Progress Report

Program Evaluation Unit
Legislative Finance Committee
August 24, 2023

Addressing Substance Use Disorders

Summary

New Mexico consistently has the highest alcohol-related death rate in the country and ranked sixth nationally for drug overdose deaths in 2021. Substance use disorders (SUD) remain a problem in New Mexico, as alcohol- and drug-related deaths increased rapidly during the pandemic.

Between 2019 and 2021, the state's alcohol-related death rate increased by 31 percent, and 2,274 New Mexicans died of alcohol-related deaths in 2021. Similarly, the state's overdose-death rate increased by 68 percent, and 1,029 New Mexicans died of a drug overdose in 2021. Preliminary 2022 overdose data suggests the state's overdose death rate may have improved slightly, though this data is preliminary and subject to change.

The state is investing relatively little effort in upstream interventions and prevention efforts, given the magnitude of the state's high rates of SUD and associated deaths, particularly for alcohol misuse. New Mexico should expand and increase uptake in prevention programs and consider strengthening population-level prevention policies.

New Mexico has made significant investments in treating substance use disorders. The state is spending roughly $800 million on the Medicaid behavioral health program, which is the primary funding source for substance use treatment in New Mexico, as well as an additional $246 million annually for behavioral health services, which may include substance use treatment, through other agencies in the Behavioral Health Collaborative.

Previous LFC studies recommended expanding evidence-based forms of treatment, including the use of medications to treat opioid and alcohol-use disorders, as well as expanding the state's harm reduction efforts. New Mexico implemented several LFC recommendations, including statutory changes to the Harm Reduction Act and investments in medications to treat SUD.

This progress report finds some forms of evidence-based treatment have expanded within the state's Medicaid behavioral health program. However, the utilization of medications to treat SUD has not grown substantially, though the elimination of federal requirements could make treatment for opioid use disorder more accessible. Overall, the state continues to struggle to leverage data in a timely way to better estimate SUD needs and treatment utilization, and New Mexico risks duplicating or underleveraging available resources without coordination.

Progress Reports foster accountability by assessing the implementation status of previous program evaluation reports, recommendations and need for further changes.

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

Efforts to Expand Treatment Have Not Kept Pace With the Increasing Magnitude of Substance Use Needs

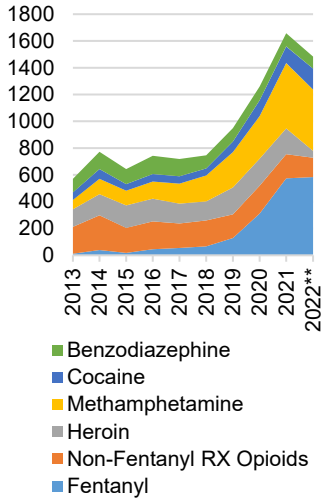
New Mexico experiences persistent challenges with substance use disorders, with trends worsening during the pandemic. In 2021, 3,303 New Mexicans died from drug overdoses and alcohol-related causes. Alcohol remains New Mexico's predominant substance-use problem, and 2,274 New Mexicans died from alcohol-related causes in 2021, roughly six people each day. The state has had the highest alcohol-related death rate in the country for over a decade, and the state's alcohol-related death rate worsened between 2019 and 2021. Yet, alcohol use disorder receives less policy attention than opioids, and treatment options do not meet the scale of need.

Substance use disorder occurs when the recurrent use of drugs or alcohol or both causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Source: SAMHSA

New Mexico's drug-overdose death rate was the sixth highest in the nation in 2021. Fentanyl deaths surged after 2019, compounding already high overdose deaths from methamphetamines and other opioids. According to the Department of Health (DOH), methamphetamine and fentanyl are now the most common causes of drug-overdose deaths in New Mexico, and the Commonwealth Fund, a healthcare advocacy organization, reported fentanyl and other synthetic opioids now play a role in 70 percent of overdose deaths nationwide. DOH reports 56 percent of New Mexico overdose rates involved fentanyl in 2021. Fentanyl has driven the increase in drug-overdose deaths since 2019, though overdose deaths involving methamphetamines have also increased. In 2021, 574 New Mexicans died from an overdose involving fentanyl, and 488 New Mexicans died from an overdose involving methamphetamines. In total, 1,029 New Mexicans died of drug overdoses in 2021, roughly three people per day.

Chart 1. Overdose Deaths by Substance 2013-2022**



*Deaths by drug type are not mutually exclusive; polysubstance deaths are common
** 2022 is preliminary and subject to change
Source: NM DOH Bureau of VItal Records and Health Statistics death

New Mexico has made significant investments and developed capacity to address substance use disorders in the state through evidence-based harm reduction and treatment programs. The state is investing roughly $800 million annually in the Medicaid behavioral health program, which is the largest payer of substance use treatment in the state and provides behavioral health insurance coverage to nearly half of all New Mexicans. Additionally, the state now has significant additional resources available to address substance use.

Despite these investments, New Mexico has not yet been able to reverse trends in substance-related deaths, which have rapidly increased in recent years. It is difficult for the state to address a rapidly-changing illicit drug market or reverse alcohol-related morbidity trends. DOH estimated in 2020 only one in three New Mexicans with a SUD are receiving treatment. Medicaid data suggest the number of New Mexicans receiving treatment through the program, which is the largest payer of SUD treatment in the state, increased by 19 percent between 2019 and 2022.

The Penn State Evidence to Impact Model (formerly Results First) estimated the lifetime cost of an illicit drug-use disorder is $245 thousand in New Mexico.

The model estimated the lifetime cost of alcohol use disorder is $154 thousand.

The overall estimated cost of substance use disorders in New Mexico is $39 billion

Source: LFC Files

Alcohol use disorder is the most prevalent form of SUD, and alcohol-related deaths are increasing at an accelerated rate.

The effects of the pandemic exacerbated existing problems. According to the National Institute of Alcohol Abuse and Alcoholism, the traumas of the pandemic, including Covid-19 infection, job losses, housing dislocation, and social isolation

caused alcohol consumption to increase 10 percent nationally and alcohol-related deaths to spike in all states. Nationally, Kaiser Family Foundation finds two-thirds of the public report they or someone in their family has been addicted to drugs or alcohol.

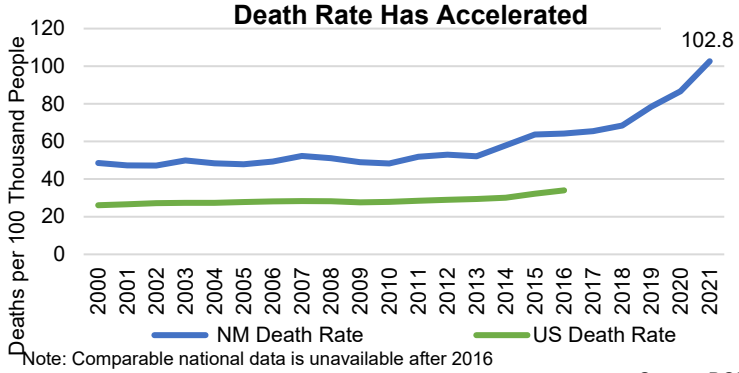
According to DOH, in 2021 roughly one in three New Mexico alcohol-related deaths were associated with alcohol-related liver disease and liver cirrhosis. Deaths resulting from alcohol-related injuries are also twice the national rate. Between 2019 and 2021, the most recent year for which DOH has published data, the state's rate of alcohol-related deaths increased from 78.5 deaths per 100 thousand people to 102.8 deaths per 100 thousand people, a 31 percent increase. While a current national comparison is unavailable because the CDC has not published a comparable national rate since 2016, in that year New Mexico's alcohol-related death rate was nearly twice the national rate. In 2019, 1,717 New Mexicans died from alcohol-related causes. In 2021, 2,274 New Mexicans died from alcohol-related causes, roughly 6 people per day. See Appendix D for alcohol-related deaths by county.

Table 1. Five Counties with Most Alcohol-Related Death Counts 2021

Bernalillo	709
McKinley	226
San Juan	199
Santa Fe	143
Sandoval	137

Source: LFC analysis of DOH Data

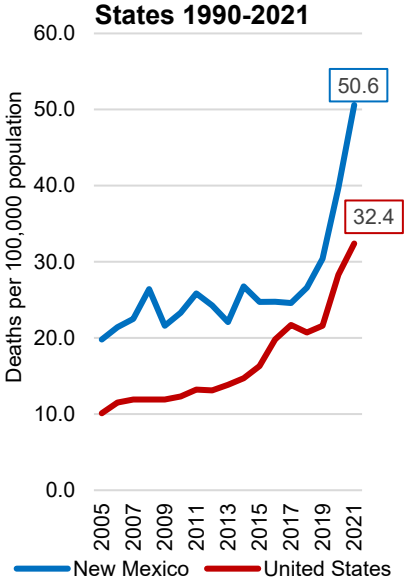
Chart 2. New Mexico's Alcohol-Related Death Rate Has Accelerated



Note: Comparable national data is unavailable after 2016

Source: DOH IBIS

Chart 3. Drug Overdose Death Rates, New Mexico and United States 1990-2021



Note: Rates are age adjusted to the US 2000 standard population

Source: United States - CDC Wonder; New Mexico - NMDOH BVRHS death data

McKinley, Cibola, Rio Arriba, San Juan, and Socorro Counties are hotspots of alcohol-related deaths. McKinley, Cibola, Rio Arriba, San Juan, and Socorro counties had the highest alcohol-related death rates in 2021, the most recent year for which DOH has reported county-level data (Appendix D). These five counties all had death rates that exceed 150 per 100 thousand people. Meanwhile, deaths in Bernalillo, McKinley, San Juan, Santa Fe, and Sandoval Counties made-up 62 percent of all 2021 alcohol-related deaths in the state in 2021, as seen in Table 1.

New Mexico persistently has one of the highest death rates from drug overdose in the country, though provisional data suggests a potential improvement in 2022.

The 2021 LFC substance use disorders progress report noted the problem worsened from 2016 to 2019.[1] Since 2019, New Mexico has experienced increasing drug overdose deaths, leading to an all-time high in 2021, when more than one thousand New Mexicans died from drug overdoses. Additionally, from 2019 to 2021, the rate of increase in New Mexico outpaced the national rate of drug overdose growth. Between 2019 and 2021, New Mexico's drug overdose death rate grew from 30.2 deaths per 100 thousand people to 50.6 deaths per 100 thousand people (68

[1] See https://www.nmlegis.gov/Entity/LFC/Program_Evaluation_Unit_Reports.

percent), while the national rate grew from 21.6 deaths per 100 thousand people to 32.4 deaths per 100 thousand people (50 percent). In 2021, DOH reported 1,029 drug overdose deaths in New Mexico, or about three people each day.

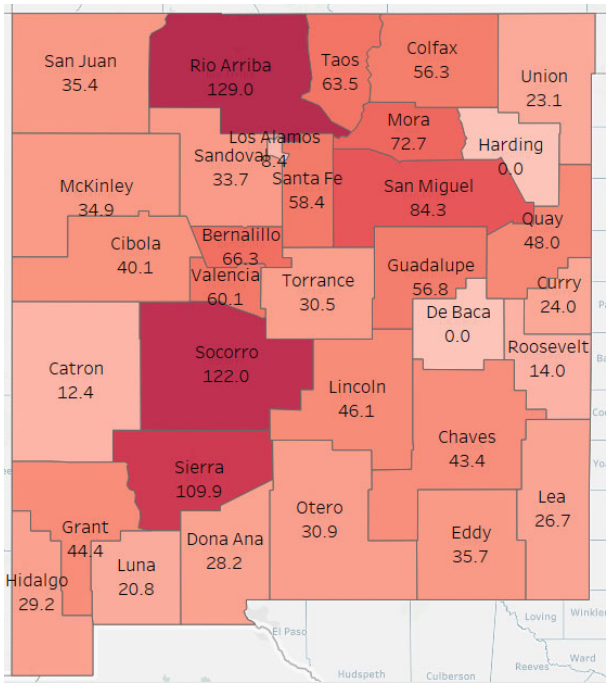
Nationally, provisional federal data suggest overdose deaths dropped during the first nine months of 2022 compared to the same period in 2021, but overdoses are still far higher than pre-pandemic levels. In May of 2023 the CDC released provisional 2022 overdose data that projects a slight reduction in overdose deaths in New Mexico in 2022. Provisional 2022 overdose death data reported by DOH indicate 957 New Mexicans may have died of drug-overdoses in 2022, which would suggest a 7 percent decline from 2021. The state's provisional overdose death rate also improved slightly to 47.0 per 100 thousand people in 2022. The 2022 data is provisional and incomplete, however, and subject to change, and no conclusions should yet be drawn from this initial data.

Table 2. Counties with the Highest Counts of Overdose Deaths 2021

Bernalillo	456
Santa Fe	81
Dona Ana	57
Sandoval	47
Rio Arriba	45

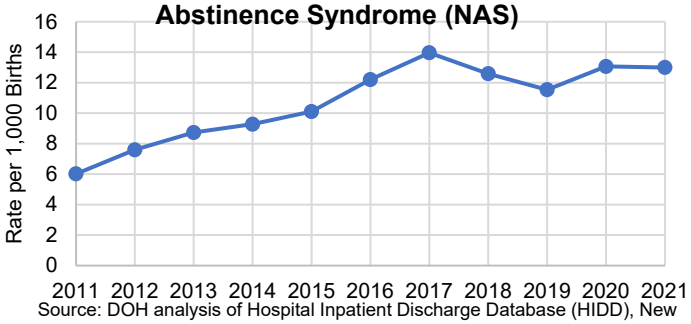
Source: LFC analysis of NM DOH

Figure 1. County Overdose Death Rates 2021
(deaths per 100 thousand people)



Source: NM DOH Bureau of Vital Records and Health Statistics death data; UNM/GPS population estimates

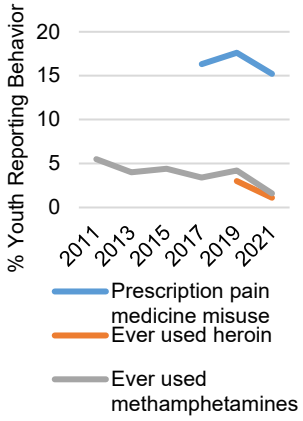
Chart 4. New Mexico Rate of Neonatal Abstinence Syndrome (NAS)



Source: DOH analysis of Hospital Inpatient Discharge Database (HIDD), New

In 2021, Rio Arriba, Socorro, Sierra, and San Miguel Counties had the highest rates of overdose deaths in the state, all exceeding 80 deaths per 100 thousand population. Nationally and in New Mexico, overdose death rates spiked in 2021. While Rio Arriba's overdose rate has outpaced the state overdose death rate for some time, the overdose death rates in Cibola, Socorro, Sierra, and Valencia Counties all increased rapidly during the pandemic, largely driven by fentanyl. See Appendix E for count of overdose deaths by county.

Chart 5. YRBS Illicit Drug-Related Questions 2011-2021

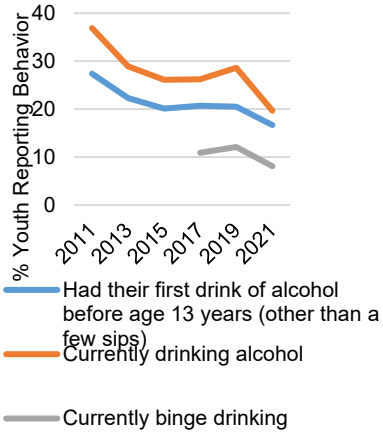


Note: Missing data for survey years in which a question was not asked

Source: CDC YRBS Data

Between 2011 and 2021, the rate of babies born with neonatal abstinence syndrome (NAS) more than doubled. NAS is a group of conditions caused when a baby withdraws from substances to which they were exposed in the womb. In New Mexico, the rate of babies born with NAS increased from 6 babies per one thousand in 2011 births to 13 babies per one thousand births in 2021. A total of 278 babies were born with NAS in New Mexico in 2021. Maternal substance use is also associated with high rates of post-partum mortality. A 2023 study of substance-use related maternal deaths found that among 87 pregnancy-associated deaths in New Mexico between 2015 and 2019, 49 percent were substance-use related.

Chart 6. YRBS Alcohol-Related Questions 2011-2021



Note: Missing data for survey years in which a question was not asked

Source: CDC YRBS Data

While substance use deaths are increasing, fewer New Mexico youth report using drugs and alcohol than a decade ago.

The Youth Risk Behavior Survey (YRBS) is used to measure health-related behaviors and experiences that can lead to death and disability among young adults. Youth reporting currently using alcohol declined from 37 percent in 2011 to 20 percent in 2021, and youth reporting binge drinking declined from 11 percent in 2017 to 8 percent in 2021. Between 2011 and 2021, surveyed youth reporting ever using methamphetamines declined from 6 percent in 2011 to 2 percent in 2021, and surveyed youth reporting ever using heroin declined from 5 percent in 2011 to 1 percent in 2021. The YRBS does not ask questions about fentanyl or synthetic opioids specifically. New Mexico's decline in adolescent drug use similarly mirrors national trends, but rates of drug use among New Mexico youth remain higher than national averages. According to the National Institutes of Health, roughly 5 percent of adolescents who use drugs and alcohol will develop problematic patterns of use that meet the criteria for substance use disorder, and over 90 percent of adults with a SUD began using drugs or alcohol during adolescence.

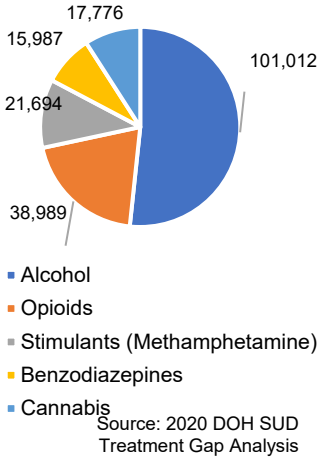
In 2020, DOH estimated 204 thousand New Mexicans were living with a SUD, and only one in three people were receiving treatment.

A 2020 DOH gap analysis, the most recent statewide estimate available, suggests just one-third, or an estimated 70 thousand, of the roughly 200 thousand New Mexicans living with a substance use disorder are receiving treatment. The gap analysis report estimates roughly 10 percent (an estimated 13 thousand people) of those not receiving treatment might enter treatment. The analysis estimated the largest gaps in people not receiving treatment exists among people with alcohol

use disorder (73 thousand New Mexicans) and people with benzodiazepine use disorder (14 thousand New Mexicans). Though roughly 18 thousand New Mexicans have cannabis use disorder, this report primarily focuses on alcohol and opioid-use disorders because of their prevalence and high death rates.

The effects of untreated SUD contribute to poor outcomes for the state, including high rates of substance related deaths and high rates of child maltreatment. In 2020, the two leading caregiver risk factors for child maltreatment in New Mexico were drug and alcohol use. Additionally, DOH reports New Mexico's persistent substance use challenges contribute to poverty, crime, unemployment, and domestic violence.

Chart 7. New Mexicans Living with Substance Use Disorders

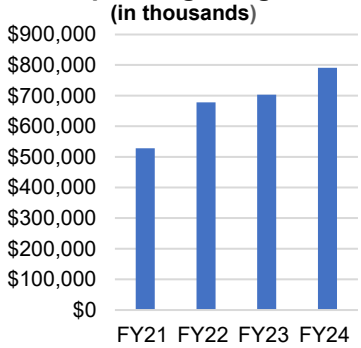


Source: 2020 DOH SUD Treatment Gap Analysis

Medicaid behavioral health is estimated to be the largest payer of SUD treatment services in New Mexico, with a budget that increased by 50 percent between FY21 and FY24.

New Mexico's Medicaid program provides healthcare. In 2014, when New Mexico expanded the Medicaid healthcare program for vulnerable and low-income children and adults to the higher-income adults eligible under the federal Affordable Care Act, the state integrated physical and behavioral health through the state's Medicaid managed care program, known as Centennial Care. Roughly 83 percent of Medicaid enrollees in New Mexico participate in managed care, though the state also operates a fee-for-service program. While the majority of New Mexico's Medicaid-eligible population are required to enroll in managed care, Native Americans may opt out of managed care and receive services through the New Mexico Medicaid Fee-For-Service (FFS) program, and Native Americans represent approximately 90 percent of all Medicaid enrollees receiving FFS. During the Covid-19 public health emergency, enrollment in the state's Medicaid program grew by roughly 20 percent, from approximately 830 thousand in February 2020 to 1 million in March 2023, when nearly half of all New Mexicans were enrolled in Medicaid. Federal funds are the primary revenue source for the Medicaid program.

Chart 8. Medicaid BH Operating Budget
(in thousands)



Source: LFC Volume II and Files

In FY24, New Mexico budgeted $790 million for the Medicaid Behavioral Health program, which provides substance use treatment coverage for nearly half of all New Mexicans. Between FY21 and FY24, the Medicaid behavioral health program operating budget increased by 50 percent, from $528 million in FY21 to $790 million in FY24. This growth was driven by enrollment growth because of the public health emergency as well as rate increases. While the state does not directly budget for SUD treatment within the Medicaid program, SUD treatment services are covered services. SUD services are wrapped into the capitation payment for behavioral health services HSD pays to MCOs, and the department does not track SUD-related expenditures specifically. Nationally, Medicaid is the single largest payer of behavioral health services. An estimated 21 percent of the Medicaid population nationally has a SUD, compared to 16 percent of the private insurance population. The 2020 DOH Substance Use Treatment Gap Analysis report suggests Medicaid funds an estimated 70 to 90 percent of all SUD treatment delivered in the state.

Under legislation enacted in 2023, the name of the Human Services Department changed to the Health Care Authority Department (HCAD). Beginning in FY25, the HCAD will be responsible for healthcare purchasing and policy. The bill also calls for the transfer of the Developmental Disabilities Services Division of the Department of Health (DOH), Division of Health Improvement (DOH), and state and local government employee health benefits (General Services Department) to transfer to the new HCAD.

New Mexico expanded SUD-related services covered under the state's Medicaid program. In 2017, the federal Centers for Medicare and Medicaid Services (CMS) announced states interested in exploring additional opportunities for flexibility to design demonstration waivers that improve access to high quality,

Table 4. Behavioral Health Operating Budgets, Excluding Medicaid (in thousands)

AOC	$17,258
HSD -BHSD (Non-Medicaid)	$91,013
DOH	$51,231
CYFD	$24,844
NMCD	$19,120
All Other BHC Agencies	$42,560
Total	**$246,026**

In FY23, the supplemental appropriations bill included $150 thousand for HSD to develop a statewide substance abuse treatment plan.

In FY23, DFA distributed $16.7 million in local driving while intoxicated (DWI) grant funds, which are used by counties for a variety of initiatives including prevention, treatment, and alternative sentencing.

The 2020 DOH Gap Analysis noted the need for AUD is particularly great, as an estimated 73 thousand New Mexicans were not receiving treatment they needed.

The Department of Health is establishing an office to focus on alcohol misuse. The department budgeted $2 million for the office in FY24 and plans to hire 11 FTE

In addition, in FY23 Senate Bill (the Junior Bill) included $100 thousand for a coordinator position within BHSD to work with state agencies to assess needs and programs for alcohol harm alleviation.

clinically appropriate treatment for opioid use disorder and other substance use disorders. Under the Centennial Care 2.0 waiver renewal program, New Mexico chose to participate in the SUD demonstration (see Appendix F) and added services to the state's benefits package, including adult residential treatment, allowing longer stays for inpatient hospital treatment, screening brief-intervention and referral to treatment (SBIRT), peer support, and crisis treatment services.

New Mexico also budgeted $246 million through other state agencies in FY24 to provide direct behavioral health services, including treatment for substance use disorders. New Mexico established the Behavioral Health Collaborative in 2004 to coordinate purchasing for the state's behavioral health system, and the vision of the Behavioral Health Collaborative is to create a single, statewide behavioral health delivery system. The Behavioral Health Collaborative includes 14 state agencies. Within the collaborative, several agencies provide direct behavioral health services. These agencies include the Human Services Department's Behavioral Health Services Division (BHSD), which funds the delivery of behavioral health services and substance use treatment for New Mexicans who do not qualify for Medicaid. In addition to funding that flows through BHSD, New Mexico delivers publicly funded SUD treatment for special populations through other agencies and programs belonging to the Behavioral Health Collaborative. DOH administers several substance use harm reduction and prevention programs and operates residential treatment programs, while the Children, Youth, and Families Department (CYFD) delivers behavioral health services for youth. The Administrative Office of the Courts (AOC) and the Corrections Department (NMCD) also administer programs to address substance use within the criminal justice system. In total, the operating budgets for behavioral health services across the collaborative agencies total $246 million, excluding the Medicaid program. See Appendix G for FY 24 General Fund appropriations for behavioral health.

The state also has significant additional resources available to address SUD that may go unused or underleveraged without coordination and data informing this approach.

The Medicaid behavioral health program, which receives about $3 in federal funds for every $1 the state invests, remains the largest payer for substance use treatment in the state. In addition, a variety of other funding sources—revenue from the pharmaceutical company settlements with states for the harms of opioid use, local gross receipts tax revenue, and other grants—may be used to address SUD, including paying for services or infrastructure not covered by Medicaid. However, without coordination, the state risks supplanting or underleveraging these resources.

The $20 million appropriated to CYFD in FY23 to expand behavioral health provider capacity has gone unspent. In FY23, the Legislature appropriated $20 million to CYFD to build the state's behavioral health provider capacity. A high-level draft plan was presented to the Behavioral Health Collaborative in April 2023, and HSD presented a proposal for the use of these funds to LFC in June 2023 (Appendix I). However, the department has provided limited details on these initiatives and has not spent or encumbered the appropriations as of the publication of this report.

State-run residential treatment facilities remain underutilized. DOH operates Turquoise Lodge and the New Mexico Rehabilitation Center (NMRC), both of which provide detox, residential treatment, and intensive outpatient programs.

Previous LFC evaluations found these facilities have low utilization, despite significant needs in New Mexico for SUD treatment. A 2022 LFC progress report about state facilities found NMRC maintained an occupancy rate of 25 percent, and Turquoise Lodge had an occupancy rate of 42 percent of licensed capacity. Staffing challenges and complex admission procedures may have contributed to low occupancy. Since the 2022 report, both facilities have made progress on hiring for vacant leadership and filled other critical roles as well as reviewed admission procedures. As of early August 2023, the licensed occupancy rate at Turquoise Lodge was 50 percent (20 patients), and the licensed occupancy rate at NMRC was 21 percent (9 patients). During fieldwork for this report, both Turquoise Lodge and NMRC reported waiting lists of roughly two weeks for admission.

The state will receive an estimated $300.4 million in payments related to opioid settlements over the next 19 years, and local governments will receive an estimated $367.1 million. In 2022, the New Mexico Attorney General announced the state had reached a settlement with three nationwide pharmacy retailers. The settlement divides proceeds between the state (55 percent) and local governments (45 percent). The settlements require the state to spend proceeds on allowable opioid addiction and prevention efforts, and the funding may be used for treatment and recovery programs for incarcerated people and people exiting the criminal justice system. The General Appropriation Act of 2023 appropriated $21 million to six state agencies and the University of New Mexico for services intended to address opioid substance use (see Appendix H).

Chapter 166 from the 2023 legislative session created two funds related to the opioid settlements: the opioid settlement restricted fund, which will house all opioid settlement revenues and receive future earnings from those revenues, and the opioid crises recovery fund, which will receive distributions from the restricted fund and from which the Legislature will appropriate for remediation in subsequent years. The restricted fund will be managed by the State Investment Council and an annual distribution of 5 percent will be made from the restricted fund to the opioid crisis recovery fund in perpetuity. However, as of this report, the transfer to the State Investment Council had not been made, and thus the state may be losing interest earnings. It is essential the state work with local stakeholders to gain the best value out of settlement funds and avoid supplanting existing resources, such as Medicaid. Other states have created regional frameworks to ensure collaboration between local governments and the state. The Behavioral Health Collaborative may be positioned to play such a coordinating role in New Mexico.

Some counties cover gaps in behavioral health services for which they potentially could bill Medicaid. Counties, including Rio Arriba, San Juan, McKinley, and Bernalillo directly provide services for people experiencing SUD, often relying on grant funding, including behavioral health investment zone (BHIZ) grant funding from BHSD, or local gross receipts tax revenue to sustain these services. In some cases, counties may be able to bill Medicaid for direct SUD services. Using BHIZ funds, Rio Arriba County invested in harm reduction, case management, and medicated-assisted treatment (MAT)[2] and experienced a decrease in overdose deaths before fentanyl use surged. Rio Arriba County attempted and was able to successfully bill for some SUD services but

Opioid settlement agreements outline allowable opioid remediation fund uses, including naloxone programs, medication-assisted treatment services for pregnant and postpartum women, treatment for neonatal abstinence syndrome, warm handoff programs and recovery services, treatment for incarcerated populations, and prevention programs.

The Behavioral Health Investment Zones (BHIZ) initiative provides funds to rural communities that lead the state in deaths attributable to alcohol, drugs, or suicide. The first zones were established in 2016 in two counties, Rio Arriba and McKinley, and funded for five years at $500 thousand per year ending in December 2020. The second round zones in San Juan and Sierra counties are now in their fourth year of implementation.

Examples of BHIZ spending to date include culturally relevant services not covered by Medicaid, renovations to a detox facility, trauma-informed prevention, outreach, education, technical assistance, capacity building, care coordination, and training.

These counties also have access to federal resources, such as the Health Resources and Services Administration, SAMHSA, and IHS to deliver evidence-based SUD treatment.

Source: LFC files

[2] SAMHSA recommends replacing the term medication assisted treatment (MAT) with medications for opioid use disorder (MOUD). The term "MAT" implies that medication plays a secondary role to other approaches while the term "MOUD" reinforces the idea that medication is its own treatment form. LFC staff will use the term MAT in the status report to avoid confusion and align with recent legislative language.

In FY23 the Behavioral Health Collaborative funded seven active local collaborative districts in the amount of $14,300 each to implement the Collaborative's overarching goals. The Collaborative will fund these local collaboratives at the same level in FY24 and plans to fund seven additional local collaboratives. There are potentially 18 local collaborative districts: 13 coincide with the state's 13 judicial districts and another five serve tribal communities. They will also conduct local needs assessments to support the update of the Collaborative's strategic plan.

Source: BHSD

New Mexico Behavioral Health Collaborative

The statutory responsibilities of the Behavioral Health Collaborative include:

1. Advocating for adults, children, and adolescents with serious mental illnesses, substance use, and co-occurring disorders
2. Reporting annually to the governor and Legislature on the adequacy of mental health services throughout the state
3. Encouraging and supporting the development of comprehensive, community-based health systems of care
4. Advising state agencies responsible for behavioral health services
5. Meeting regularly with members
6. Reviewing and making recommendations about state plans and applications for federal funding related to behavioral health, including Medicaid

Source: Section 9-7-6 NMSA 1978

discontinued Medicaid billing because of infrastructure challenges, including insufficient financial expertise and IT infrastructure challenges.

Bernalillo County has publicly expressed interest in billing Medicaid, and a behavioral health working group in the county recommended pursuing Medicaid credentialing. The county relies on a local gross receipts tax earmark to fund its behavioral health initiative.[3] The county used some funds for behavioral health services, including a health expansion program that allows community providers to apply for funding to expand or develop services, for renovations to the Comprehensive Assessment and Recovery through Excellence (CARES) campus facility, to support the county's housing voucher fund, and to administer MAT at the Metropolitan Detention Center. However, the county accumulated a fund balance of $91.8 million in FY22, up by $14.3 million over the prior year. In addition, the county anticipates receiving $4.4 million in opioid settlement funds.

Despite significant investments to address SUD, the state is not leveraging data effectively to inform investments or identify trends, risks, needs, and gaps in a timely way to strategically address treatment needs. Over the last decade, LFC reports have repeatedly highlighted a lack of utilization and performance data related to Medicaid behavioral health that make it difficult to determine how many Medicaid clients are receiving what behavioral health services and the outcomes for these services. In 2016, Senator Ben Ray Lujan noted in the *Congressional Record* in 2016 "a lack of meaningful data that is needed to hold policymakers accountable" when it comes to the Medicaid program and a deterioration of data "leaving the question of whether enrollees are receiving more or less care." Without comprehensive, recurring, and timely data about behavioral health trends and treatment utilization, the state struggles to identify trends and gaps in client needs.

Additionally, though the state expanded the services available under Centennial Care, HSD is not publicly reporting progress toward the demonstration waiver goals and metrics. The federal Centers for Medicare and Medicaid Services (CMS) articulated goals and milestones for state SUD demonstration programs. HSD is required to report progress and metrics related to these goals and milestones quarterly to CMS throughout the course of the demonstration waiver (See Appendix F). HSD provided LFC with the SUD demonstration reports through 2020, but more recent reports were unavailable. In addition, a 2018 letter from CMS suggests states should publicly post information about state progress toward metrics and goals, as well as demonstration evaluations. CMS also recommended states include reporting metrics related to SUD spending. While some states, including Ohio and Louisiana post SUD demonstration waiver performance reports online, HSD has not publicly shared this information. Doing so would allow the state to track progress about substance use treatment, outcomes, and spending as well as potential gaps and additional needs.

HSD has discontinued reports that previously shared information about unduplicated client service utilization and costs. The agency is currently working to replace its Medicaid Management Information System (MMIS) and reports the new system will include client utilization reporting capability. The project was

[3] Bernalillo County's behavioral health initiative is supported by a one-eighth of one percent GRT to be used for behavioral health, in accordance with state statute (NMSA 1978 7-20-E-28). According to the county's FY22 annual financial

initially scoped for completion in 2019. However, the project has experienced substantial delays and cost overruns and is now estimated to be completed in FY27.

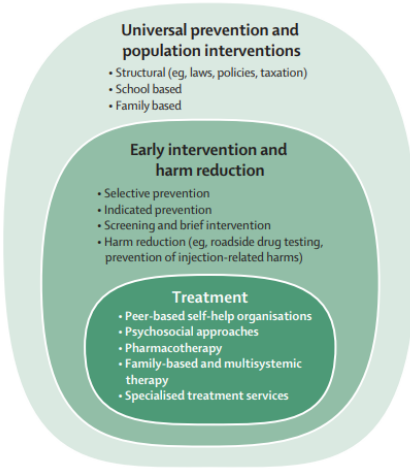
Finally, the Legislature lacks timely information about the public-health impacts of substance use disorders. The state is measuring and tracking alcohol-related and overdose death data. However, changes to these outcomes and reporting about these indicators lag considerably behind policy efforts. For example, 2021 is the most recent year for which final overdose death data is available, and SUD-related deaths are an outcome at the very end of the continuum of lifetime impacts. Moving forward, DOH could help identify and report about timely leading indicators to measure state progress to address SUD.

Providing the Legislature with recurring and consistent information about how many New Mexicans need and are receiving SUD treatment, the types of services they are receiving, and the spending on these services could allow the state to track progress toward meeting treatment gaps and ensuring public investments are made in evidence-based approaches.

The Behavioral Health Collaborative's statutory role positions the organization to play a strategic role in developing a comprehensive plan to address substance use disorders in the state. Given all the additional resources available to address substance use in the state, collaboration and coordination is needed to avoid resource duplication or supplanting. The Behavioral Health Collaborative is currently operating under a strategic plan that is about to end. It is funding needs assessments by the local collaboratives in support of its next strategic plan. LFC previously noted the Behavioral Health Collaborative should enhance its overarching coordinating role. Additionally, the LFC has previously noted reporting data from the administrative services organization (ASO, the private payment processor under contract with the state collaborative) would help track performance related to behavioral health across departments. The Behavioral Health Collaborative has an opportunity to play a coordinating function, particularly related to the use opioid settlement funds and coordination of services, across all three branches of government.

New Mexico has Resources to Invest in Upstream Programs and Strengthen Prevention Policies

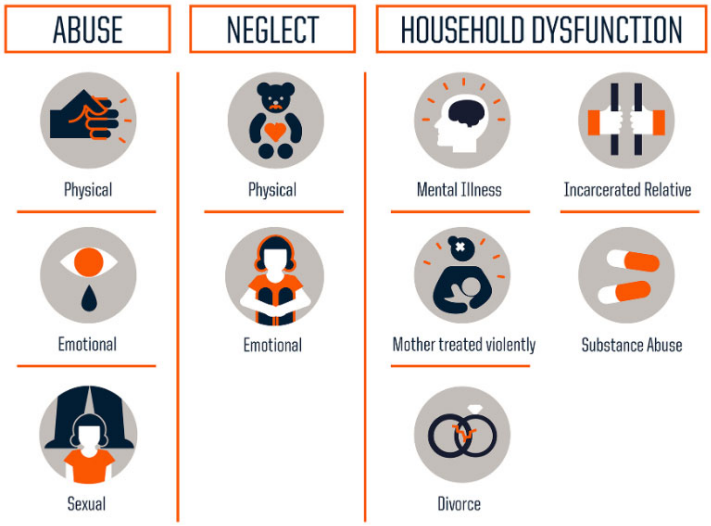
Figure 2. Spectrum of Interventions to Address Substance Use



Source: Stockings et al., 2016

Substance use may be addressed on a continuum, with prevention efforts at the family, school, or structural levels, or through harm reduction. While the state has invested significantly in treatment, New Mexico has not dedicated similarly-sized efforts toward prevention. A variety of strategies could be used to prevent people from initiating substance use and intervene early among people who may be at risk or show signs of problematic substance use. These strategies include family-based interventions, such as home visiting or family therapies, and school-based interventions, such as the Good Behavior Game. Additionally, states may employ structural policies to reduce access or utilization of substances. Previous LFC studies documented the need for evidence-based family and school-based interventions, which are currently limited in their scope and uptake. Additionally, New Mexico could take action to strengthen policies that increase the cost or access of alcohol, which research consistently documents results in decreased alcohol misuse and alcohol use disorder (AUD). These policies may be particularly impactful, given the persistent prevalence of AUD and alcohol-related deaths in the state. However, over the last few decades, New Mexico's alcohol excise taxes and other policies related to alcohol access have weakened.

Figure 3. Adverse Childhood Experiences



Source: CDC

Investments in upstream family and school-based services are needed to prevent substance use disorders in New Mexico.

New Mexico has very high rates of adverse childhood experiences (ACEs) and other risk factors and must address social determinants of health. According to America's Health Rankings, New Mexico's children and youth experience the highest rates in the country of adverse childhood experiences (ACEs), which are potentially traumatic events, including experiencing abuse and neglect, growing up in a household with substance use or behavioral health problems, and food or housing insecurity. According to DOH, 67 percent of adults have at least one adverse childhood experience, and nearly one in four adults have four or more ACEs. The National Institutes of Health suggests interventions in early childhood can help prevent future drug use. Additionally, research finds some evidence that suggests parent training that focuses on psychosocial development, using cognitive behavioral therapy, family skills training, and structured family therapy can prevent substance use among youth, though parent education about substance misuse alone is ineffective.

Previous LFC reports identified opportunities to invest in and expand family-based prevention and early intervention strategies. LFC reports have identified evidence-based programs that support families, improve parenting skills, and reduce child maltreatment, including the state's Home Visiting Program, which delivers home-based parenting support, differential response, which is an evidence-based prevention approach to divert families and children away from child welfare interactions, functional family therapy, and high fidelity wrap around services. These reports suggest effective prevention and community-based programs can reduce the prevalence of ACEs that result in poor outcomes, including substance use.

A 2022 LFC report about child maltreatment found New Mexico spent $38.3 million on foster care services compared with $10.4 million on prevention through CYFD programs, including $684 thousand spent on differential response specifically.

The federal Family First Prevention Services Act provides resources to turn the focus on the system toward avoiding trauma that results from out-of-home care, but New Mexico did not have an approved IV-E prevention plan.

CMS has encouraged states to use Medicaid managed care programs to address social determinants of health and to reduce health disparities within the flexibilities available under the program. Social determinants of health (SDOHs) are upstream conditions, such as housing, food, education, employment, and transportation, that affect quality of life and population health outcomes. As reported by the Center for Budget and Policy Priorities, people of color are more likely to experience barriers to treatment and have worse outcomes due to differentials in quality of treatment. In a 2021 CMS communication to state Medicaid agencies, CMS notes Medicaid beneficiaries may have challenges such as limited access to nutritious food, affordable housing, and strong social connections, and cites research about the connections between these challenges and poor health outcomes. According to Kaiser Family Foundation research, most managed care states reported leveraging Medicaid managed care contracts to incorporate at least one strategy to address social determinants of health. Kaiser reports more than half of states with Medicaid managed care require MCOs to screen enrollees for social needs, screen enrollees for behavioral health needs, provide referrals to social services, and partner with community-based organizations. Centennial Care 2.0, New Mexico's managed care program now covers community health workers (CHWs) and supportive housing tenancy and pre-tenancy support to members with serious mental illness. New Mexico's 1115 managed care demonstration waiver renewal application, known as Turquoise Care, proposes new covered services, including a pilot of home delivered meals for pregnant and parenting members and seniors and members with long-term care needs, and a closed loop referral system. New Mexico should study its pilots as well as other state's 1115 waiver pilots that address social determinants of health to determine the most effective models and services.

A 2023 LFC evaluation of the state's home visiting program noted home visiting programs likely reduce child maltreatment and improves parenting skills, but only 6 percent of children under age 5 in New Mexico receive services. The report recommended a variety of strategies to increase uptake and completion.

Traditional Healing Services

Within Centennial Care 2.0, traditional healing services are covered through MCO value-added services through a set budget. HSD's draft 1115 Medicaid Demonstration waiver proposes covering traditional Native American healing services as a covered benefit, potentially with an annual dollar limit or budget.

Structural strategies, such as policies that reduce alcohol consumption, can reduce substance misuse, but the state's policies have weakened over time.

Given the prevalence of alcohol misuse and alcohol use disorder, the state should consider greater investments in population-level strategies to prevent alcohol misuse. Data from the 2021 New Mexico Behavioral Risk Factor Surveillance Survey suggest 46 percent of New Mexicans drink alcohol monthly, and 15 percent engage in binge drinking. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), preventing alcohol misuse can reduce the risk of individuals developing AUD. SAMHSA reports a variety of policies have a base of strong evidence associated with reductions in alcohol misuse and related harms.

Table 4. SAMSHA- Recommended Policies to Reduce Alcohol Misuse and AUD

Evidence-Based Approach Policy	New Mexico Policy
Limiting/ restricting where alcohol retailers may be located through licensing or zoning	In 2021, New Mexico's Liquor Control Act was amended to allow home delivery for certain licensees. NMAC limits the authorization of liquor licenses within certain distances from churches and schools. NMAC also requires licensees to prohibit the access of minors to certain licensed areas. Through statute, New Mexico limits the concentration of dispenser and retailer licenses to one per 2,000 inhabitants in a county. Prior to 2021, the state also limited certain types of liquor licenses through high fees. Certain types of fees were lowered in 2021.
Minimum legal purchase age	The minimum legal age to buy, sell, or consume alcohol is 21. It is illegal for anyone to sell, give, or procure alcohol for minors.
Limiting days or hours of sales	In 2021, New Mexico shifted the start time of Sunday alcohol sales from 11am to 7am and removed the prohibition of Christmas Day sales. Alcohol may be sold between 7am and 11pm, midnight, or 2am, depending on the establishment.
Increasing alcohol taxes	New Mexico imposes a range of taxes on alcohol. Rates vary according to the type of alcohol (beer, wine, spirits) and the size of the producer. Currently, New Mexico's distilled spirits tax rate is the sixth highest among states with such excise taxes, while the beer rate is the ninth highest. However, many states have not adjusted rates for inflation in decades. In 2019, the Legislature amended the definitions of microbrewers and winegrowers, extending the definitions of producers and quantities that fit into the small producer, lower tax rate categories
Increasing the minimum unit price of alcohol	New Mexico does not have a minimum unit price of alcohol but does prohibit certain pricing practices, including sales of 2 drinks for the price of 1, pricing alcohol at less than half of the usual or customary price, and selling or delivering alcohol for less than the cost
Limiting alcohol advertising and marketing, specifically related to underage drinking	The Federal Trade Commission code requires no more than 28.4 percent of the audience for an ad may consist of people under 21, based on reliable audience data. New Mexico does not have specific laws related to marketing to people under 21
Dram shop (commercial host) liability laws	New Mexico is one of several states that allows someone injured or overserved to seek damages against the liquor seller (41-11-1 NMSA).

Source: SAMHSA, New Mexico Regulation and Licensing Department, NMAC 15.10.2, Johns Hopkins University

Table 5. New Mexico Liquor Excise Tax Rates

Spirituous liquors	$1.60 per liter
Beer	$0.41 per gallon
Beer produced by a microbrewer	$0.08 per gallon
Wine	$0.45 per liter
Fortified wine	$1.50 per liter
Wine produced by a small winegrower	$0.10 per liter on the first 90K liters and $0.20 per liter on liters sold after 80K but less than 950K
Cider	$0.41 per gallon

Source: NMTRD

Liquor excise taxes reduce alcohol misuse, but New Mexico's relative rate has decreased over time with inflation, though the state's current rates are among the middle to high range compared to other states. New Mexico imposes a liquor excise tax on wholesalers who sell alcoholic beverages, according to the type of beverage. New Mexico last increased alcohol excise tax rates in the 1990s. According to the Tax Policy Center, which converts state alcohol excise tax rates to dollars per gallon for comparison, New Mexico has alcohol excise tax rates that are among the middle to high range of states that set a flat dollar amount, as opposed to applying a flat rate. Nationally, the relative excise tax rate on alcohol has declined with inflation, decreasing the inflation-adjusted cost of alcohol significantly over time.

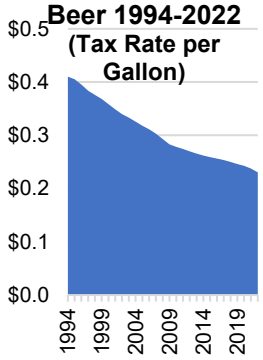
New Mexico has not raised its alcohol excise tax rate in 20 years, shrinking the impact by 44 percent. The Legislature included an increase to the state's alcohol tax in the 2023 omnibus tax bill, which would have increased the current liquor excise tax rates by 20 percent, and the bill would have required a portion of the proceeds be distributed to a newly created alcohol harms alleviation fund. However, the governor vetoed the increase to the liquor excise tax rates.

With a few exceptions, studies consistently find price or tax levels to be inversely related to sales and consumption of alcohol, with a 10 percent increase in alcohol pricing producing a 2 to 10 percent reduction in consumption. Additionally, most

but not all studies have found an association between higher costs of alcohol and lower rates of alcohol dependence, though one study has found higher alcohol prices to be associated with an increase in cannabis consumption among youth. Notably, a study of two increases in Alaska's alcohol excise taxes found significant reductions in alcohol-related morbidity, ranging between 11 and 29 percent. The study concluded alcohol taxes reduced morbidity two to four times more than other common prevention efforts.

In recent years, the state loosened some market-based policy interventions that limit access to alcohol. In 2019, legislation amended the definitions of microbrewers and winegrowers, extending the definitions of producers and quantities that fit into the small producer tax rate categories. In 2021, legislation made significant changes to New Mexico's liquor laws. The statute shifted the start time for Sunday alcohol sales from 11am to 7am, permitted the home delivery of alcohol, and created a new category of restaurant liquor license that reduced the cost of providing spirits, not just beer and wine. However, the bill also restricted the sale of liquor other than beer for some licenses that sell gasoline, prohibited the sale of small alcohol containers, and required DOH to study the effect of home alcohol delivery.

Chart 9. NM Effective Tax on Beer 1994-2022 (Tax Rate per Gallon)



Source: LFC

A study published by the National Bureau of Economic Research finds a tax increase of 10 percent would be expected to result in 2.1 percent decrease in sales. A 1 percent decrease in alcohol sales is associated with a 0.23 percent decrease in alcohol-related mortality rates.

Extrapolating to New Mexico, if the state's current alcohol tax rates had simply kept pace with inflation, an estimated 522 fewer New Mexicans would have died from alcohol-related causes since 1994, when tax rates last increased, and New Mexicans would pay roughly 44 cents more per serving of beer today.

Source: Cook et al., 2005

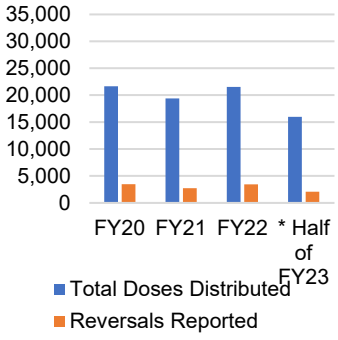
New Mexico is a leader in SUD harm reduction efforts, but implementation challenges remain.

Harm reduction includes a practical set of strategies, such as the distribution of naloxone to reverse overdoses or safe drug-use devices, to prevent drug-use related deaths. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), harm reduction is an evidence-based approach to engage people who are currently using drugs, equipping them with life-saving tools and information to create positive change and potentially save their lives. Harm reduction is a key pillar of the U.S. Department of Health and Human Services' overdose prevention strategy and, according to SAMHSA, can access to healthcare and treatment. New Mexico was the first state to implement harm reduction legislation and has been a leader in harm reduction nationally.

Since 1997, the harm reduction program within DOH has been focused on distributing supplies and devices related to the intravenous use of illicit drugs, which can spread HIV, hepatitis C, and other infectious diseases. However, the illicit drug environment has changed, with oxycodone, fentanyl, and other synthetic opioids, which are sometimes used illicitly by crushing and smoking tablets, now the most prevalent form of illicit opioid use.

The Legislature amended the Harm Reduction Act in 2022, providing the state with additional tools to reduce harm associated with illicit drug use. The 2021 LFC progress report about SUD noted the state's Harm Reduction Act prohibited the distribution of fentanyl test strips, an evidence-based strategy to reduce harm associated with fentanyl use. In 2022, legislation amended Section 24 NMSA to expand the allowable activities to control adverse outcomes of substance use, including overdose deaths and the spread of infectious diseases. Specifically, the amendment redefined the program, expanding allowable supplies and devices that may be distributed to include supplies to prepare or consume drugs in a sterile manner, provide a means of testing drugs for adulterants, such as fentanyl, and provide other supplies to prevent overdose and infection. New Mexico allows non-healthcare professionals to carry and administer naloxone, protects people who administer emergency care during overdoses from civil damages, and requires health care providers co-prescribe naloxone when prescribing opioids in certain

Chart 10. Naloxone Distribution and Reversals



Note: FY23 data is provisional and only includes the first six months of the fiscal year.

Source: DOH

cases. Since FY20, the state's harm reduction program has distributed over 78 thousand doses of naloxone. DOH also records information about overdoses reversed with naloxone. Between FY20 and the first half of FY23, DOH recorded 11,655 reversals, or potentially fatal overdoses averted. If the trend observed in the first half of FY23 continues, an estimated 4,000 overdoses will be avoided in FY23. Given the state's current number of overdoses is roughly one thousand annually, the number of fatal overdoses in the state could be up to four times higher without naloxone reversals.

Despite the increase in overdose reversals associated with naloxone use, a 2022 DOH survey suggests only 36 percent of New Mexicans know where to get naloxone if they need it. The survey concluded this metric has not meaningfully changed since 2019, despite education and outreach efforts. LFC fieldwork suggests stigma may prevent high-risk individuals from taking advantage of existing naloxone distribution programs. Ensuring access to individuals who may need naloxone is critical, and people who surround the individual who may need naloxone also must know how to obtain the reversal drug.

Stigma is the greatest barrier to patient engagement in MAT and SUD treatment nationwide. According to the National Council for Behavioral Health, pregnant and postpartum women experience the highest prevalence of stigma, followed by residents in rural communities, racial minority and tribal populations, and tribal populations, justice-involved populations, veterans, and families involved with Child Protective Services.

States may use a variety of methods to address and reduce stigma, including training staff, community education, changing language about substance use (e.g., replacing "drug habit" with "substance use disorder"), and disseminating information from government sources such as SAMHSA's Provider's Clinical Support System.

According to the National Council for Behavioral Health, some patient populations are particularly challenging to reach and engage in treatment:

- Speakers of indigenous languages,
- Residents of impoverished or rural regions of the state that cannot access treatment or resources,
- Young adults, aged 18–26 years) with OUD

Source: National Council for Behavioral Health

New Mexico has Made Some Progress but Should Expand the use of Evidence-Based Treatment, Particularly Medication-Assisted Treatment

Previous LFC evaluations have found limited access and utilization of numerous evidence-based models, including screening, brief intervention, and referral to treatment (SBIRT), intensive outpatient programs, certain forms of psychotherapy, and medication-assisted treatment (MAT). Since 2021, the state has made some progress to expand harm reduction efforts and evidence-based treatment delivered through the Medicaid program and BHSD. However, the state is unable to determine how large a share of the SUD treatment these patients receive is evidence-based, and the Medicaid program has seen a decline in SBIRT utilization. While some growth in MAT use has occurred, medications to treat SUD are underutilized, and barriers exist to expanding the use of buprenorphine, a medication used to treat opioid use disorder, and other medications.

In 2022, HSD spent at least $164 million to provide SUD treatment for roughly 87 thousand Medicaid and non-Medicaid clients, but the state knows little about some of the most common forms of treatment received.

The 2020 DOH gap analysis estimated the state's Medicaid program pays for 70 to 90 percent of all substance use treatment in the state. According to HSD, New Mexico spent at least $153.2 million to provide substance use treatment services to over 80 thousand New Mexicans through the Medicaid behavioral health program in 2022. These estimates of both patient counts and spending are likely conservative because they do not include pharmacy data, except for methadone. In 2020, the LFC estimated the Medicaid program spent roughly $22 million for MAT drugs other than methadone. In addition to Medicaid spending, HSD spent $10.8 million to provide SUD treatment for 6 thousand New Mexicans not covered by Medicaid through BHSD in 2022.

Treatment Continuum
From lowest to highest intensity

Early Intervention: provides education, resources, and counseling for people at risk for SUD

Outpatient Services: involves less than nine hours of treatment weekly for adults. May include medication treatment as well as group or individual therapy

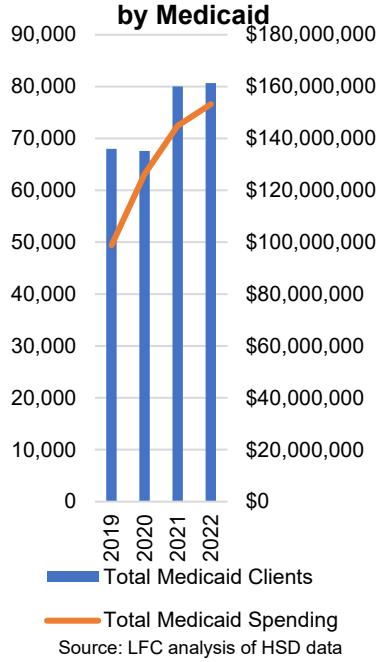
Intensive Outpatient or Partial Hospitalization: provides nine or more hours of services weekly for adults and may include medication treatment as well as group or individual therapy

Residential or Inpatient Services: offer 24-hour treatment services within a residential setting

Intensive Inpatient or Hospitalization: provides 24-hour nursing and physician care and includes counseling available for 16 hours per day. It is sometimes known as medical detoxification

Source: American Society for Addiction Medicine

Chart 11. SUD Treatment Provided by Medicaid



Source: LFC analysis of HSD data

Table 6. Select Common Services for SUD Treatment Medicaid Claims 2022

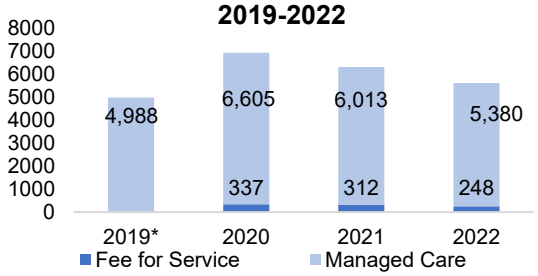
Service	Total Clients	Total Expenditures	% of Total Spend	Estimated ROI
Outpatient Hospitals (header-priced claims)	25,798	$33,518,301	22%	NA
Evaluation and Management Services in an Emergency Room	19,667	$4,099,169	3%	$4.72
Individual Psychotherapy	18,887	$11,045,761	7%	-$0.52 to $150
New Patient Office Visit	13,707	$1,823,693	1%	NA
Psych. Diagnostic Evaluation	10,749	$1,562,118	1%	NA
Alcohol and/or Drug Services-Methadone	8,063	$31,331,116	20%	$4.06
Alcohol and/or Drug Prevention	5,075	$2,311,611	2%	NA
Group Therapy	4,255	$2,389,181	2%	NA
Alcohol and/or Drug Services-Intensive Outpatient Programs	3,666	$21,222,811	14%	NA
Self-Help and Peer Support Services	2,495	$1,035,068	1%	$13.55
Inpatient Hospitals (header-priced claims)	2402	$20,209,652	13%	NA
Comprehensive Community Support Services	1,775	$4,057,917	3%	NA

Notes: The services presented in this table reflect either services that clients most frequently received or services that account for the largest share of Medicaid SUD-related claims spending.
ROI estimates are included for services in the Penn State's Evidence to Impact Collaborative Model to treat SUD.
Services that the LFC could not map to the model are listed as NA.
Psychotherapy reports a range because ROI varies widely, depending on the form of psychotherapy, which is unknown
Header-priced claims include inpatient and outpatient stays that may include non-SUD related services. As such, the spending totals in the inpatient and outpatient hospital categories may inflate the estimated total spend on SUD services.

Source: LFC analysis of HSD Medicaid Claims data

Expanding universal screenings, brief interventions, and referrals to treatment (SBIRT) could improve access to SUD treatment, but utilization has declined since 2020. SBIRT is an adult screening and early intervention tool typically delivered in primary care settings to integrate behavioral and medical health care. Since 2019, SBIRT has been a Medicaid-billable service in New Mexico. HSD included SBIRT as one of the state's key metrics to measure progress toward increasing the rate of identification, initiation, and engagement in treatment within the state's SUD demonstration waiver from CMS. SBIRT utilization declined 19 percent between 2020 and 2022, when 5,628 people, or less than one percent of the Medicaid population received SBIRT. The Legislature appropriated $2.8 million to the behavioral health Medicaid program in 2023 for SBIRT.

Chart 12. SBIRT Utilization 2019-2022



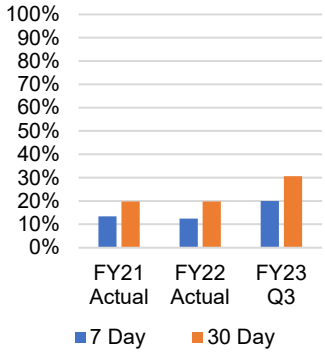
Note: LFC does not have 2019 FFS SBIRT data available data for fee-for-service
Source: HSD (2020-2022) and SUD Demonstration Waiver Report (2019)

HSD Accountability in Government Act (AGA) measures do not explicitly track SBIRT. However, connecting patients to treatment following a substance-use related emergency room encounter is an HSD performance measure. Performance on this measure has remained in the red or yellow for several years (Appendix A). Two-thirds of those screened in the emergency room are not connected to treatment. In addition, LFC analysis of Health Effectiveness Data and Information Set (HEDIS)

data suggest follow-up is particularly poor for children under age 18; in 2021 only 9 percent of children received a follow-up visit within 30 days after presenting in the emergency room for substance use. HSD plans to increase hospital accountability to improve emergency room follow-up using value-based purchasing incentives in Medicaid contracts.

Psychotherapy and evaluation-related procedures are some of the most frequently utilized SUD treatment services, though the state does not have information about how many people receive different types of therapy readily available. Among Medicaid clients receiving SUD treatment, evaluation and diagnostic services are common, as is treatment in an outpatient hospital settings, such as an emergency department visit, as noted in Table 6 above. In 2022, over 18 thousand clients received a psychotherapy visit. Psychotherapy, sometimes known as "talk therapy," refers to a variety of different treatments. The evidence basis for these forms of treatment for SUD, as well as their ROI, varies. As noted in previous LFC reports, HSD has been unable to readily report how many people receive different types of evidence-based forms of psychotherapy. The department plans to use new billing codes and provide enhanced Medicaid reimbursement rates to incentivize certain evidence-based approaches to psychotherapy. Services received in an outpatient hospital setting, such as an emergency room, are also common and costly service, with over 25 thousand Medicaid clients receiving such services in 2022. Yet, as noted above, two out of three clients who receive care in the emergency rooms are not connected to timely follow-up care.

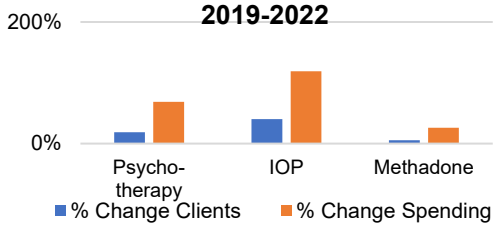
Chart 13. ER Visits for Medicaid members ages 13 and older with a principal diagnosis of alcohol or drug dependence with a follow-up visit



Source: BHSD Q3 FY23 Report Card

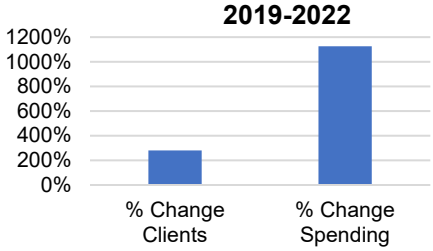
Between 2019 and 2022, the number of clients receiving psychotherapy, IOP and peer support services all grew, though spending increased at a faster rate. The 2021 LFC progress report on SUD noted spending on core substance use services tripled between 2014 and 2020, with methadone administration, along with other medication assisted treatment (MAT) drugs, psychotherapy, and IOP spending categories driving much of the spending growth. The report also noted the number of clients served in each category also grew, but at a slower rate than spending. This trend continued between 2019 and 2022, and a combination of increased encounters for these services as well as provider payment rate increases may have played a role in the overall spending increases. Peer support service utilization grew at particularly high-rates, with the number of clients receiving these service increasing by 280 percent and spending increasing by over 1,000 percent between 2019 and 2022. This growth likely occurred because peer support became a Medicaid-billable service in 2019. HSD has also focused efforts on training peer support workers. While the number of clients receiving Methadone increased by only 427 clients, the service accounts for a large share of total costs. In 2022, spending for Methadone administration for 8 thousand clients in 2022 cost $31.3 million.

Chart 14. Increase in Utilization and Spending Select SUD Services 2019-2022



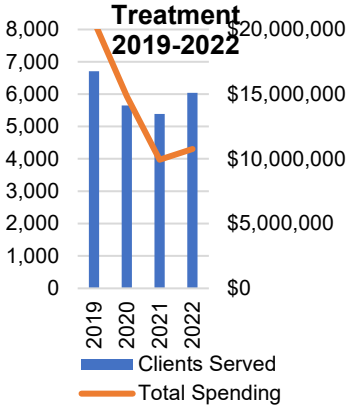
Source: LFC analysis of HSD Medicaid caims data

Chart 15. Increase in Utilization Peer Support Services 2019-2022



Source: LFC analysis of HSD data Medicaid claims

Chart 16. Non-Medicaid BHSD Substance Use Treatment 2019-2022



Source: LFC analysis of

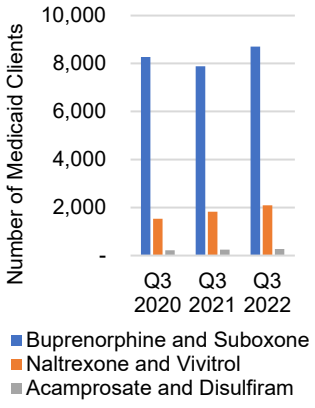
Between 2019 and 2022, BHSD non-Medicaid SUD spending and clients declined as Medicaid enrollment grew. In 2022, BHSD spent $10.8 million to provide SUD services to 6,039 non-Medicaid clients, a 48 percent decrease in spending and 10 percent decrease in clients. These declines may have been driven by increased Medicaid enrollment because more clients were enrolled in Medicaid and received services through this source of payment. Residential treatment services were the most billed SUD service paid for by BHSD; 3,582 clients received this service at a cost of $7.9 million in FY22. Individual psychotherapy was also a frequently used service, though BHSD is currently unable to report the forms of therapy and whether they are evidence based. BHSD spent $507 thousand to provide psychotherapy to 1,846 clients in FY22.

Effective use of medications to treat SUD continue to trend upward slightly while remaining limited in overall use, particularly for alcohol-use disorders.

According to CMS, people with untreated alcohol use disorder (AUD) use twice as much healthcare and cost twice as much as those with treated AUD. Total healthcare costs are 30 percent less for individuals receiving MAT than for individuals not receiving

According to SAMHSA, several medications approved by the Food and Drug Administration (FDA) may be used to treat substance use disorders, often in combination with psychosocial therapies, to provide a "whole-patient" approach. The use of such medications is clinically driven and tailored to meet patient needs. Research shows the use of such medications can successfully treat SUD, help sustain recovery, and reduce overdoses when used to treat OUD. In addition, medications to treat SUD have been shown to improve patient survival, increase retention in treatment, decrease the use of other illicit substances, increase a patient's ability to obtain and sustain employment, and improve birth outcomes among pregnant women with SUD.

Chart 17. Medicaid MCO Enrollees: MAT Patients



Source: Medicaid MCO Q3

Medicaid managed care data suggest MAT may be underutilized, particularly to treat alcohol use disorders. Effective and federally approved medications for both OUD and AUD exist and remain the standard of care for both types of substance use disorder. LFC's 2019 *Health Note: Substance Use Disorder* and 2021 progress report found MAT especially for AUD is underutilized.[4] Most notably, acamprosate and disulfiram, which are exclusively used for alcohol-use disorders, are underutilized given the prevalence of AUD in New Mexico. This trend appears to have continued between 2020 and 2022. Analysis of quarterly MCO pharmacy reports suggests the number of Medicaid managed care patients receiving acamprostate or disulifiram increased from only 221 to 274 in 2020 to 2022 respectively. DOH estimates show approximately 73 thousand New Mexicans have an untreated SUD and approximately 7,300 (10 percent) would accept treatment. SAMHSA recommends MAT combined with psychosocial treatment for people with moderate to severe AUD. DOH could direct its new alcohol office to further study this treatment gap.

Although AUD treatment can be offered within inpatient settings, residential, or outpatient settings, particularly in rural areas patients are most likely to seek treatment from primary care providers. In New Mexico, DUI courts are another common referral for AUD treatment. However, this study was unable to determine where people are receiving treatment for AUD and if medications to treat AUD are available locally. New Mexico does not have state-level information about

[4] See https://www.nmlegis.gov/Entity/LFC/Program_Evaluation_Unit_Reports.

provider or patient attitudes about MAT to treat AUD, and future DOH stigma surveys or the Behavioral Health Collaborative could be leveraged to gather this information.

The federal Mainstreaming Addiction Treatment Act of 2023 aims to expand access to medication-assisted treatment for opioid use disorder, but additional barriers may remain.

Medications to Treat Alcohol-Use Disorder

SAMHSA recommends acamprostate, disfuliram, and naltrexone to treat patients with moderate or severe AUD as part of a comprehensive treatment approach that includes psychosocial treatment.

Source: SAMHSA

The Mainstreaming Addiction Treatment Act of 2023 eliminated the so-called "X-waiver," which required clinicians to undergo training and a registration process with the federal Drug Enforcement Agency to prescribe buprenorphine. This process was believed to present a barrier to the number of buprenorphine prescribers and stigmatize the practice. The federal policy change may potentially increase access to MAT significantly, as primary care physicians may prescribe the treatment without a waiver. Nationally, public health experts suggest clinicians will need training and information to understand the policy change, reduce stigma, and increase prescriptions to treat opioid use disorder. The Behavioral Health Collaborative intends to survey providers who formerly held X-waivers to understand their prescribing patterns and identify potential barriers.

According to the *Journal of the American Medical Association*, a quarter of all patients who need OUD treatment are currently receiving treatment. The use of medication to treat OUD is associated with reduced overdose deaths, reduced opioid use, and reduced criminal activity.

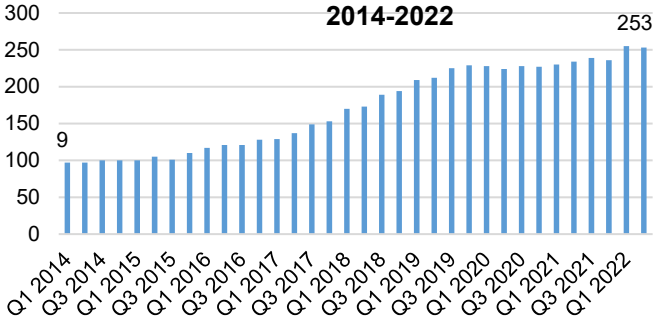
In 2021, HSD reports 8,186 Medicaid clients received buprenorphine treatment

Source: JAMA

While the MAT Act eliminated a formal policy limitation associated with prescribing, additional dispensing barriers remain. According to a 2019 national survey, barriers to expanding MAT include individual provider decisions and stigma associated with prescribing, confusion about regulations related to dispensing, a general lack of training, and a shortage of community providers to whom providers can refer patients. Stigma is a particularly strong barrier in small and rural communities because of the lack of anonymity. Lack of transportation and inadequate insurance coverage were also cited as significant barriers.

Providers who can prescribe buprenorphine continue to underutilize their prescribing ability. Buprenorphine is approved by the FDA to treat opioid use disorder and can be prescribed or dispensed in physician offices, unlike methadone which must be dispensed in a specialized clinic. The Penn State Evidence to Impact Model suggests buprenorphine has a benefit-to-cost ratio of $3.30 for every $1 spent. When the former X-waiver was in place, SAMHSA reported the number of providers in each state who consented to report they held an X-waiver. In 2022, SAMHSA listed roughly 600 providers with New Mexico licenses who possessed X-waivers on their websites. However, many of these providers tend to see few, if any, buprenorphine patients. According to data from the state's prescription monitoring system, roughly 250 providers in New Mexico were prescribing buprenorphine to 10 or more patients in 2022. The number of buprenorphine prescribers statewide has increased 161 percent since 2014.

Chart 18. Buprenorphine-Certified Providers with 10+ Patients 2014-2022



Source: NM Board of Pharmacy Prescription Monitoring Program

Despite the statewide increase of buprenorphine prescribers, access to buprenorphine treatment may remain limited. As noted in the December 2022 LFC Medicaid access and utilization report, though managed care organizations

Table 7. Buprenorphine-Certified Providers by Managed Care Organization

	MCO A	MCO B	MCO C
Number of Buprenorphine-Certified MD/CNP	232	Data unavailable	39

Source: MCO Geoaccess Reports, Q4 2022

(MCOs) tend to meet contractual network adequacy standards, these standards are too low, and patients may be unable to access appointments with behavioral health providers. MCO contracts do not establish time-to-appointment or provider-to-patient ratio standards for MAT. Contracts only require MCOs to ensure a MAT provider is available within a certain distance for all clients, and all MCOs met contractual distance standards for MAT in 2022.

However, fieldwork suggests patients may experience challenges accessing MAT providers, particularly in rural communities in New Mexico. In addition, access may vary between Medicaid MCOs. Fourth quarter MCO network data from 2022 suggests while one MCO reported 232 buprenorphine-prescribers in network, another MCO reported only 39 buprenorphine-certified providers in the MCO's network.

New Mexico's prescription monitoring program (PMP) is a data repository for prescribers used to monitor prescription drug utilization of patients. Prescriber requirements to check the PMP were expanded in 2012, 2016, and 2017. According to a 2019 LFC SUD report, New Mexico experienced a 20 percent decline in the number of opioid prescriptions and55 percent reduction in patients filling multiple prescriptions for controlled substances.

Research suggests training and support for providers increase MAT prescribing and willingness to accept larger SUD patient loads. A 2022 evaluation of the Project ECHO approach to providing training and mentorship to primary care clinicians who treat Medicaid patients found it increased their likelihood of obtaining the former X-waiver to administer buprenorphine. In addition, the number of patients with opioid use disorder (OUD) providers treated was 8 percent higher than other primary care clinicians who treat Medicaid clients Fieldwork indicates the initiation and treatment of OUD patients using fentanyl is more challenging and complex than MAT treatment for heroin or prescription opioids and requires training and mentoring. Project ECHO, based at the University of New Mexico, has demonstrated the effectiveness of tele-mentoring in building the capacity of local primary care providers to use MAT to treat SUD and to treat chronic pain disorders that cause dependency. Project ECHO shares the organization plans to develop a new model for training and mentoring clinicians in the treatment of alcohol use disorder (AUD). Expanding training for primary care clinicians in New Mexico could increase the number of providers delivering MAT services. In 2012, state law was amended to require the medical boards to require non-cancer pain management continuing education for health care providers who hold a federal drug enforcement registration and licensure to prescribe opioids. Currently, the boards require five hours of training every three years. The Legislature could expand continuing education requirements related to treating SUD with medications, including the treatment of AUD.

In 2022, pharmacies and providers reported 26 issues to DOH regarding buprenorphine prescription access in a two-month period. Counties with incident reports included:

- Bernalillo
- Dona Ana
- Grant
- Lea
- Rio Arriba
- Santa Fe
- Sierra

Source: NM DOH

Wholesalers are artificially limiting buprenorphine supplied to retail pharmacies, preventing patients from filling MAT prescriptions. Dispensing barriers including supply and stocking issues have surfaced in the aftermath of the opioid settlement, despite the elimination of the X waiver. The 2017 federal CARES Act created barriers to pharmacies stocking enough buprenorphine to meet patient demand by establishing "suspicious ordering thresholds" for controlled substances, including buprenorphine used to treat OUD. Wariness on the part of wholesalers concerned about additional litigation after the opioid settlement agreement has led them to deny requested medication orders from pharmacies they deem to suddenly increase in volume.[5] According to LFC field work and press reports, wholesalers' actions have made it difficult for patients to fill their prescriptions for buprenorphine, leading to potential continued reliance on illicit

[5]In May 2023, congressional members, including Senator Martin Heinrich and Representative Ben Ray Lujan, sent a letter to the U.S. Drug Enforcement Agency, documenting supply and other barriers and requesting DEA action.

opioids and increasing chances of overdose. Further, prescribing clinicians have the additional burden of locating the medications or rerouting scripts, which may result in their unwillingness to take on new patients or continue treating OUD patients In 2022, DOH collected incident reports from pharmacies and providers confirming constituent reports to congressional staff that patients are unable to fill their prescriptions and pharmacies are experiencing challenges maintaining sufficient stock of buprenorphine in some counties. Local practitioners are working with congressional staff and local DEA representatives to address federal regulations and guidance for wholesalers. However, action by the DEA and Congress is needed to remove buprenorphine from the list of controlled substances subject to unusual ordering reporting and to clarify whether buprenorphine ordering may prompt a DEA audit.

Table 8. JAMA Recommended State Buprenorphine Pharmacy Regulations

Goal	State Action	New Mexico
Ensure the availability of buprenorphine at retail pharmacies	Pass legislation that will require pharmacies stock a minimum inventory of at least 1 buprenorphine product.	Should consider legislation
Prevent pharmacists from declining to dispense buprenorphine prescriptions	Pass state legislation that requires pharmacies to fill all valid buprenorphine prescriptions for OUD	Should consider legislation
Expand home-delivery of buprenorphine	Remove in-person dispensing requirements and home-delivery restrictions for buprenorphine	No policy restrictions

Source: JAMA and NM Board of Pharmacy

New Mexico's pharmacy regulations allow virtual prescribing and home delivery of buprenorphine access, but the state could further expand prescription access. Table 8 summarizes the potential policy solutions states may take to reduce barriers to dispensing buprenorphine. New Mexico does not place limits on home delivery of buprenorphine but could expand access by requiring pharmacies stock and fill prescriptions. The Legislature could pass legislation requiring these activities. The New Mexico Board of Pharmacy should consider reviewing all current dispensing regulations and eliminate regulations that may be unintentionally imposing barriers for the dispensing of buprenorphine in retail pharmacies.

SAMHSA endorses telehealth to address the SUD treatment gap, make treatment more accessible and convenient, and reduce health disparities. According to a 2022 federal issue brief, Medicaid beneficiaries used telehealth in 2021 at a higher rate than other groups. The 2022 LFC study of Medicaid access and utilization found telemedicine utilization in New Mexico increased 1,700 percent between 2019 and 2021

Though utilization of some behavioral health services may have increased, New Mexicans who need SUD treatment may face barriers to care.

The 2020 DOH SUD gap analysis estimated 204 thousand New Mexicans are living with a SUD and estimated 134 thousand New Mexicans are not receiving the care that they need. New Mexicans experience a variety of challenges accessing SUD treatment, including insufficient numbers of providers and challenges with stable housing. New Mexico is currently a behavioral health shortage area according to the U.S. Health and Human Services Department. U.S. HHS reports 18 percent of the state's behavioral health needs are met, and 90 additional providers are needed to eliminate this designation. LFC reports have highlighted a variety of strategies to address these challenges, including increasing the number of people served in New Mexico state-run facilities, leveraging telehealth, improving the Medicaid provider network, and increasing supportive housing. In 2022, the Medicaid program provided SUD treatment for 80,656 New Mexicans.

Previous LFC reports highlighted behavioral health provider shortages across the state, and Medicaid clients in particular experience challenges accessing care. Despite expanding coverage to care and increasing spending, access to behavioral healthcare among Medicaid clients is limited. A 2022 LFC program evaluation of the Medicaid managed care network found Medicaid enrollees in New Mexico are experiencing significant challenges accessing care. Managed care contracts establish time-to-appointment standards MCOs must maintain; Medicaid clients should be able to access out-patient appointments for

MCOs do not have enough providers in their networks to delivery timely care. A 2022 LFC Program Evaluation of Medicaid Network Adequacy, which included a secret shopper survey resulted in behavioral health appointments for only 13 percent of behavioral health providers listed in MCO directories.

The Mortgage Finance Authority (MFA) recently awarded $2 million in federal housing program funds to two projects for rehabilitation and acquisition of recovery housing in Gallup and Albuquerque. The MFA Board of Directors approved two awards of $969 thousand to Hozho Center for Personal Enhancement in Gallup and $1.14 million to Crossroads for Women in Albuquerque. The federal 2018 Support for Patients and Communities Act authorized the program to develop or maintain recovery housing and services. MFA administers the program and awards funds through a competitive application process MFA has received a total of $5 million since FY20.

Source: MFA

Senate Bill 425 creates the medication-assisted treatment program fund in the state treasury and designates HSD as the fund administrator. Money for the fund shall be appropriated to HSD to assist counties that operate correctional facilities to establish and operate MAT programs.

Source: NMSA 1978 24-1-5.9

DOH is establishing plans to administer MAT in local public health offices to expand access, including to formerly justice-involved patients. To address provider and access shortages to MAT, DOH is planning to leverage public health offices to administer MAT. In 2023, House Bill 2 appropriated $3.5 million to DOH to expand MAT access. The department has delivered this service through the Southwest Pathways program, located in Dona Ana County. The department is in the initial planning phases of this initiative and plans to leverage both Medicaid billing and the state appropriation for MAT to fund the program.

non-urgent needs within 14 calendar days and urgent conditions within 24 hours. MCOs, however, were not meeting these and other standards related to access to behavioral healthcare. The 2022 LFC report recommended strengthening and improving quality initiatives and contractual accountability and increasing Medicaid provider rates to improve the provider network. The report also recommended and increasing the state's overall healthcare workforce through investments such as loan repayment and continuing to leverage telehealth to improve behavioral health access. For FY23, the Legislature appropriated $32 million to increase Medicaid behavioral health fee-for-service rates to 120 percent of the Medicare benchmark, and House Bill 2 included language that MCOs should not set rates lower than fee-for-service rates. HSD has implemented the fee-for-service rates increases and directed MCOs to do the same; rate increases took effect in July 2023.

Lack of affordable housing, a social determinant of health, is also a significant barrier to treatment access and success. A 2023 LFC report on homelessness supports and affordable housing documents the growing need across the state for affordable housing with supports and the increase in housing insecurity.[6] LFC fieldwork found a lack of affordable housing, particularly recovery and transitional housing, is a current barrier to SUD treatment. New federal and state funding fills gaps in affordable housing for individuals with SUD who need recovery and supportive housing. BHSD funds SUD transitional recovery housing through Oxford House™, which operates self-run, self-supported housing for individuals recovering from substance use disorder. There are currently multiple houses for men and women in Las Cruces and Albuquerque which provide the time, peer support, and structured living environment to achieve the behavior change necessary for long-term recovery.

In FY24, BHSD received $2 million from opioid settlement revenue to support housing. BHSD reports that because funding is specific to opioid use disorder, there will be more opportunity to support an OUD/SUD in some capacity. The funds will support a OUD move in assistance eviction prevention program (MIAEP), which is the same as the existing MIAEP but with OUD eligibility criteria; a fresh start rental assistance which provides 3-6 months of rental assistance; and possibly more Oxford House recovery housing.

Linkages, the state's permanent supportive housing program, targets those who are chronically homeless or precariously housed, have a serious mental illness, and have incomes at or below 30 percent of area median income as defined by the U.S. Department of Housing and Urban Development. Linkages eligibility has been specific to serious mental illness, with SUD as a co-occurring disorder as defined in state statute.[7] BHSD staff report that often an individual with a SUD has a serious mental illness diagnosis. For FY24, the Legislature allocated an additional $1 million in recurring and $1 million in nonrecurring funding for Linkages.

Access to evidence-based forms of treatment also remains limited within the state's criminal justice system, though efforts are underway to expand treatment options.

[6] See https://www.nmlegis.gov/Entity/LFC/Program_Evaluation_Unit_Reports.
[7] See Section 1912 of the Public Health Service Act as amended by Public Law 102-321 and the Linkages policy and procedures manual for diagnosis codes and criteria for symptom severity risk factors and co-occurring disorders.

The National Institute of Drug Abuse estimates the rate of substance use disorders among people who are incarcerated to be 65 percent. Without treatment, formerly incarcerated people are at an increased risk of overdose within the first few weeks of reentry. According to the Centers for Disease Control and Prevention, people recently released from lockups made up 13 percent of all New Mexico overdose deaths in New Mexico, and according to U.S. Health and Human Services people released from detention facilities are 10 to 40 times more likely to die of opioid overdose than the general population.

NMCD's ability to run evidence-based treatment programs, including the residential drug abuse program, may be impacted by staffing. Previous LFC reports have noted inadequate services within jails and prisons perpetuate substance use disorders and contribute to recidivism. The evidence-based Residential Drug Abuse Program (RDAP), New Mexico Correction Department's (NMCD) largest in-prison approach to addressing substance use, served 1,365 inmates in FY22 and 1,979 inmates in FY23, a 45 percent increase. Although RDAP graduates are almost half as likely to recidivate as non-graduates, only about 10 percent of those enrolled in the program in FY23 successfully completed it, a total of 192 individuals, though 773 participants were in the final phase of the program. At the end of FY23, the recidivism rate for RDAP graduates was 19 percent, an improvement over the FY22 rate of 22 percent. The FY23 year-end recidivism rates for the women's recovery center and men's recovery center were 11 percent and 17 percent respectively, better than the target rates.

Statewide behavioral health shortages impact NMCD. Between FY23 and FY24, NMCD reclassified 20 behavioral therapist roles, which require licensed clinicians, to direct care and substance use social work roles, which do not require candidates be licensed clinicians. NMCD reports this change was made because of staffing shortages and the inability to hire qualified candidates. However, staffing roles that have traditionally provided treatment with unlicensed clinicians may have a negative impact on treatment program outcomes. Despite shortages, during the last fiscal year, the Behavioral Health Bureau has increased the number of program participants being served in some of the NMCD evidence-based treatment programs, including the department's intensive outpatient program, Men Seeking Safety program, and Cross Roads for Women programs. NMCD is also working to expand the peer support partnership with Project ECHO, which will create reentry programming in all NMCD facilities, resulting in more inmate participation in evidence-based programming in the upcoming year.

Historically, MAT was unavailable to inmates in New Mexico, with exceptions for pregnant inmates in limited settings. Previous LFC reports also found offenders on probation and parole in the community lack sufficient access to treatment. In FY19, only 8.5 percent of the estimated 12.6 thousand offenders needing treatment were served by community corrections substance abuse programs, and LFC was unable to gather updated data for this report.

Legislation passed in 2023 may improve some of the treatment gaps in the state's criminal justice system identified in the 2021 LFC SUD progress report. NMCD received a $235 thousand grant from SAMHSA to run the pilot program at Western New Mexico Correctional Facility in Grants, in partnership with HSD. The pilot project also includes a needs assessment to determine the prevalence of SUD among prison inmates, the specific forms of SUD that are most common, and the willingness of inmates to seek MAT services. At the time of this report, NMCD is in the second year of the pilot MAT program. The first year

Corrections Q3 FY23 SUD-Treatment Outcomes

- RDAP graduates reincarcerated within 36 months of release: 14%
- Graduates from the women's recovery center who are reincarcerated within 36 months: 6%

Source: NMCD Q3 Report Card

Metropolitan Detention Center MAT Program

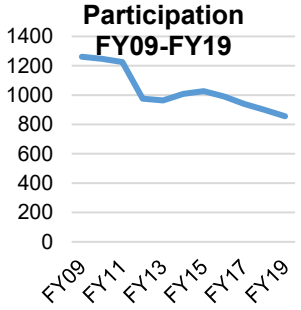
The Metropolitan Detention Center (MDC) in Albuquerque has historically provided medication-assisted treatment only to pregnant women. In 2021, MDC began delivering buprenorphine maintenance treatment, and in 2022 the jail began induction (treatment initiation). MDC contracts with Recovery Services of New Mexico to provide clinical assessments, behavioral counseling, case management, and medication assessment.

In 2023, the County aims to provide buprenorphine maintenance for up to 150 people each month and induction treatment for 50 people each month.

Source: LFC files

focused on screening and identifying potential patients and assessing their interest in participation. The pilot program offers Vivitrol, a long-acting injectable medication authorized to treat both opioid and alcohol-use disorders. The department experienced grant funding delays and began MAT administration in May 2023. NMCD is targeting inmates set for release within six months because overdose risk is particularly high following release from prison. The department offered the treatment to inmates with a history of substance use. At the time of this report, the pilot remains ongoing, though only one inmate had received the Vivitrol treatment as of July 2023. Corrections noted implementation challenges include inmates declining Vivitrol, which requires lab work that is clear of substances to initiate treatment, as well as total abstinence from alcohol and opioids.

Chart 19. Treatment Court Participation FY09-FY19

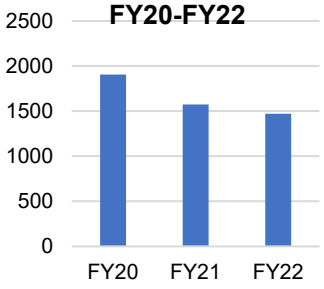


Note: In FY19, AOC changed from reporting a quarterly snapshot of participation to cumulative participation totals
Source:AOC

Laws 2023, Chapter 49 creates the medication-assisted treatment (MAT) for incarcerated program fund in the Human Services Department to administer MAT to people in county-operated jails and state correctional facilities. Historically, only pregnant women were able to access MAT continuation while in correctional facilities, including county jails. The bill requires HSD to promulgate rules associated with providing MAT in detention facilities by December 2023, and the bill requires NMCD to provide MAT to people in their facilities by end of calendar year 2025. Given the prevalence of alcohol use disorder (AUD) in New Mexico, HSD should include rules associated with administering MAT to people with AUD in both county jails and state corrections facilities. The bill requires HSD report annually to LHHS and LFS, beginning October 1, 2023.

Bill analysis estimated the cost to treat all incarcerated individuals requiring MAT to be $11.3 million. The General Appropriation Act of 2023 appropriated $1 million to NMCD to administer MAT in prisons. Corrections medical staff report offering a range of medications to treat SUD, including buprenorphine and methadone, would provide a more comprehensive range of effective treatment options. However, additional clinical staff would be required to implement such a program because methadone requires specific staffing for licensure as an Opioid Treatment Center, and buprenorphine often requires daily administration. Analysis submitted by NMCD for the fiscal impact report estimated the cost to administer MAT at a single facility of 250 inmates to be roughly $3 million, depending on the size of the facility. Bill analysis also estimated that initially costs would exceed potential benefits, but benefits are projected to exceed costs by FY26, and recurring net benefits were estimated to be $698 million annually.

Chart 20. Treatment Court Participants FY20-FY22



Note: In 2020, AOC changed from reporting point-in-time snapshots of participation to cumulative annual participation
Source:AOC

Participation in treatment court programs continues to decline. Previous LFC reports have noted reducing incarceration, recidivism, and justice-system participation requires effective diversion, access to evidence-based programming in prison, and re-entry services that facilitate access to treatment on release. However, such programs do not exist or are not widely utilized in New Mexico. Cost benefit analyses suggest a $3 to $1 return on investment among treatment court programs. Previous LFC reports also noted treatment courts, an effective diversion program, were at less than half of all capacity in 2021 and 2022. Statewide, participation in the state's treatment courts continues to decline.

In FY22, a total of 1,470 people participated in treatment courts, a 23 percent decrease from 2020. Previous LFC analysis found low participation levels suggest defendants may avoid treatment court or pursue alternatives because treatment courts fail to address root causes. Additionally, AOC reports the program has seen a decline the members who meaningfully participate in the program teams, which include members sentencing court as well as the treatment provider. AOC is working with BHSD to develop a forensic peer training program to utilize peers in care management to increase and improve client engagement.

Next Steps

The Department of Health should consider:

Reporting to the Legislature about its plans, scope of responsibility, and timeline for the creation of the Office of Alcohol Prevention;

Continue and expand efforts to gather information about provider and patient attitudes about SUD treatment, particularly medication-assisted treatment (MAT), in future surveys.

The Corrections Department should consider:

Continuing to implement evidence-based treatment while ensuring implementation fidelity, such as RDAP;

Reporting back to the Legislature about MAT pilot implementation and outcomes, including potential clinician workforce needs to expand MAT treatment access and the findings from the SUD needs-assessment;

Evaluating outcomes associated with reclassifying clinical, including turnover, vacancy, inmate recidivism, and treatment outcomes.

The Human Services Department should consider:

Implementing a claims tracking system or process that accounts for all SUD related services provided to beneficiaries across all categories of service;

Reporting to the Legislature and public annually about the number of patients receiving substance use treatment, the forms of evidence-based treatment they receive, and expenditures for these programs;

Moving forward with its proposed plan to create additional billing codes and differentials for evidence-based forms of psychotherapy;

Studying pilots contained within New Mexico's and other state's 1115 Medicaid waivers that address social determinants of health to determine the most effective models and services;

Ensuring that the MCO contracts for Turquoise Care require the MCOs to maintain an adequate Behavioral Health network and ensure that access to those providers is readily available;

Ensuring that the Medicaid incentive programs reward and sanction, as appropriate, the MCOs who perform well in delivery of SUD services;

Reporting back to the Legislature about the outcomes associated with Medicaid provider rate increases, including impact to the state's number of behavioral health providers and access to patient care;

Reporting to the Legislature about the plans, scope of responsibility, and timeline for the BHSD coordinator role focused on alcohol use disorders (AUD);

Reporting to the Legislature about the plans, timeline, and outcomes of the statewide substance use treatment plan.

The Behavioral Health Collaborative should consider:

Supporting counties in developing their opioid settlement fund plans to maximize Medicaid-provided services and to avoid supplanting Medicaid funds;

Playing a coordinating function to develop a framework and collaborative that includes all branches of government in planning to allocate opioid settlement funds to avoid duplication or supplanting of Medicaid resources.

The medical licensing boards should consider:

Expanding existing continuing medical education requirements related to opioid use disorders to include treatment of AUD for all providers.

The Board of Pharmacy should consider:

Reviewing existing state dispensing regulations to ensure no state-level regulations prevent retail pharmacies from dispensing buprenorphine.

The Legislature should consider:

Passing legislation to require retail pharmacies to stock a minimum supply and fill valid MAT prescriptions.

Appendix A: BHSD Report Card Q3 FY23 Performance Measures

BHC Budget: $924,292.1 **FTE: 53**

	FY21 Actual	FY22 Actual	FY23 Target	FY23 Q1	FY23 Q2	FY23 Q3	Rating
Adult Medicaid members diagnosed with major depression who received continuous treatment with an antidepressant medication	42.5%	42.8%	35%	42.7%	42.8%	38.2%	G
Medicaid members ages 6 to 17 discharged from inpatient psychiatric hospitalization stays of four or more days who receive follow-up community-based services at seven days	53.7%	50.8%	51%	53.5%	53.5%	47.6%	Y
Medicaid members ages 18 and older discharged from inpatient psychiatric hospitalization stays of four or more days who receive follow-up community-based services at seven days	53.7%	31.8%	51%	32.8%	32.7%	28.3%	R
Increase in the number of persons served through telehealth in rural and frontier counties*	74.8%	-9.5%	N/A	7.3%	-4.7%	-13.8%	Y
Readmissions to same level of care or higher for children or youth discharged from residential treatment centers and inpatient care	10.8%	9.8%	5%	10.8%	10%	7%	R
Individuals served annually in substance use or mental health programs administered by the Behavioral Health Collaborative and Medicaid	200,932	212,486	200,000	256,241	294,958	156,286	R
Emergency department visits for Medicaid members ages 13 and older with a principal diagnosis of alcohol or drug dependence who receive follow-up visit within seven days and 30 days	13.4% 7day; 19.8% 30 day	12.4% 7 day; 19.8% 30 day	25%	13% 7 day; 20.2% 30 day	12.4% 7 day; 20% 30 day	20% 7 day; 30.6% 30 day	Y
Persons receiving telephone behavioral health services in Medicaid and non-Medicaid programs	75,140	62,439	60,000	25,919	34,748	42,040	G
Program Rating	Y	Y					Y

*Measure is classified as explanatory and does not have a target.

Appendix B: DOH Report Card Performance Measures Q3 FY23

Public Health

Budget: $213,192.6 **FTE:** 786	**FY21 Actual**	**FY22 Actual**	**FY23 Target**	**FY23 Q1**	**FY23 Q2**	**FY23 Q3**	**Rating**
Percent of female New Mexico department of health's public health office family planning clients, ages fifteen to nineteen, who were provided most or moderately effective contraceptives	88.8%	86%	62.5%	88.6%	85.3%	89.4%	G
Percent of school-based health centers funded by the department of health that demonstrate improvement in their primary care of behavioral healthcare focus area	73%	91%	≥95%	Reported Annually			
Percent of New Mexico adult cigarette smokers who access New Mexico department of health cessation services	1.9%	1.9%	≥2.6%	0.3%	0.3%	0.4%	R
Number of successful overdose reversals in the harm reduction program	2,572	3,420	2,750	965	722	404	Y
Percent of preschoolers ages nineteen to thirty-five months indicated as being fully immunized	65%	66%	≥65%	68%	70%	69%	G
Number of community members trained in evidence-based suicide prevention practices	NA	NA	225	126	248	147	G
Program Rating	R	R					Y

*Measure is classified as explanatory and does not have a target.

Epidemiology and Response

Budget: $127,901.5 **FTE:** 298	**FY21 Actual**	**FY22 Actual**	**FY23 Target**	**FY23 Q1**	**FY23 Q2**	**FY23 Q3**	**Rating**
Number of people admitted to the emergency department of participating hospitals with a suicide diagnosis	NA	NA	3,408	71	69	89	G
Percent of death certificates completed by Bureau of Vital Records & Health Statistics within ten days of death	50%	50%	64%	55%	56%	48%	R
Percent of hospitals with emergency department based self-harm secondary prevention programs	2.5%	5%	7%	5%	5%	5%	R
Rate of persons receiving alcohol screening and brief intervention services	52.2	69.1	72.6	5.3	11.5	Not Reported	R
Program Rating	R	R					R

*Measure is classified as explanatory and does not have a target.

Facilities Management

Budget: $183,833.3 **FTE: 1,930**	**FY21 Actual**	**FY22 Actual**	**FY23 Target**	**FY23 Q1**	**FY23 Q2**	**FY23 Q3**	**Rating**
Number of medication errors causing harm per one thousand patient days within identified categories	0.6	0.2	2.0	0	0	0	G
Percent of medical detox occupancy at Turquoise Lodge Hospital	70%	69%	75%	68%	74%	69%	R
Percent of medication assisted treatment utilized in the management of opioid use disorders while at Turquoise Lodge Hospital	NA	73%	65%	100%	100%	100%	G
Percent of patients educated on medication assisted treatment options while receiving medical detox services	NA	89%	90%	99%	50%	100%	G
Percent of patients eligible for naloxone kits who received the kits	NA	NA	50%	26%	61%	50%	G
Percent of licensed beds occupied	58%	52%	75%	41%	42%	44%	R
Percent of eligible third-party revenue collected at all agency facilities	92%	93%	93%	82%	84%	94%	G
Program Rating	R	R					Y

*Measure is classified as explanatory and does not have a target.

Appendix C: New Mexico Corrections Department Report Card Q3 FY23

Reentry

Budget: $23,544.9 **FTE:** 130	FY21 Actual	FY22 Actual	FY23 Target	FY23 Q1	FY23 Q2	FY23 Q3	Rating
Recidivism							
Prisoners reincarcerated within 36 months[1]	44%	37%	40%	35%	35%	34%	G
Prisoners reincarcerated within 36 months due to new charges or pending charges	14%	14%	17%	14%	17%	16%	G
Prisoners reincarcerated within 36 months due to technical parole violations[1]	30%	24%	20%	20%	18%	18%	G
Sex offenders reincarcerated on a new sex offense conviction within 36 months of release on the previous sex offense conviction	6%	1%	5%	6%	8%	0%	G
Education							
Eligible inmates enrolled in educational, cognitive, vocational, and college programs	41%	45%	60%	35%	40%	44%	R
Percent of eligible inmates who earn a high school equivalency credential	9.7%	7.7%	80%	2.4%	1%	9%	Y
Number of inmates who earn a high school equivalency credential	118	82	165	15	6	71	Y
Other Programming							
Residential drug abuse program graduates reincarcerated within 36 months of release*	22%	22%	N/A	20%	19%	14%	G
Graduates from the women's recovery center who are reincarcerated within 36 months	27%	18%	20%	8%	14%	6%	G

Appendix D: Alcohol-Related Deaths by County

Decedent's County of Residence	Deaths per 100,000 Population, Age-adjusted	Number of Deaths	Population Estimate (years combined)
McKinley	335.7	226	71,780
Cibola	179.4	51	27,184
Rio Arriba	176.6	75	40,179
San Juan	169.3	199	121,237
Socorro	156.2	25	16,346
Mora	144.3	6	4,196
Taos	118.6	41	34,623
Sierra	115.1	18	11,523
Colfax	108.8	14	12,369
San Miguel	106.4	32	27,150
Quay	102.7	9	8,709
Luna	101.9	27	25,429
Union	98.4	4	4,036
Valencia	98	78	77,190
Bernalillo	96.8	709	676,626
Otero	94	68	68,549
Torrance	91.8	16	15,041
Guadalupe	91.2	5	4,439
Chaves	87.8	60	64,454
Sandoval	87.3	137	151,369
Lincoln	84.5	20	20,557
Grant	81.8	29	27,889
Santa Fe	81.5	143	155,201
Eddy	74.8	48	61,939
Curry	66.4	31	49,230
Lea	63.8	43	72,637
Dona Ana	57.2	126	221,508
Roosevelt	52.7	10	19,232
Los Alamos	35.2	9	19,391
NM Resident, County Unknown	.	6	.
Catron	**	**	3,731
De Baca	**	**	1,685
Harding	**	**	659
Hidalgo	**	**	4,102
Overall	102.7	2,274	2,120,188

Source: DOH IBIS

Appendix E: Overdose Deaths by County, 2021

County	Total Deaths	Death Rate per 100,000
Bernalillo	456	66.28
Santa Fe	81	58.44
Dona Ana	57	28.22
Sandoval	47	33.71
Rio Arriba	45	129.00
Valencia	43	60.12
San Juan	39	35.37
Chaves	29	43.38
McKinley	22	34.90
Otero	22	30.88
San Miguel	21	84.28
Taos	21	63.46
Eddy	20	35.67
Lea	18	26.70
Socorro	17	121.99
Lincoln	12	46.15
Cibola	11	40.15
Curry	11	24.00
Sierra	10	109.92
Grant	9	44.41
Colfax	6	56.25
Luna	5	20.81
Torrance	4	30.50
Quay	*	*
Roosevelt	*	*
Guadalupe	*	*
Los Alamos	*	*
Mora	*	*
Catron	*	*
Hidalgo	*	*
Union	*	*
De Baca	*	*
Harding	*	*
New Mexico	**1,029**	**50.63**

Notes:* Counts of less than 3 are suppressed
Rates are per 100,000 population and age adjusted to the US 2000 standard population

Source: NM DOH Bureau of Vital Records and Health Statistics death data; UNM/GPS population estimates

Appendix F: Centennial Care 2.0 1115 SUD Demonstration Waiver

SUD Demonstration Waiver SUD Goals	SUD Demonstration Waiver Milestones
Increased rate of identification, initiation, and engagement in treatment for opioid use disorder (OUD) and other SUD	Access to critical levels of care for OUD and other SUD
Increased adherence to and retention in treatment for and OUD and other SUD;	Widespread use of evidence-based, SUD-specific patient placement criteria
Reductions in overdose deaths, particularly those due to opioids	Use of nationally-recognized, evidence-based, SUD program standards to set residential treatment provider qualifications
Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where utilization is preventable or medically inappropriate through improved access to other continuum of care services;	Sufficient provider capacity at each level of care, including Medication Assisted Treatment (MAT)
Fewer readmissions to the same or higher level of care where readmission is preventable or medically inappropriate for OUD and other SUD	Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD
Improved access to care for physical health conditions among beneficiaries with OUD or other SUD	Improved care coordination and transitions between levels of care

Source: New Mexico Medicaid Section 1115 SUD Demonstration Monitoring Report

Appendix G: Behavioral Health Appropriations FY24

FY24 General Fund Recurring Behavioral Health Appropriation (in thousands)

	2023 Appropriations
Human Services Department (HSD)	
Medicaid Behavioral Health	$ 169,772.5
Medicaid BH residential crisis mgmt & transition services	$ 500.0
BHSD personnel	$ 4,967.8
Linkages housing	$ 7,342.7
Non-Medicaid eligible services rate increase	$ 1,200.0
NMConnect app	$ 140.0
988 Crisis Now mobile crisis units	$ 3,771.8
Local BH collaboratives	$ 100.0
Telehealth	$ 119,600.0
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	$ 2,782.0
Certified Community BH Clinics Expansion	$ 1,500.0
Subtotal HSD	**$ 311,676.8**
Children, Youth and Families Department (CYFD)	
Establish 3 CBHC Teams	$ 963.4
Protective Services and Behavioral Health Compensation Adjustment	$ 5,498.5
Child Advocacy	$ 1,000.0
BH Respite and Other Services	$ 600.0
CYFD Safe Care - Home Visiting Program	$ 1,000.0
CYFD CARA -Plan of Safe Care	$ 1,000.0
Subtotal CYFD	**$ 10,061.9**
Early Childhood Education and Care Department (ECECD)	
Childrens' physical and behavioral health	$ 12,000.0
Child maltreatment prevention	$ 1,000.0
Infant Mental Health	$ 1,000.0
Subtotal ECECD	**$ 14,000.0**
Department of Health (DOH)	
Medication Assisted Treatment	$ 4,733.0
Medication Assisted Treatment Tribal	$ 1,000.0
Alcohol Misuse Program	$ 2,000.0
Subtotal DOH	**$ 7,733.0**
Public Education Department (PED)	
Wellness Rooms	$ 200.0
Subtotal PED	**$ 200.0**
University of New Mexico Health Sciences Center (UNM HSC)	
ECHO provider training	$ 800.0
Child psychiatric hospital	$ 1,000.0
Subtotal UNM HSC	**$ 1,800.0**
Total Recurring	**$ 345,471.7**

Appendix H: FY23 Appropriations from Opioid Settlement

State of NM Opioid Settlement Appropriations 2023

(in thousands)

Human Services Department	
Certified Community Behavioral Health Clinics	$1,500
Housing assistance- opioid use disorder	$2,000
SBIRT	$2,000
Telehealth for opioid use disorder	$1,000
Department of Health	
MAT related to opioid use disorder	$2,500
MAT for tribal members related to opioid use disorder	$1,000
Corrections Department	
MAT in prisons	$1,000
Children Youth and Families Department	
Improving reporting and adherence to plans for safe care	$1,000
Capacity building for in-home safe care skills program	$1,000
Early Childhood Care and Education Department	
Child Care Assistance	$5,000
Infant Mental Health	$1,000
Public Education Department	
Pilot Wellness Rooms	$200
UNM	
Children's Psychiatric Hospital (opioid use-related)	$1,000
Hepatitis Community Health Program (opioid-use related)	$800
Total	**$21,000**

Source: HB2

$20M FOR CHILDREN'S BEHAVIORAL HEALTH

Agency	Initiative	Estimated Number of New Mexicans Served	Benefit	SFY'24 Amount	SFY'25 Amount
CYFD	Thriving Families Plan Family Resource Centers	Rio Arriba County: Under 5 pop= 2,158/Minors=8,769 Valencia County: Under 5 pop= 4,320/Minors=17,934 Dona Ana County: Under 5 pop=13,600/Minors=52,954	Decrease in repeat maltreatment, improved parental health and emotional well- being, families increased connections and engagement of community resources.	$ 3,000,000	$ 3,000,000
CYFD	Children in State Custody (CISC) Placement Stabilization (Foster Care +)	Year 1 pilot to initially serve approx. 5 children/youth and kinship/resource families, with plan to expand.	Immediate placement and stabilization option for children/youth with high BH needs impacting ability to stabilization in other settings.	$ 1,500,000	$ 1,500,000
CYFD	Immediate Placement TFC Respite Placements	Approx. 1,500 bed nights per year	Immediate placement and stabilization option for children/youth with high BH needs impacting ability to stabilization in other settings.	$ 500,000	$ 500,000
CYFD	Immediate Placement Crisis Stabilization Services	Each Crisis Stabilization provider will serve approx. 60-120 children/youth per year, depending upon community need.	Multi-service Community Home stay/care that is trauma informed, family and youth driven, culturally and linguistically competent and strengths-based to safely assess, stabilize, and mobilize the most permanent placement option for children and youth in PS custody or under their care or supervision.	3,000,000	1,500,000
CYFD	Trauma Responsive Training	Approx. 1,250 providers, staff, community members, Resource Parents, school staff per year	Training on understanding trauma, how to engage with individuals affected by traumatic experiences, and how to help with regulation.	$ 600,000	$ 600,000
		Approximately 200 providers, staff, community members, Resource Parents, school staff per year	Trauma-responsive and trauma-informed approach of providers and community members working with children, youth and families.	$ 300,000	$ 300,000
		See above	Logistics coordination and participant registration/follow-up.	$ 200,000	$ 200,000
CYFD	Mobile Response and Stabilization Services (MRSS)	Approx. 900 calls per year	Development of MRSS provider network. Reduction in placement disruption, emergency room visit, or other crisis placements.	$ 500,000	$ 500,000
HSD	Native American Services Program	Approx. 500 children served per year	Nearly 500 Native American youth will be served through the funding attached to the Native American Services RFA and allocation process.	$ 574,527	$ 700,000
CYFD	Evidence-Based Practice (EBP)/ Priority Services Incentives to start new programs	MST: Team of 4 clinicians = approx. 60 clients/yr. FFT: Team of 5 clinicians = approx. 140 clients/yr. FPSS/YPSS: Approx. 40 families each worker/yr. HFW: Team of 1 Sup/2 Facilitators= approx. 25 clients/yr.	Increased number of providers implementing services statewide; Increased access to services.	$ 500,000	$ 500,000
SFY ANNUAL TOTAL				**$ 10,674,527**	**$ 9,300,000**
FY24-FY25 Funds Available					**$20,000,000.00**
FY24-25 GRAND TOTAL					**$19,974,527.00**
BALANCE					**$25,473.00**

HUMAN SERVICES DEPARTMENT

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