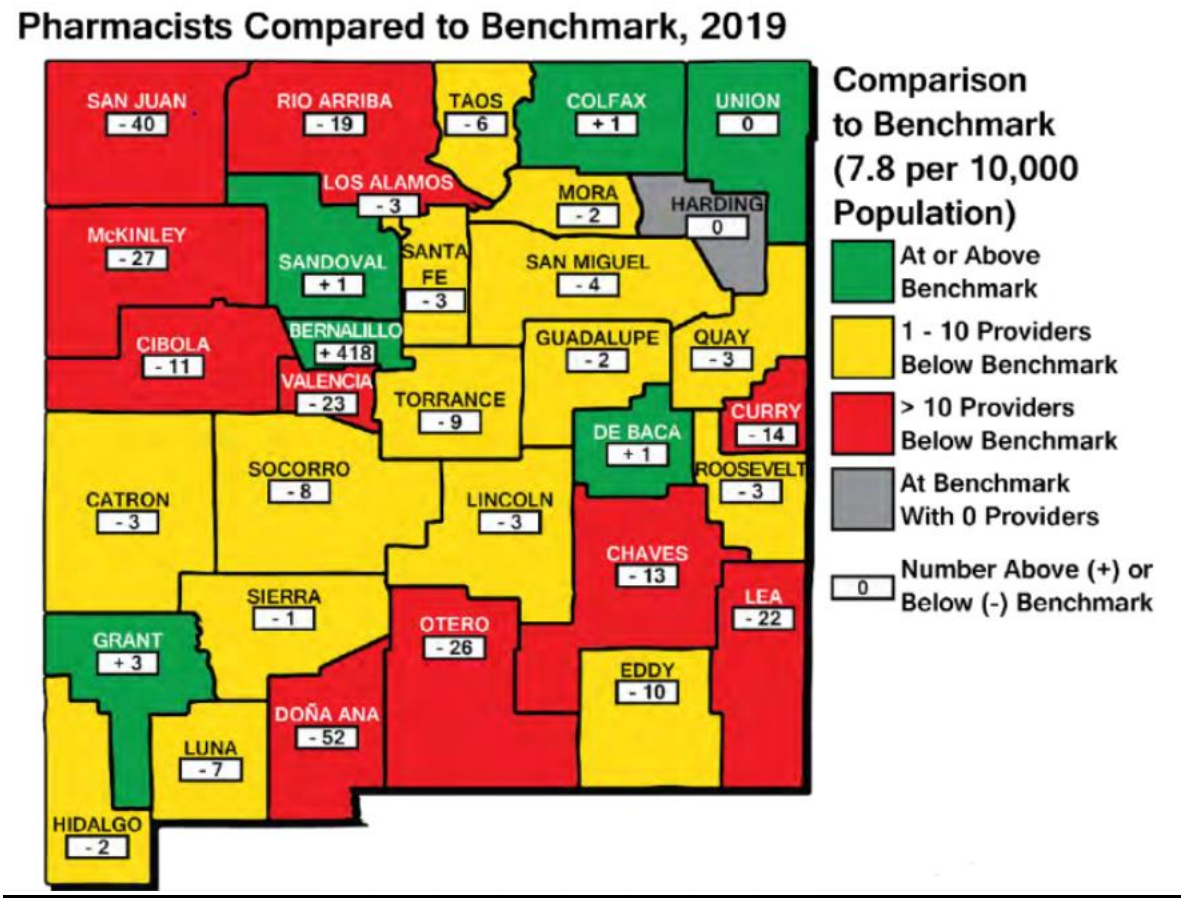
Table 6: Metrics for expanding access to underserved populations, including individuals in criminal justice facilities

Outcome	How to measure progress - Relevant measure(s)	Data source	Interpretation
Correctional facilities provide MOUD	Number of jails that have implemented procedures for maintaining and initiating all three FDA-approved medications	Jail reporting	Higher is better
	Number of prisons that have implemented procedures for maintaining and initiating all three FDA-approved medications	NMCD reporting	Higher is better
Everyone in correctional facilities is screened for OUD	Percentage of individuals screened*	Jail reporting, NMCD electronic health record (EHR)	Higher is better
People with OUD receive MOUD	Percentage of people with OUD who receive MOUD (with sub-analyses by medication and for initiation and maintenance)*	Jail reporting, NMCD EHR	Higher is better
People with OUD receive follow-up care in the community	Percentage of people with appointments with community providers scheduled*	Jail reporting, NMCD EHR	Higher is better
	Percentage of buprenorphine patients receiving a bridge prescription or bridge medication*	Jail reporting, NMCD EHR	Higher is better
	Percentage of Medicaid enrollees who attend follow-up appointment*,†	Jail and NMCD release records, Medicaid claims	Higher is better
Fewer people die of an overdose after incarceration	Rate of overdose deaths within 12 months of release from incarceration†	Jail and NMCD release records, Vital statistics	Lower is better

* Adapted from Mace, S., Siegler, A. Wu, K., Latimore, A., & Flynn, H. The National Council for Behavioral Health and Vital Strategies. (2020). Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit, https://www.thenationalcouncil.org/wp-content/uploads/2020/09/MAT_in_Jails_Prisons_Toolkit_Final_12_Feb_20.pdf. This report provides additional information on implementing these metrics, including considerations for collecting data from jails.

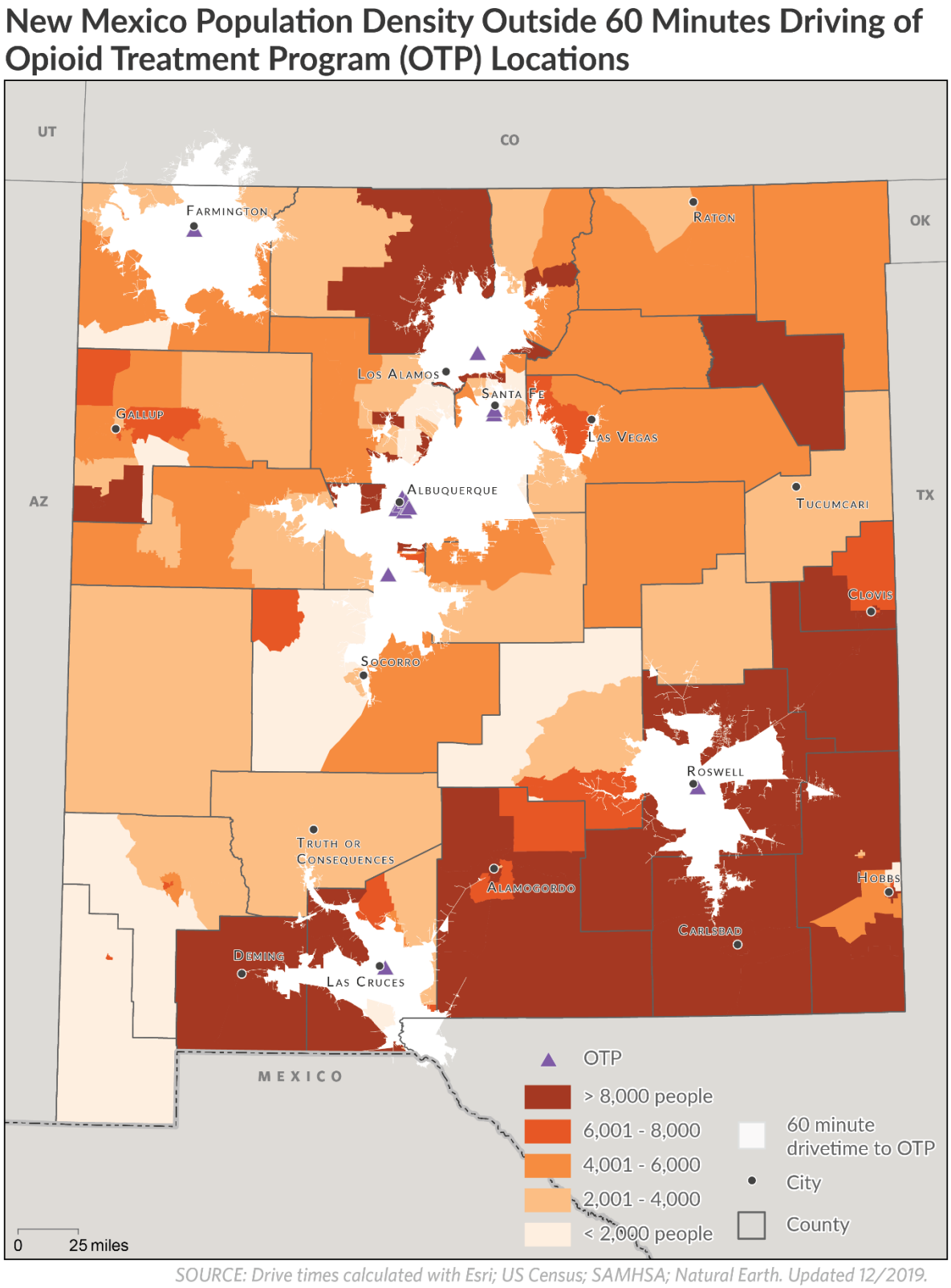
† These measures require linking data sets. Development of these data linkages should begin early in the planning stages for expanding the use of MOUD in correctional facilities.

Attachment 2: Pharmacists by county, compared to National Benchmark



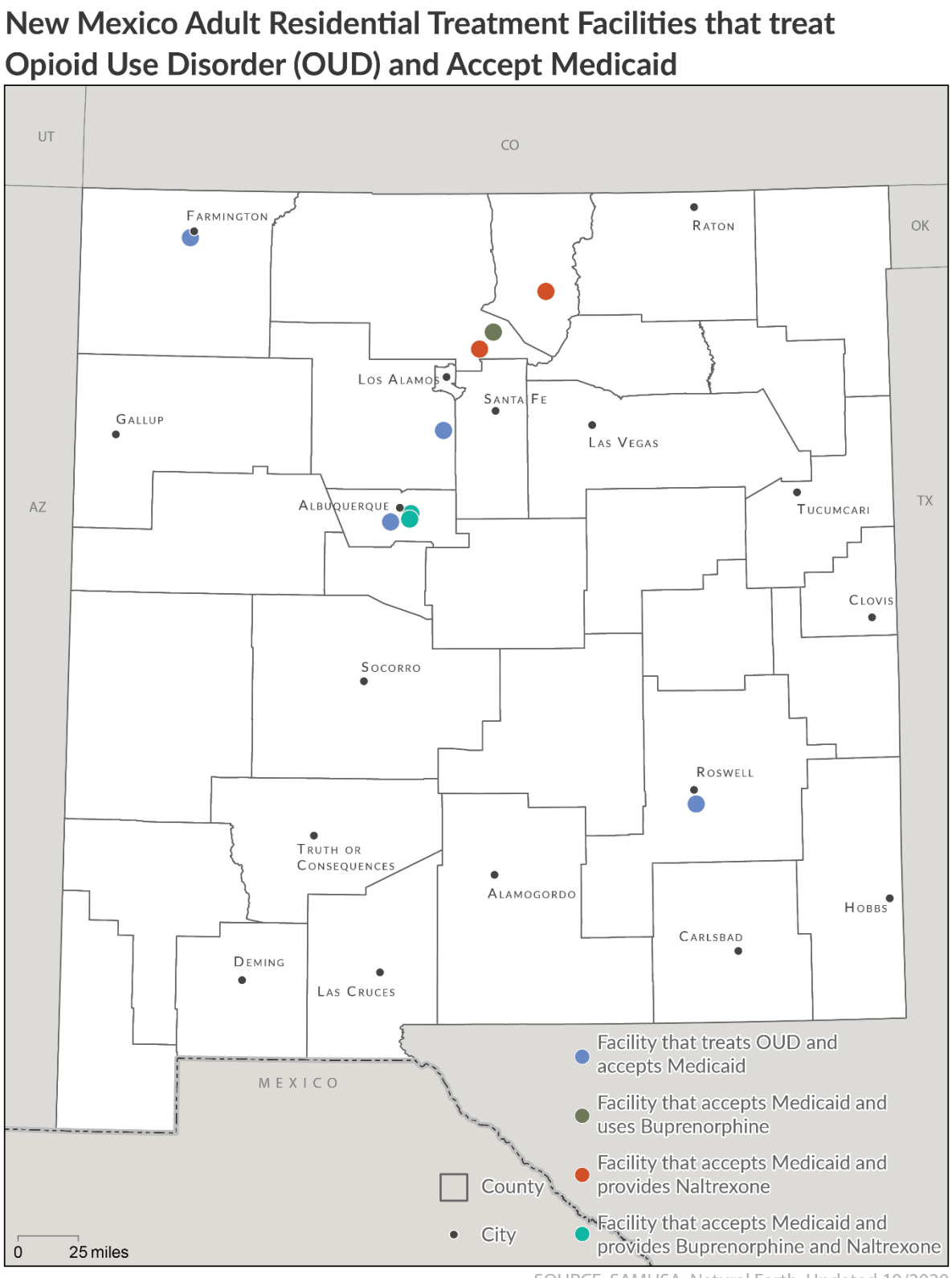
Source: New Mexico Health Care Workforce Committee. 2020 Annual Report. Albuquerque NM: University of New Mexico Health Sciences Center, 2020. https://digitalrepository.unm.edu/nmhc_workforce/8/

Attachment 3: Map of OTPs, population density, estimated 60-minute driving time



SOURCE: Drive times calculated with Esri; US Census; SAMHSA; Natural Earth. Updated 12/2019.

Attachment 4: Map of adult residential treatment facilities, by Medicaid acceptance and MOUD availability



Attachment 5: Addiction and Recovery Treatment Services (ARTS) Benefit

The Addiction and Recovery Treatment Services (ARTS) benefit, which redesigned Virginia's Medicaid program to improve access to care for people with OUD, originated from a recommendation from the Virginia Governor's Task Force on Prescription Drug and Heroin Abuse. The Governor established the Task Force in 2014 to identify immediate steps to address prescription opioid and heroin misuse and improve access to treatment for people with OUD. To implement the benefit, Virginia's Medicaid program—working closely with the Department of Behavioral Health and Developmental Services—submitted an amendment to the state's Medicaid plan, known as the Section 1115 Demonstration Waiver. The Governor included the new benefit in the proposed budget for FY 2017, and it passed the General Assembly in March 2016 with strong bipartisan support.

The ARTS benefit:

- Expands short-term SUD inpatient detoxification to all Medicaid members.
- Expands short-term SUD residential treatment to all Medicaid members.
- Increases reimbursement rates for existing Medicaid SUD addiction and recovery services.
- Pays for peer support services for individuals with SUD and/or mental health conditions.
- Provides provider education, training, and recruitment activities.
- Gives the state's Medicaid Managed Care Organizations responsibility for community-based SUD treatment services to promote full integration of physical health, mental health, and addiction treatment services (known as a "carve-in").

The ARTS benefit provides access to addiction treatment services for all enrolled members in Medicaid, Family Access to Medical Insurance Society (FAMIS, Virginia's health insurance program for children of eligible families), and FAMIS MOMS (Virginia's health insurance program for uninsured pregnant women). Additionally, the ARTS benefit required Medicaid health plans and providers to organize patient assessment and service delivery around one single set of criteria. Implementing a nationally-recognized standard across care settings helps health care providers and payors communicate around patient needs to make objective decisions about patient care that are individualized, clinically-driven, and outcome-informed. Virginia selected use of the ASAM Criteria as the standard criteria for assessment of patient need and to standardize service delivery settings. To design and implement a strategic plan for the ARTS benefit, and ensure its alignment with the ASAM Criteria, Virginia created the ARTS Core Workgroup, comprised of representatives from all key state health agencies. The ARTS benefit took full effect in April 2017 and represents a significant redesign of Virginia's Medicaid benefit for individuals with SUD.

Notably, the ARTS benefit included significant reimbursement rate increases to align Medicaid rates with, or exceed, commercial reimbursement rates. This was done to address concerns from providers who had expressed unwillingness to provide SUD treatment services due to low reimbursement rates.

Table 1 presents the benefit's major changes to service coverage and reimbursement rates.

Table 1. Changes under the Virginia ARTS benefit passed by the Governor and General Assembly in March 2016

Addiction and recovery treatment service	Children < 21	Adults*	Pregnant women
Traditional services			
Inpatient (ASAM level 4.0)	P	New	New
Outpatient (ASAM level 1.0)	P	P	P
Medication-assisted treatment (MAT) - medication component	P	P	P
Non-traditional services			
Residential (ASAM levels 3.1, 3.3, 3.5, and 3.7)	P	New	50% rate increase
Partial hospitalization (ASAM level 2.5)	400% rate increase	400% rate increase	400% rate increase
Intensive outpatient (ASAM level 2.1)	400% rate increase	400% rate increase	400% rate increase
Opioid treatment - counseling component of MAT (ASAM level 1.0)	400% rate increase	400% rate increase	400% rate increase
Crisis intervention	P	P	P
Case management	50% rate increase	50% rate increase	50% rate increase
Peer recovery coaching (DBHDS certified peers)	New	New	New

Key:
P = Service was previously covered
New = ARTS benefit newly-covered service as of April 1, 2017. Rate increases were also included in the ARTS benefit.
***** = Dual eligible individuals have coverage for inpatient and residential treatment services through Medicare

Table 2 illustrates appropriations for the ARTS benefit in FY17 and FY18.

Table 2. Funds for the ARTS benefit appropriated in 2016 budget

Fiscal Year	General Fund	Non-general Fund (federal match)	Total ARTS Benefit Expenditures	Virginia's Total Medicaid Expenditures
17	$2.6 million	$2.6 million	$5.2 million	9.8 billion
18	$8.4 million	$8.4 million	$16.8 million	9.6 billion

Table 3 presents outcomes from the first year after ARTS implementation:

Table 3. Outcomes from the first year of ARTS implementation

	Before ARTS (Apr 2016-Mar 2017)	**After ARTS** (Apr 2017-Mar 2018)	**% Change**
Access to care			
Members with OUD receiving treatment	10,092	14,917	↑ 48%
Total number of OUD outpatient providers	570	1,352	↑ 137%
Outcomes			
ED visits related to OUD	5,016	3,756	↓ 25%
Hospitalizations related to OUD	3,520	3,315	↓ 6%
Total number of prescriptions for opioid pain medications	549,442	399,678	↓ 27%

To see additional outcomes measured in the first year after ARTS implementation, please refer to a presentation titled, "Outcomes from the First Year," created by the Virginia Department of Medical Assistance Services in September 2018. For a list of outcomes observed during the first five months of the ARTS benefit implementation, please see the independent evaluation conducted by the Virginia Commonwealth University School of Medicine in December 2017 titled, "Addiction and Recovery Treatment Services: Access, Utilization, and Spending for the Period of April 1 – August 31, 2017."

Attachment 6: Tribes, Pueblos, and Nations – Access to MOUD

During Pew's system assessment, stakeholders frequently mentioned the lack of access to MOUD and behavioral therapy among people living in rural, Tribal, Pueblo, and Nations communities. For instance, one stakeholder mentioned that transportation to MOUD services is among the biggest barriers to care for patients, along with a lack of technical capacity for telehealth services including broadband and equipment. Stakeholders indicated that utilizing the transportation options available through MCO plans was often inefficient or presented prohibitive logistical challenges. For this reason, utilizing mobile addiction treatment vans, or mobile units, and increasing buprenorphine prescribing capacity in community-based facilities could be particularly useful for expanding rural, Tribal, Pueblo, and Nations access.

Studies suggest that mobile MOUD units are successfully able to reach and retain patients who are often hardest to engage in treatment, including people with long-term drug use and multiple comorbidities, people who are unstably housed, uninsured, and with extensive prior or ongoing justice-involvement. In New Jersey, a mobile unit offering methadone and buprenorphine successfully enrolled a greater proportion of African Americans, Latinos, homeless people, uninsured individuals, and those without a recent history of treatment compared to local fixed-site OTPs. Colorado has used SOR funding to implement a series of mobile MOUD programs to address treatment shortages in its rural counties.

A more granular assessment of the nature and scope of the opioid crisis among Tribal, Pueblo, and Nations members in New Mexico is complicated by a lack of data. Stakeholder interviews indicated that access to MOUD in many Tribal, Pueblo, and Nation areas is limited. Stakeholders also emphasized that Tribal, Pueblo, and Nations members have diverse experiences attempting to access MOUD, depending on the services available through their sovereign governments and their geographical location, particularly whether they are in urban or rural areas. Consequently, there is no one-size-fits-all approach to expanding access to MOUD to Tribal, Pueblo, and Nations members, and a range of approaches – tailored to specific needs in specific areas – will be necessary.

At a policy level, Tribal, Pueblo, and Nations stakeholders expressed the desire to engage in peer-to-peer learning sessions with other Tribal governments throughout the country that have implemented successful behavioral health programs. Pew hopes to support these efforts by identifying successful Tribally-operated OUD programs and facilitating contact. The Pascua Yaqui Tribe in Arizona, for example, offers MOUD services and operates one of the few tribally-run OTPs in the country according to Indian Health Service (IHS) stakeholders. Stakeholders in New Mexico also expressed the need for increased representation and communication between BHSD/HSD and DOH.

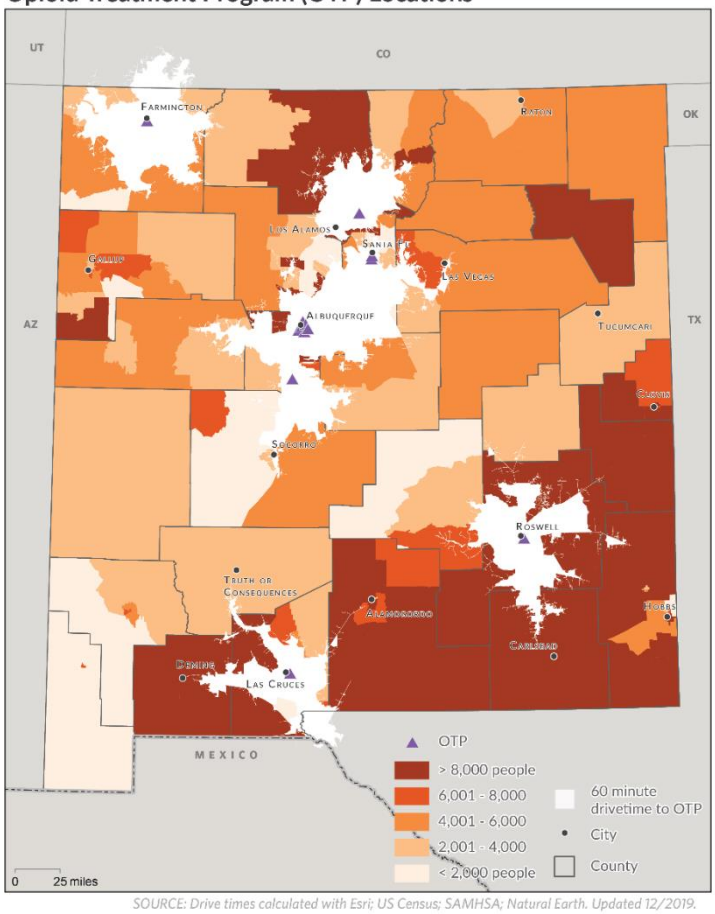
The Office of the Tribal Liaison, situated in DOH, and the Indian Affairs Department have recognized the need for better communication with BHSD/HSD. Their Overdose Prevention and Education Program hired a coordinator before the onset of COVID-19 to facilitate contact between state agencies and the twenty-three Tribal, Pueblo, and Nations governments in New Mexico. Their goals include increasing MOUD availability in primary care settings and ensuring naloxone availability.

Recommendations to Increase Access to
Substance Use Disorder Treatment

Prepared by The Pew Charitable Trusts for New Mexico

- In New Mexico, 63% of drug overdose deaths involved opioids in 2018; a total of more than 338 fatalities.[1]
- Among opioid-involved deaths, those involving synthetic opioids such as fentanyl—which is 50 to 100 times stronger than morphine—accounted for 108 fatalities.
- Deaths involving heroin or prescription opioids accounted for a respective 130 and 176 fatalities.
- In January 2020, HSD estimated that nearly 39,000 people were living with OUD in the state in 2018.[2]
- New Mexico recorded the highest Hispanic drug overdose mortality rate in the United States in 2017.[3]

New Mexico Population Density Outside 60 Minutes Driving of Opioid Treatment Program (OTP) Locations



SOURCE: Drive times calculated with Esri; US Census; SAMHSA; Natural Earth. Updated 12/2019.

[1] NIDA. 2020, April 3. New Mexico: Opioid-Involved Deaths and Related Harms. Retrieved from https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/new-mexico-opioid-involved-deaths-related-harms on 2020, November 18.
[2] Substance Use Disorder Treatment Gap Analysis, New Mexico Department of Health, January 2020. https://www.nmhealth.org/publication/view/marketing/5596/
[3] Manuel Cano (2020) Drug Overdose Deaths Among US Hispanics: Trends (2000–2017) and Recent Patterns, Substance Use & Misuse, 55:13, 2138-2147, DOI: 10.1080/10826084.2020.1793367

Pew's Policy Recommendations

Increasing the adoption of best practices for OUD treatment in the state's hospital system

Recommendation 1: The Governor's Office should direct the Department of Health to require hospitals, as a condition of state licensure, to have protocols for initiating MOUD, distributing naloxone, and transitioning patients treated for a drug overdose.

Recommendation 2: The Department of Health should use State Opioid Response funds to support practice facilitation.

Improving the quality and quantity of residential treatment for Medicaid patients

Recommendation 3: The Children, Youth, and Families Department, the Behavioral Health Service Division of the Human Services Department, and the Department of Health should create an inter-departmental council that coordinates regulation and compliance for residential treatment facilities.

Recommendation 4: The Behavioral Health Services Division of the Human Services Department should coordinate with the Regulation and Licensing Department and the Department of Health to phase in service requirements that expand the use of MOUD in residential treatment facilities using state licensure regulations.

Recommendation 5: The Behavioral Health Services Division of the Human Services Department should coordinate with the Regulation and Licensing Department and the Department of Health to require residential treatment facilities, as a condition of licensure, to provide treatment to public-insurance recipients on a non-discriminatory basis and report the facility's payer mix.

Aligning Opioid Treatment Program regulations with federal directives

Recommendation 6: The Governor should appoint a workgroup tasked with revising Department of Health and Board of Pharmacy regulations, as needed, to better align the state's Opioid Treatment Program workforce regulations with federal requirements on what kinds of providers can dispense methadone.

Increasing buprenorphine prescribing capacity and strengthen care coordination services

Recommendation 7: The Human Services Department should pursue a Centennial Care 2.0 managed care contract amendment to pay for care coordination services at the point-of-care to facilitate team-based care, with the goal of increasing the number of providers offering buprenorphine.

Reducing preventable deaths from OUD

Recommendation 8: The New Mexico Legislature should consider amending the 911 Good Samaritan Law to ensure legal protections for overdose bystanders.

Recommendation 9: The Department of Health should allocate funding to purchase and distribute fentanyl test strips through the Hepatitis and Harm Reduction Program.

Recommendation 10: To support the distribution of fentanyl testing strips, the New Mexico Legislature should consider introducing legislation to exempt drug testing materials from the Controlled Substances Act.

Expanding access to underserved populations, including individuals in criminal justice facilities

Recommendation 11: The Governor's office should direct the Department of Health to develop a plan with the Department of Corrections and the Behavioral Health Services Division of the Human Services Department to initiate MOUD programs in state prisons.