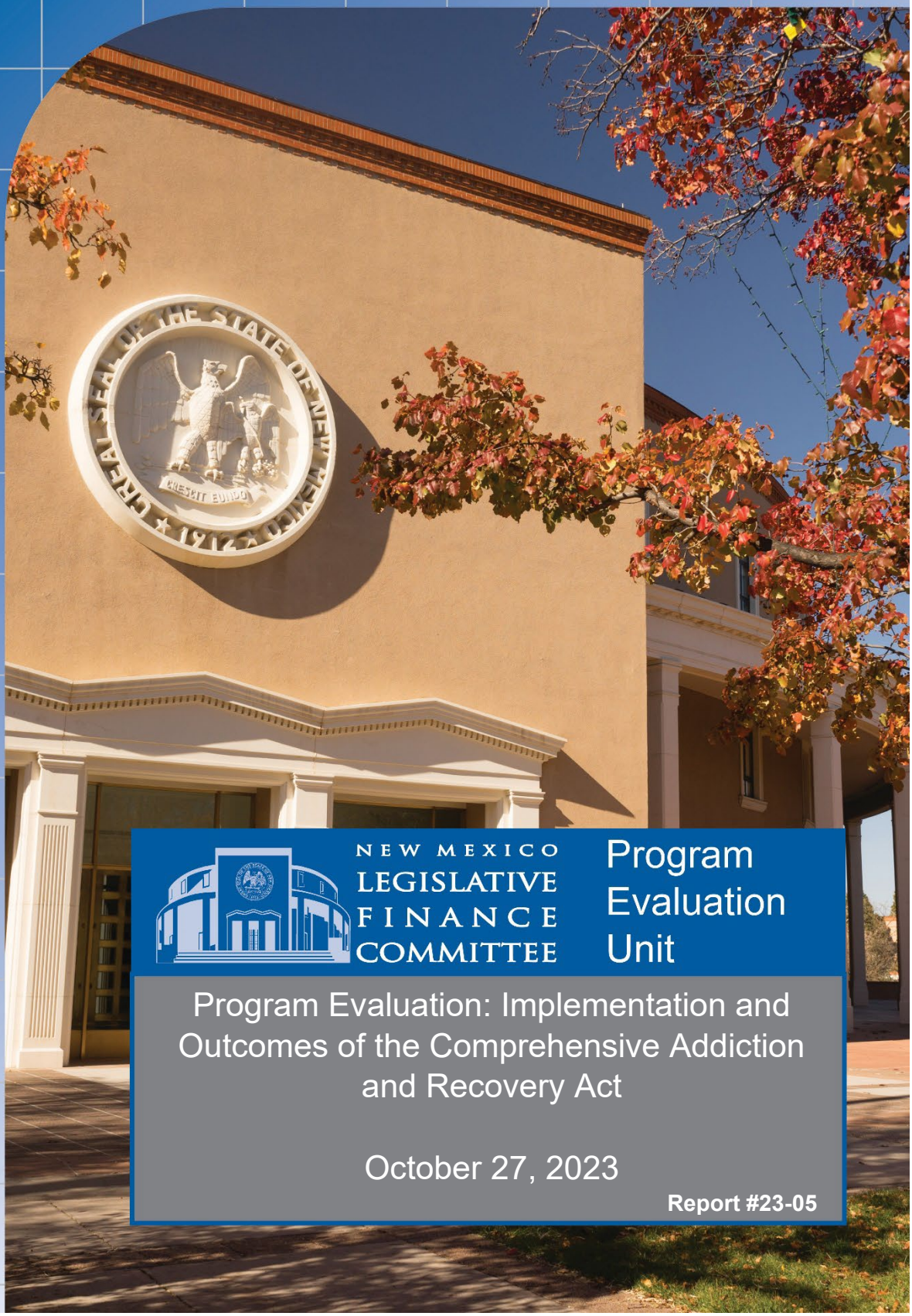

NEW MEXICO
LEGISLATIVE
FINANCE
COMMITTEE

Program
Evaluation
Unit

Program Evaluation: Implementation and Outcomes of the Comprehensive Addiction and Recovery Act

October 27, 2023

Report #23-05

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Charles Sallee
Director

October 27, 2023

Teresa Casados, Acting Cabinet Secretary
Children, Youth and Families Department
1120 Paseo De Peralta
Santa Fe, NM 87501

Dear Secretary Casados,

The Legislative Finance Committee (LFC) is pleased to transmit the evaluation, *Implementation and Outcomes of the Comprehensive Addiction and Recovery Act (CARA).* The program evaluators examined the outcomes and processes of implementing CARA in the state. An exit conference was held with you and your staff on October 23, 2023 to discuss the contents of the report.

The report will be presented to the LFC on October 27, 2023. LFC would like plans to address the recommendations within this report from your departments within 30 days of the hearing.

I believe this report addresses issues the LFC asked us to review and hope your departments, families on plans of care, and other stakeholders will benefit from our efforts. We appreciate the cooperation and assistance we received from you and your staff.

Sincerely,

Charles Sallee, Director

Cc: Senator George K. Muñoz, Chair, Legislative Finance Committee
Representative Nathan Small, Vice-Chair, Legislative Finance Committee
Senator Gerald P. Ortiz y Pino, Chair, Legislative Health & Human Services Committee
Rep. Elizabeth Thompson, Vice-Chair, Legislative Health & Human Services Committee
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Mariana Padilla, Cabinet Director, Children's Cabinet
Patrick M. Allen, Cabinet Secretary, Department of Health
Kari Armijo, Acting Cabinet Secretary, Human Services Department
Elizabeth Groginsky, Cabinet Secretary, Early Childhood Education and Care Department

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Despite Statutory Overhaul, the Vast Majority of CARA Families are Not Receiving Support Services or Substance Use Treatment

New Mexico has a higher rate of newborns who have been exposed to drugs than the national average. The federal Comprehensive Addiction and Recovery Act (CARA) requires healthcare professionals to develop plans of care for substance-exposed infants and for each state to enact their own laws governing plans of care. In 2019, New Mexico passed legislation requiring staff in hospitals and birthing centers develop plans of care for substance-exposed newborns, which refer families to voluntary support and treatment services. New Mexico's CARA law takes a public health approach by treating drug and alcohol use during pregnancy as a disorder requiring services rather than as a reason for reporting suspected child maltreatment to the state Children, Youth and Families Department (CYFD). After New Mexico enacted its CARA law in 2019, CYFD's removal of infants from families fell below the national rate.

The state pays Medicaid managed care organizations (MCOs) roughly $1.5 million in federal funds each year to have care coordinators connect CARA families to services and state agency staff to monitor plans of care. Despite this spending, CARA is not meeting its intended purposes of keeping substance-exposed newborns safe and directing families to treatment. Two out of three families with plans of care are not directed to or accepting substance abuse treatment services. Even when families accept services, the state does not regularly track family follow-through with treatment and services.

Parental substance use is a leading risk factor for child neglect and maltreatment, with drugs or alcohol a caregiver risk factor in at least 26 percent of cases. Families with a plan of care subsequently have higher rates of abuse or neglect compared to similar families without substance exposed newborns (meaning they do not have a plan of care). Infants with a plan of care also have similar mortality rates to all other infants.

The state's implementation of its CARA policy has substantive gaps. New Mexico birthing centers are under-identifying substance-exposed newborns by up to 40 percent according to a DOH analysis of Medicaid claims for 2020 and 2021 birth cohorts. Although about 1,300 families with substance-exposed newborns receive plans of care each year, roughly 500 infants exposed to drugs or alcohol each year do not receive a plan of care. Of the 1,300 families with plans of care, only 306 families receive early intervention services, only 52 receive home visiting services, and only 190 accept referrals to addiction treatment. The current online portal for monitoring plans of care has limited functionality to track CARA families across agencies and systems.

CYFD is proposing a new division with 20 state-funded employees dedicated to CARA, duplicating existing state staff and care coordinators. If CYFD remains the lead agency on CARA going forward, CYFD has hundreds of vacant positions available to potentially dedicate more staff to CARA oversight.

Evaluation Objectives:

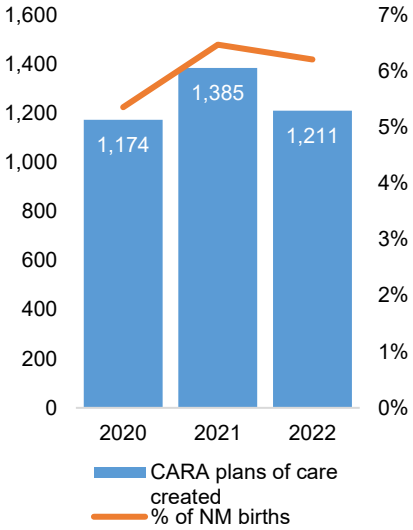
Examine CARA policy outcomes and services provided.

Examine barriers, challenges, and successes to CARA policy implementation.

Examine best practices and alignment with New Mexico CARA statute and rule.

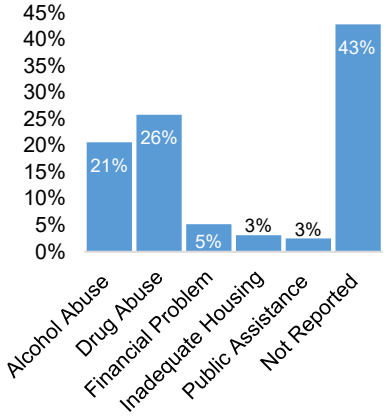
Infants with a plan of care have similar mortality rates to infants without a plan of care.

Chart 1. CARA Plans of Care Created



Source: DOH

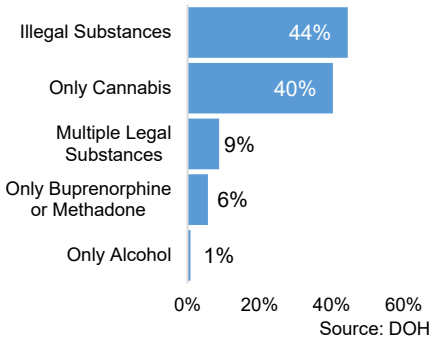
Chart 2. Child Victims With Caregiver Risk Factors
2021



Source: ACF Child Maltreatment 2021

The contracted process mapping and gap analysis of the state's CARA policy concluded the involved CARA agencies are taking steps to address recommendations and clearly identify ownership of CARA, which the cabinet secretaries determined would be DOH.

Chart 3. Percent of Substance Exposure Types on Plans of Care
2020-2022



Source: DOH

A 2023 consultant's report on CARA noted the cabinet secretaries of CYFD and the Health, Human Services and Early Childhood Education and Care departments determined the Department of Health should be the lead agency on CARA. Alternatively, the Legislature could consider moving CARA oversight to the Health Care Authority, the newly created department that took over the responsibilities of the Human Services Department.

Key Findings

The vast majority of CARA families are not receiving support services or substance use treatment.

CARA-related case management, screening, and identification of substance-exposed newborns should be improved.

CYFD is requesting more staff despite challenges with capacity, duplicative services, and unclaimed federal funds.

Key Recommendations

The Legislature should consider:

- Amending CARA statute to include references to implementing prenatal CARA plans of care alongside references to plans of care developed at birth; and
- Adopting statute that designates the Health Care Authority as the lead agency for CARA following New Mexico's public health approach to CARA.

Until the Health Care Authority is the lead agency for CARA with rulemaking authority, the Children, Youth and Families Department should:

- Promulgate rules requiring hospitals and birthing center staff to report families to CYFD if referrals for substance use treatment for illegal drugs in a plan of care are declined;
- Promulgate rules requiring hospitals and birthing centers to require a referral to early intervention or evidence-based home visiting for every CARA family; and
- Implement differential response in line with best practices and expand statewide.

The Human Services Department should:

- Require hospitals to develop policies to universally screen pregnant women for substances using screening, brief intervention, and referral to treatment (SBIRT) or other evidence-based verbal screening tools;
- Direct MCO care coordinators to monitor completion of specific action steps and services agreed to by the family in the plan of care and notify CARA navigators; and
- Revise its contract for the CARA portal to have case management and reporting functionality.

Background

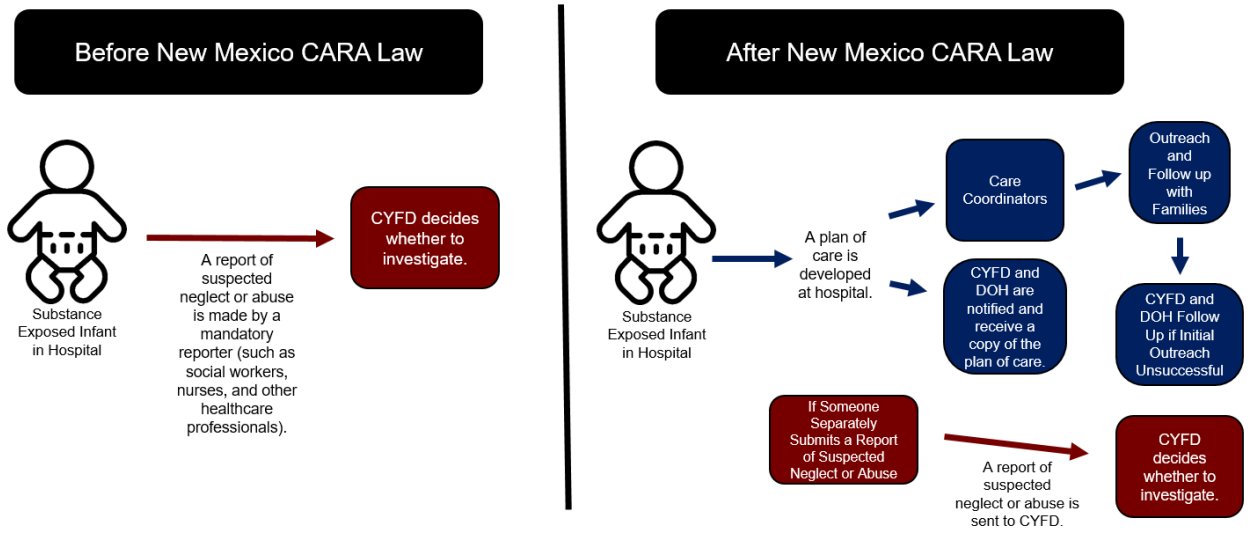
Substance use during pregnancy has detrimental impacts to infant and maternal health, lifetime healthcare costs, and costs to the state. New Mexico has higher rates of newborns with neonatal withdrawals than the national average. The total lifetime costs for caring for children who were prenatally exposed to drugs or alcohol ranges from $1.3 million to $2.4 million.[i] The state also has higher child maltreatment rates than the national average with child caregiver substance use a leading risk factor for child maltreatment in the state. The federal Comprehensive Addiction and Recovery Act (CARA) of 2016 required states to develop local policies on plans of safe care (POSC) for substance-exposed newborns. To comply with federal law, New Mexico enacted amendments to the Children's Code and Public Assistance Act in 2019.

Table 1. Quick Facts: Statistics Regarding Substance Abuse and Child Welfare

	New Mexico	United States
Rate of Neonatal Abstinence Syndrome (per 1,000 births)	13 (2021)	6.3 (2020)
Drug Overdose Death Rates (Deaths per 100,000 population)	56 (2021)	32.4 (2021)
Alcohol Related Death Rate (Deaths per 100,000 population)	102.7 (2021)	34 (2016)
Infant Mortality (per 1,000 children)	4.8 (2021)	5.4 (2020)
Rate of Infant Maltreatment (per 1,000 infants)	30 (2021)	25.3 (2021)
Rate of Child Maltreatment (per 1,000 children)	12.6 (2021)	8.1(2021)
Repeat Maltreatment (12 month rate)	14% (2023)	N/A
Abuse or Neglect Deaths (per 100,000 children)	2.11 (2021)	2.5 (2021)

Source: LFC Files

Figure 1. Change in Reporting of Suspected Abuse or Neglect Before and After New Mexico CARA Statute



Note: A report of suspected neglect or abuse to CYFD is different from CYFD receiving a notification of a plan of care. A report necessitates a CYFD family assessment and potential investigation. A notification of a plan of care does not necessitate a family assessment or potential investigation. Prior to the CARA law, CYFD reported to LFC that the birth of a newborn exposed to substances constituted substantiated child abuse or neglect.

Source: LFC Staff Review of Statute and Rule

New Mexico's CARA law changed the reporting requirements to Children, Youth and Families Department (CYFD) so that a finding that a pregnant woman is using or abusing drugs would not alone be a sufficient basis to report child abuse or neglect. Research shows children removed from the home often have worse outcomes than those not removed, costing taxpayers and families tens of millions of dollars per year. New Mexico's CARA law takes a public health approach rather than a child protective approach, requiring healthcare professionals to create a plan of care with the intent of ensuring the safety and well-being of a substance-exposed newborn by addressing the treatment needs of the child, parents, and family.

"**Plan of care**" means a plan created by a healthcare professional intended to ensure the safety and well-being of a substance-exposed newborn by addressing the treatment needs of the child and any of the child's parents, relatives, guardians, family members or caregivers to the extent those treatment needs are relevant to the safety of the child.

Source: Section 32A-1-4(Y) NMSA 1978

After New Mexico enacted its CARA statute, child protective removal of infants from the home due to substance abuse fell below national rates. However, the same families have not, on average, experienced changes to their safety or well-being.

The law is having its intended effect in keeping families intact. After New Mexico enacted its CARA statute, child protective removal of infants from the home due to substance abuse fell below national rates. However, the same families have not, on average, experienced changes to their safety or well-being.

New Mexico's CARA law spreads the responsibilities for developing and monitoring voluntary plans of care across multiple state agencies and healthcare organizations. In 2023, legislators and the governor made multiple proposals to revise, restructure, or reform how CARA and plans of care are implemented in New Mexico.

Ninety-one newborns in New Mexico were born diagnosed with neonatal abstinence syndrome (NAS) in 2009 compared to 298 born with NAS in 2020.

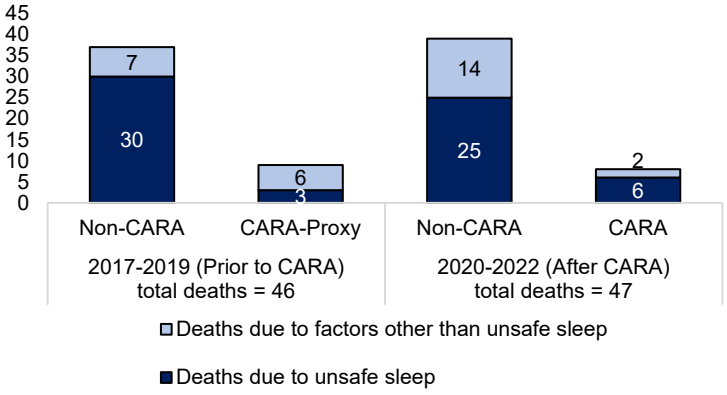
Thirty-four percent of newborns diagnosed with NAS in New Mexico do not have a plan of care.

Substance use during pregnancy has detrimental impacts to a newborn's health, maternal health, lifetime care costs, and costs to the state.

Substance use during pregnancy can have substantial detrimental effects on a newborn, including birth defects, developmental disabilities, preterm birth, and sudden infant death. Neonatal abstinence syndrome (NAS) is a group of conditions caused when babies withdraw from certain drugs they are exposed to in the womb. While NAS is mainly linked to opioids (such as heroin, codeine, oxycodone, methadone, and buprenorphine), some prescription medications (like antidepressants) and illegal substances (such as methamphetamine) lead to NAS as well. Drinking during pregnancy can cause fetal alcohol spectrum disorders (FASD), including fetal alcohol syndrome (FAS). The effects of NAS are curable, but FASD is a lifelong developmental condition (see Appendix B for a further explanation of FASD, NAS, and their possible effects on newborns).

LFC staff requested child mortality data and case records from CYFD to further study child and infant mortality risk factors such as parental substance abuse, but CYFD did not provide the requested data and records.

Chart 4. The Number of Infant Fatalities Investigated by CYFD has Remained the Same Since CARA was Enacted



Note: CARA-proxy are those newborns who would have been eligible for a CARA plan of care prior to passage of New Mexico CARA statute.

Source: CYFD Data

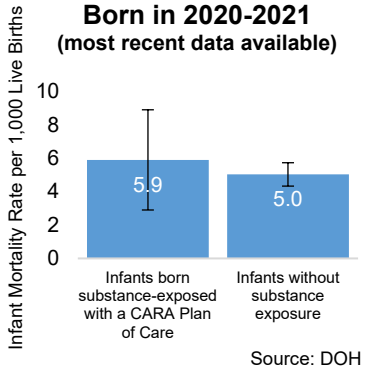
Some of the medical issues for the newborn exposed to substances include potential issues with fetal growth, congenital anomalies, withdrawal symptoms, and neurobehavioral abnormalities. Potential longer-term effects related to prenatal drug exposure include effects on behavior, cognitive and executive functioning, language development, academic achievement, and higher prevalence of substance abuse.

Substance use is a leading factor in many maternal and infant deaths. According to the New Mexico Maternal Mortality Review Committee, substance use disorders were a contributing factor in 49 percent of the 87 maternal deaths in the state from 2015 through 2019. DOH's 2022 child fatality review report found 1-in-5 reviewed child deaths (36 deaths out of 163 reviewed deaths) were supervised by an individual with a known history of a substance use disorder. The American Academy of Pediatrics recommends parents should avoid alcohol and illicit drug use during pregnancy and after the infant's birth to reduce the risk of infant mortality through substance-exposure or unsafe sleep practices.[ii] LFC staff requested child mortality data and case records from CYFD to further study child and infant mortality risk factors, such as parental substance abuse, but CYFD did not provide the requested data and records. Fifteen of the

Unsafe sleep practices include infants sleeping on their tummies or sides or in places other than cribs, bassinets, or play yards, such as adult beds, baby slings, car seats, couches, or armchairs. Sleeping with pets, other children or adults, or with blankets or other bedding, crib bumpers, or stuffed toys is also considered unsafe.

infants born in 2020-2021 and provided with a plan of care died (15 out of a total 218 New Mexico infant deaths), and six of those deaths were ruled sudden unexpected infant deaths (SUID). Infants with a plan of care experienced mortality rates similar to that as infants without substance exposure (5.9 compared to 5.0 deaths per 1,000 live births).

Chart 5. Infant Mortality Rate per 1,000 (C.I.'s) Live Births of Infants Born in 2020-2021
(most recent data available)

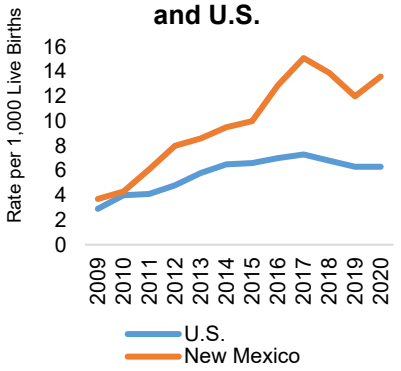


Source: DOH

New Mexico has higher rates of substance-exposed newborns than the national average and ranks among highest in nation.

The rate of neonatal abstinence syndrome (NAS) among newborn hospitalizations has increased in New Mexico and ranks among the highest in the nation. According to the Agency for Healthcare Research and Quality, the incidence rate of NAS has increased since 2009, from 3.7 per 1,000 births to 13.6 per 1,000 births in 2020. In other words, 91 newborns in New Mexico were born diagnosed with NAS in 2009 compared to 298 born with NAS in 2020. New Mexico ranks sixth nationally for incidence rate of NAS. Over the last two decades, data indicates substance use during pregnancy has increased nationally, and in New Mexico, these rates are now higher than most other states. The incident rate of NAS was 13.6 per 1,000 in 2020, compared with the national rate of 6.3 per 1,000. [iii,iv]

Chart 6. Trends of Neonatal Abstinence Syndrome, New Mexico and U.S.



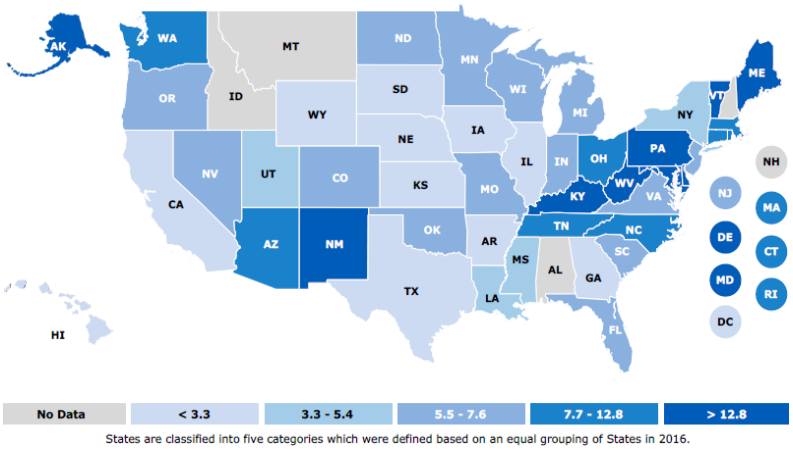
Source: Healthcare Cost and Utilization Project & Agency for Healthcare Research and Quality

New Mexico has higher child maltreatment rates than the national average, with caregiver substance use a leading risk factor for child maltreatment in the state.

New Mexico is consistently among the poorest performing states when it comes to repeat child maltreatment.[v] Over the long-term, repeat child maltreatment causes physical, psychological, and behavioral consequences leading to negative outcomes for individuals and society. According to data from the U.S. Administration for Children and Families (ACF), New Mexico regularly ranks among the top six states for repeat child maltreatment occurring within 12 months of an initial allegation.

According to the U.S. Department of Health and Human Services, child caregiver alcohol and drug use are the two leading risk factors for child maltreatment in New Mexico.[1] According to the U.S. Department of Health and Human Services, in 2021, 1-in-4 maltreatment victims in New Mexico had a caregiver abusing drugs and 1-in-5 had a caregiver abusing alcohol (of 25.8 percent and 20.6 percent, respectively).

Figure 2. Rate of Neonatal Abstinence Syndrome (NAS) per 1,000 Newborn Hospitalizations 2020, National Rate: 6.3

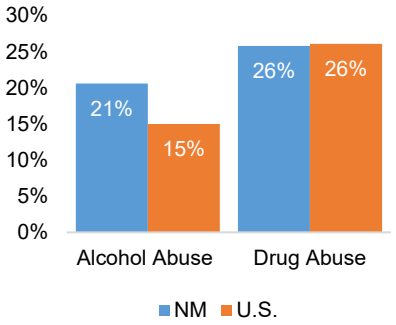


States are classified into five categories which were defined based on an equal grouping of States in 2016.

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP)

[1] Note: The National Child Abuse and Neglect Data System (NCANDS) collects case-level data, called a child file, from states submitting an electronic file of child-specific records for each report of alleged child abuse and neglect that received a CPS response in the form of an investigation or alternative response. Case-level data include information about the characteristics of the reports of abuse and neglect, the children involved, the types of maltreatment, the CPS findings, the risk factors of the child and the caregivers, the services provided, and the perpetrators.

Chart 7. Child Victims with Caregiver Drug or Alcohol Abuse as Risk Factors in New Mexico and Nationally in 2021



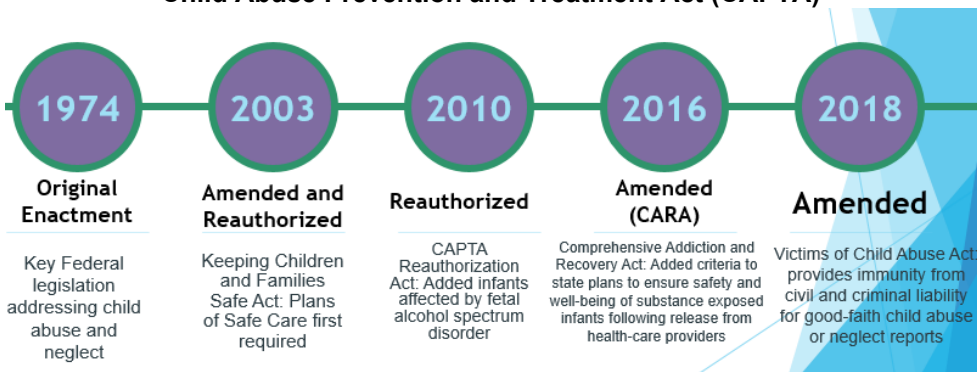
Source: Child Maltreatment Report 2021

Substance-exposed infants have an increased risk of maltreatment and involvement with child protective services. Substance-exposed infants have an increased likelihood of hospitalizations and clinic visits for suspected maltreatment, maternal self-reported risk of maltreatment behaviors, adolescent retrospective self-report of maltreatment, and child protective services involvement compared to unexposed infants, as found in a 2022 study published in *Child Maltreatment.*[vi] The study undertook a comprehensive review of 30 research articles examining the association of child maltreatment with exposure to any and multiple substances, including cocaine, alcohol, opioids, cannabis, and amphetamine/methamphetamine.

New Mexico amended state law in 2019 to comply with federal law, which requires states develop local policies on plans of care for substance-exposed newborns.

A plan of care is a plan developed by a health professional, in collaboration with the family, intended to ensure the safety and well-being of a newborn prenatally exposed to substances, such as drugs or alcohol (see Appendix C for New Mexico's plan of care form). Federal law requires healthcare professionals to develop plans of care for substance-exposed infants, states to enact their own plan of care laws, and states to report on data relating to plans of care. Originally enacted in 1974, the federal Child Abuse Prevention and Treatment Act (CAPTA) is the key federal legislation addressing child abuse and neglect. CAPTA provides funding and guidance to states to support prevention, assessment, investigation, prosecution, and treatment activities. CAPTA also provides grants to public agencies and nonprofit organizations, including tribal organizations. CAPTA has been reauthorized and amended several times since 1974 and was last amended in 2018. Plans of care for infants affected by illegal substance abuse have been a requirement in child welfare legislation since 2003.

Figure 3. Timeline of Federal Child Abuse Prevention and Treatment Act (CAPTA)



Source: LFC Staff Review of Federal Law

In 2016, the federal CAPTA law was amended with the passage of the federal Comprehensive Addiction and Recovery Act (CARA), requiring states to develop plans of care policies. CARA requires states to provide assurance they have "policies and procedures to address the needs of substance-exposed infants, including requirements to make appropriate referrals to child protective services (CPS) and other appropriate services, and a requirement to develop a plan of care for the affected infants." CARA also requires states to annually report the number of substance-exposed infants, the

number for whom a plan of care was developed, and the number for whom referrals are made for services, including services for the affected family or caregiver. The U.S. Department of Health and Human Services is responsible for monitoring state compliance with child protective services system grant requirements.

Under CARA, annual state data reports must include:

1. Number of infants born substance-exposed,
2. Number of infants for whom a plan of care was developed,
3. Number of infants for whom referrals are made for services (but not whether they engaged in treatment), including services for the affected family or caregiver.

In 2019, New Mexico enacted legislation in response to the federal requirement that states develop local policies and procedures to implement plans of care for substance-exposed newborns. After the federal CARA law was enacted, the state CYFD convened a working group in 2017 to develop proposals for implementing plans of care in New Mexico. The workgroup included representatives from the state Department of Health, state Human Services Department, hospitals, managed care organizations (MCOs), and community providers to decide how to implement plans of care in New Mexico. This group, together with the J. Paul Taylor Task Force (an existing group legislatively mandated to propose strategies to improve child mental health and prevent adverse childhood experiences), helped develop House Bill 230, which was passed during the 2019 legislative session and signed by the governor (Laws 2019, Chapter 190).[vii]

The statutory deadline for establishing CARA rule was missed by roughly two years, delaying implementation. Chapter 190 stipulated that by January 1, 2020, CYFD, in consultation with Medicaid managed care organizations, private insurers, the Office of Superintendent of Insurance, the Human Services Department, and the Department of Health, would develop rules to guide hospitals, birthing centers, medical providers, Medicaid managed care organizations, and private insurers in the care of newborns who exhibit physical, neurological, or behavioral symptoms consistent with prenatal drug exposure, withdrawal symptoms from prenatal drug exposure, or fetal alcohol spectrum disorder.[viii] Administrative rule regarding roles and responsibilities of different entities involved with the plan of care were not promulgated until February 22, 2022.[ix] Some of this delay in implementaton may be attributed to the Covid-19 pandemic.

Advantages of Placing CARA Oversight in Different Types of State Agencies

Public Health Departments: Responsible for administering laws and exercising functions related to health services and programs.

Human Services Departments: Provide direct oversight of Medicaid, managed care providers (MCOs), and MCO care coordinators serving Medicaid populations.

Child Protection Departments: Directly provide family assessments and investigations to protect children from maltreatment.

Source: LFC Files

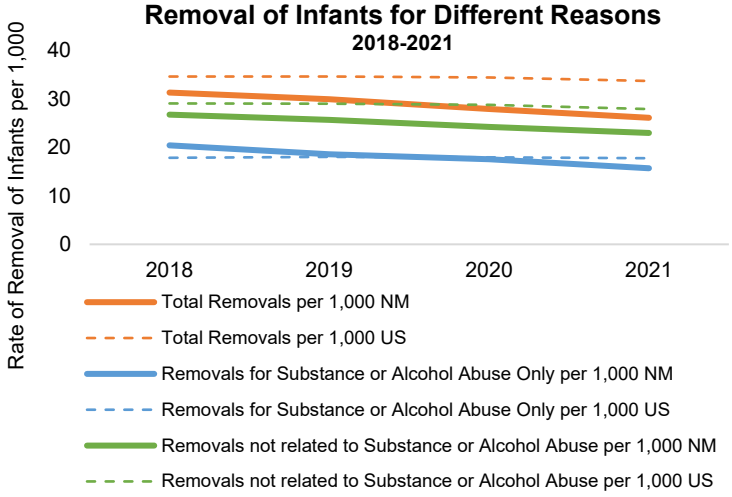
States can place CARA responsibilities within child protective agencies or public health agencies. States can choose whether to place the oversight of CARA and plans of care with their child protective agencies (e.g., Texas) or their public health agencies (e.g., Colorado, New York). Although federal CAPTA funding is required to flow through a state's child protective agency, not all CAPTA funds or programming is required to stay with the state's child protective agency. This information indicates states can have flexibility in choosing where to place CARA responsibilities within state government.

Based on a public health approach, New Mexico's CARA statute states a woman's use of drugs during pregnancy cannot be a reason to report child abuse or neglect. Before New Mexico enacted its CARA law in 2019, state law considered a woman's use of drugs during preganacy as a form of child maltreatment to be reported to CYFD. New Mexico's CARA law changed this and clarified the role of hospital and birthing center staff in reporting child abuse and neglect based solely on a finding of drug use by a pregnant woman. New Mexico's CARA statute specifically mentions that a pregnant woman's use of drugs "shall not alone form a sufficient basis to report child abuse or neglect to the department (CYFD)." (Section 32A-4-3(G) NMSA 1978). New Mexico's CARA law still obligates people to *notify* CYFD when a substance-exposed newborn receives a plan of care, but this

notification is explicitly distinct from a *report* of child abuse or neglect. According to the CARA project description from CYFD and DOH, this law was intended to ensure that babies born exposed to substances, and their families, receive the supports and services they need without being stigmatized, discriminated against, or punished.[x]

After New Mexico enacted its CARA statute, child protective removal of infants from the home due to substance abuse fell below national rates. Prior to the passage of New Mexico's CARA statute, the state removed infants from the home for reasons of substance or alcohol abuse at higher rates than the rest of the United States. However, following the passage of the state's CARA statute in 2021, New Mexico's removal of infants from the home for reasons of substance or alcohol abuse declined by 23.2 percent, driving the state's removal rates lower than the national average.

Chart 8. Comparing NM and the U.S. on Rates of Removal of Infants for Different Reasons
2018-2021



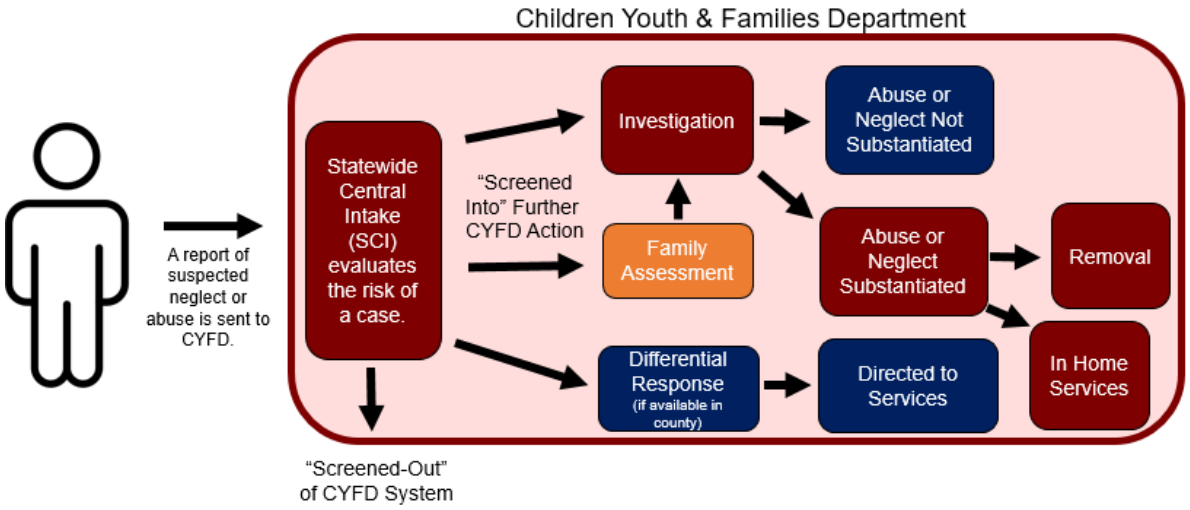
Source: AFCARS 2018-2021

New Mexico's child protective services process is separate and distinct from the CARA plan of care process for substance-exposed infants. When a person submits a report of suspected neglect or abuse to CYFD, the department's statewide central intake (SCI) staff decides whether the report is screened-out of the CYFD system or screened in for further CYFD action (either a family assessment or a full investigation). For low-risk families, CYFD can direct those families to needed services through an approach called "differential response." Differential response, also known as multilevel response, was enacted in 2019 in state law (Section 32A-4-4.1 NMSA 1978). The evidence-based approach is meant to prevent child maltreatment and avoid costly and more traumatic interactions with the child welfare system. CYFD began piloting differential response in 2021, but the approach is only being implemented in 13 out of 33 counties (McKinley, Sandoval, Valencia, Los Alamos, Rio Arriba, San Miguel, Mora, Lea, Catron, Otero, Sierra, Socorro, and Lincoln). State law requires CYFD to have provided a plan for expanding the differential response approach statewide by July 1, 2022 (Section 32-4-4.1(G)(5) NMSA 1978). CYFD should provide LFC with a plan to expand its differential response approach statewide as required by state law.

State law requires CYFD to provide LFC a plan for statewide expansion of its "differential response" approach (directing low-risk families to services).

CYFD can assess higher risk families that refuse services or an investigation of suspected child abuse or neglect. When an investigation is conducted, CYFD investigators can either "substantiate" or "not substantiate" suspected abuse or neglect. Once a report of suspected abuse or neglect is substantiated, then CYFD takes action to remove the child and place them into foster care.

Figure 4. New Mexico's Child Protective Services Process

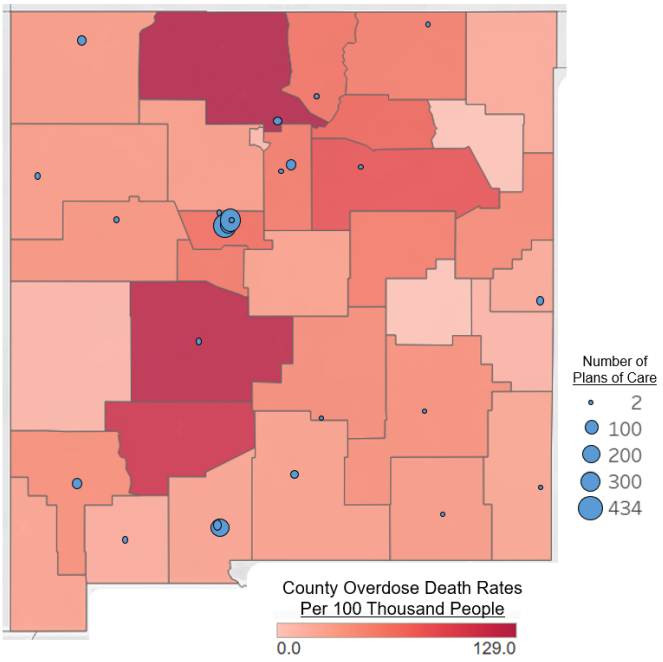


Note: A report of suspected neglect or abuse to CYFD is different from a notification to CYFD of a CARA plan of care.
Source: LFC Staff Review of New Mexico Statute and Regulations

New Mexico's CARA law spreads the responsibility of developing and monitoring voluntary plans of care across multiple state agencies and healthcare organizations.

New Mexico's CARA law changed the requirements for hospitals to create a voluntary plan of care for all substance-exposed babies instead of requiring reports of suspected abuse and neglect to CYFD. The plan of care is meant to support a baby's safety, health, and development by offering services for the baby and its parents or caretakers. The services offered to parents—such as housing, food, counseling and other services for substance misuse, addiction, and mental health—focus on reducing stressors.

Figure 5. Number of New Mexico CARA Plans of Care
2020-2021
(n = 2,321 CARA plans of care)



Source: LFC Analysis of CYFD and DOH Data

Brief Summary of CARA Responsibilities in New Mexico

Healthcare staff: Help families with substance-exposed newborns develop a voluntary plan of care if the family chooses to develop a plan.

Care coordinators: Help families connect with the family's desired support services or treatment options if the family chooses to accept a plan of care. Care coordinators work for Medicaid managed care organizations (MCOs), private insurers, or DOH.

CYFD: Collect data on plans of care, evaluate plan of care information, try to contact hard-to-reach families, help connect families to services, and conduct assessments of families if there is a report of child maltreatment (does not include substance-exposure or use).

DOH, HSD, and ECECD: Collect data on plans of care, evaluate plan of care information, try to contact hard-to-reach families, and help connect families to services.

Source: LFC Files

Table 2. Estimated Annual Spending on CARA

Cost Category	Dollar Amount
Estimated Medicaid managed care organization (MCO) spending on care coordination for families on CARA plans of care.	$1,202,906
Salary costs for four staff positions in state agencies dedicated to monitoring CARA plans of care.	$296,788
Total CARA Spending	**$1,499,694**

Note: Table uses the most recent data available for Medicaid care coordination costs from 2021 and October 2023 state agency salary data.

Source: LFC Analysis of Medicaid and State Personnel Office Data

The plan of care offers a referral to a care coordinator (employed by an insurance company or a Medicaid managed care organization) who assists families with navigating supportive services and assisting with any other needs the family may have. Before healthcare staff can release patients with a substance-exposed newborn, state law requires healthcare staff create plans of care with the patients and care coordinators attempt to connect the patients with supportive services. Hospital staff are required to notify the state, via an online CARA portal accessible by the agencies, when a plan of care is completed for a substance-exposed newborn. In cases when a positive toxicology screening is received after an infant and the mother is discharged from the hospital, the hospital is still required to complete a plan of care.

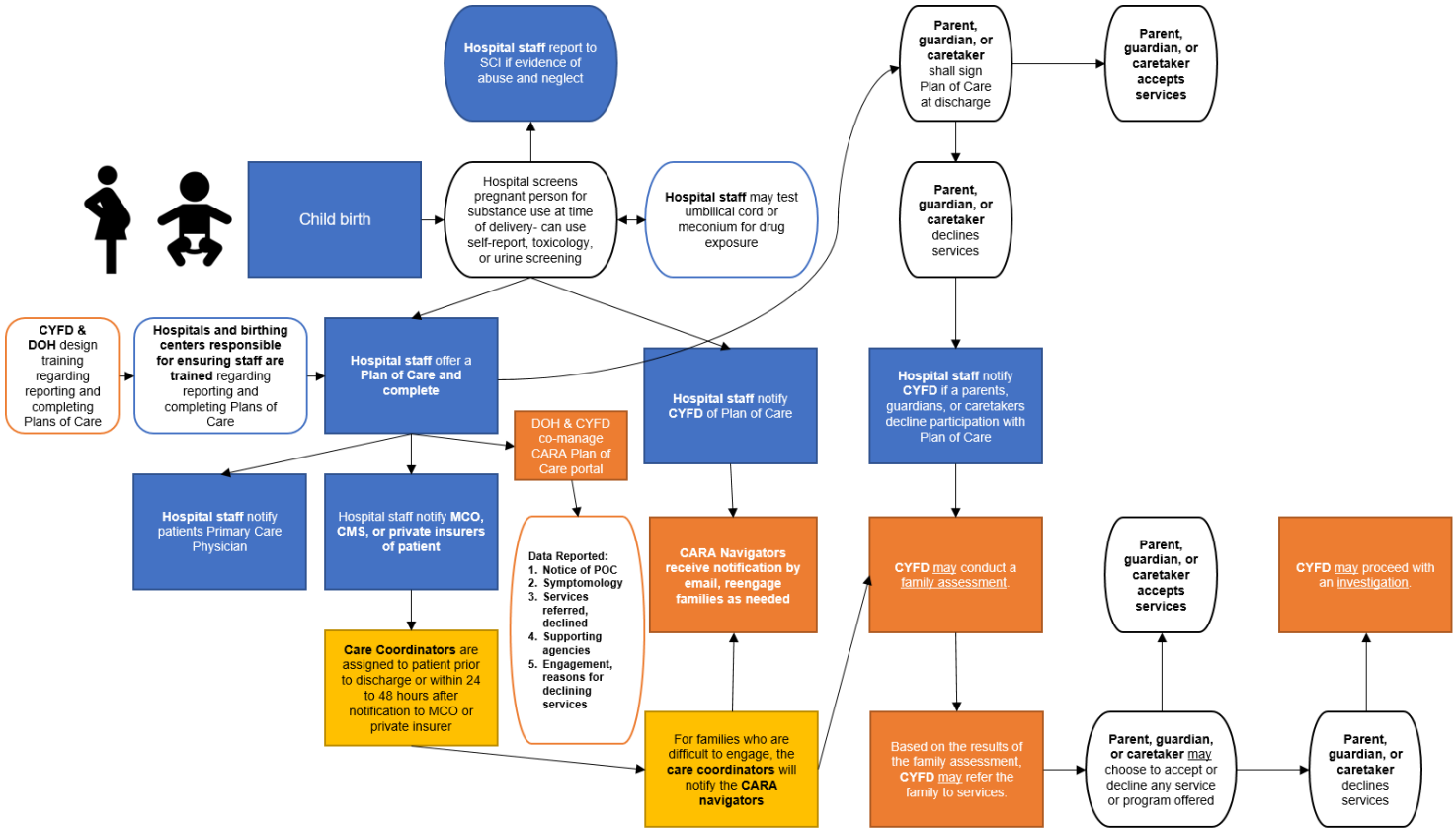
CYFD is responsible for working with the state Human Services Department (HSD), the Department of Health (DOH), and Medicaid managed care organizations (MCOs) to develop rules and trainings for healthcare providers on developing plans of care for newborns who were substance-exposed during pregnancy or exhibit symptoms of drug withdrawal, or fetal alcohol syndrome. The rules and training include discharge planning, screening, data collection, and engagement of the child's caretakers to identify access to services or treatment.

CARA implementation at CYFD is supported by roughly $200 thousand in federal funding through CAPTA in FY22. The federal funding at CYFD pays for two full-time CARA navigator positions and training modules. According to State Personnel Office data from October 2023, state agencies dedicate four staff positions, with a combined annual salary cost of $297 thousand, to monitoring CARA plans of care. Agency analysis for the bill that created New Mexico's CARA law, indicated minimal costs associated with implementation and ongoing administration and would bring New Mexico into federal compliance allowing the department to receive federal CAPTA funding.

An online CARA portal, which houses all plans of care, is paid for by CYFD through the Interagency Behavioral Health Purchasing Collaborative. DOH's Family Health Bureau is responsible for collecting data relevant to plans of care as needed for evaluation purposes.[xi] DOH's children medical services can also offer care coordination for parents who are on Medicaid but not enrolled in an MCO. The state Early Childhood Education and Care Department (ECECD) also employs a CARA navigator to connect families with early childhood services, even though ECECD's duties related to CARA are not required in statute.

According to the 2023 LFC *Medicaid Accountability Report*, managed care organizations (MCOs) spend roughly $2,785 per individual each year on care coordination services. MCO data indicates roughly 36 percent of families (or 432 families) on a CARA plan of care receive care coordination services, which equates to a $1.2 million annual cost for care coordination for families on CARA plans of care.

Figure 6. Roles and Responsibilities of Different Entities Involved With the Plan of Care



Note: Blue boxes indicate healthcare provider responsibilities, yellow boxes indicate MCO responsibilities, and orange boxes state agency responsibilities.
Source: LFC Staff Review of Laws 2019, Chapter 190 (House Bill 230) and Section 8.10.5.10 NMAC

In 2023, legislators and the governor made multiple proposals to revise, restructure, or reform how CARA and plans of care are implemented in New Mexico. Introduced legislation varied, with some bills seeking to reorganize agency CARA-related responsibilities (House Bill 434), requiring universal screening (HB477), requesting a study of prenatal substance abuse exposure (House Memorial 52), requiring CYFD to conduct a family assessment in the event of noncompliance with a plan of care (Senate Bill 150), and creating felony charges for exposing a child, in utero, to a schedule I or II narcotic (HB221). Efforts to reform CYFD and child welfare programs in general have been widespread with the recent and persistent high-profile cases of child abuse across the state (see Appendix D for a list of proposed legislation). The governor recently issued Executive Order 2023-020, reorganizing CYFD; however, the impacts of the reorganization are unclear. Additionally, CYFD submitted a budget expansion request for FY25 for a new division with 20 staff dedicated to CARA and monitoring plans of care, which this program evaluation addresses in its third finding.

The Vast Majority of CARA Families are Not Receiving Support Services or Substance Use Treatment

New Mexico's CARA statute takes a public health approach to addressing substance-exposed newborns. However, the policy is not accomplishing its intended purpose of improving the well-being of substance-exposed infants by keeping them out of child protective services and getting mothers and caregivers into treatment. DOH and CYFD have not maintained efforts to evaluate the outcomes of CARA newborns. The state currently does not have a policy or mechanism for implementing plans of care prenatally, which could connect mothers to treatment and supportive services earlier during pregnancy.

New Mexico's plan of care policy is not achieving its intended purpose of ensuring the safety of substance-exposed newborns.

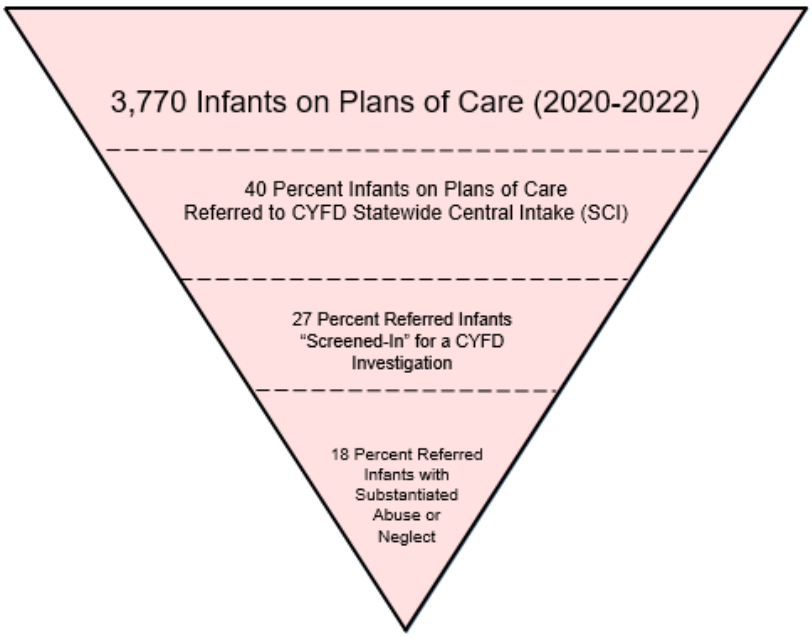
Nearly a third of CARA mothers and families have had a prior substantiated case of abuse or neglect, indicating previous system efforts to support the family have not prevented subsequent substance-exposure to those newborns. CYFD investigations involving infants on a CARA plan of care have higher substantiation rates compared to investigations of suspected abuse or neglect of infants not born substance-exposed, indicating that these families are at high risk of maltreatment.

CYFD's CAPTA state grant report indicates hospital staff have struggled with the change in reporting standards because, prior to CARA legislation, they would make reports based solely on a positive toxicology report.

Almost 1-in-3 families who received a plan of care had a previous substantiated investigation from CYFD. In fiscal year 2023, among families who received a plan of care, 39 percent had a prior CYFD Protective Services interaction. In 2020, DOH reported 42 percent of families who received a plan of care had a prior history with CYFD Protective Services and 29 percent of families had a prior substantiated case of abuse or neglect. In other words, New Mexico's CARA statute changed the legal requirement to make a report to statewide central intake in these cases when there was already a known risk for possible abuse or neglect to the newborn.[xii] The role of hospital staff could be clarified in rule so staff know they should report suspected abuse or neglect when infants are born substance-exposed to illegal drugs and a family declines substance abuse treatment or declines to participate in a plan of care.

Families with a plan of care subsequently have a higher maltreatment substantiation rate for abuse or neglect compared to families of infants without a plan of care. When people suspect abuse or neglect, they report it to statewide central intake (SCI). Healthcare providers reported 40 percent of CARA families to SCI for suspected abuse or neglect in FY23. When a report of abuse or neglect is made, SCI determines whether to screen-out the report or screen-in the report for an investigation. Among all families who received a plan of care from 2020-2022, 27 percent were screened-in for an investigation for suspected abuse or neglect. After an investigation, CYFD investigators determine whether the reported abuse or neglect is substantiated or not. Eighteen percent of all CARA families were found to have a substantiated case of abuse or neglect. Thirty-four percent of CARA cases with a substantiated case of abuse or neglect were exposed to only cannabis. Ninety percent of CARA cases with a substantiated case of abuse or neglect were for neglect or deprivation of necessities. Furthermore, CARA families investigated for abuse or neglect have a higher substantiation rate (66 percent) than other families with infants (41 percent), indicating they are a group at high risk for abuse and neglect when a report is made and appropriately screened in for an investigation.

Figure 7. Infants on a CARA Plan of Care Reported to SCI and Investigated for Abuse or Neglect

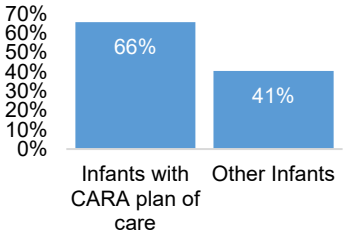


Source: LFC Analysis of CYFD Data

A 2021 evaluation by DOH found, among families investigated for maltreatment, the substantiation rate of infants with a plan of care (49 percent) was nearly twice that compared to the substantiation rate of infants of the same age without a plan of care (29 percent), indicating that cases on a plan of care are at higher risk for substantiated cases of abuse or neglect. Of the families with CARA cases later found to have a substantiated case of abuse or neglect, 53 percent exposed their newborn to illegal substances, 37 percent were not referred to any kind of substance use treatment services, and another 22 percent declined referrals to any kind of substance use treatment.[xiii]

Given incidents of lack of transparency and cooperation from CYFD, oversight and transparency of the agency could be strengthened. As reported as far back as at least 2011 in an LFC program evaluation on CYFD's Protective Services Division, CYFD failed to produce critical incident reviews

Chart 9. Infants With a CARA Plan of Care Reported for Suspected Abuse or Neglect Have a Higher Substantiation Rate Than Other Infants
2020-2022



Source: CYFD

(CIR) data to LFC staff. The LFC evaluation team requested to review the CIRs on-site with confidential information redacted; however, the data request was denied. The evaluators were unable to make conclusions about how the CIR process had improved safety.

More recently, an LFC staff memorandum sent to the committee in September 2021 reported there are numerous oversight mechanisms external to CYFD but they are either inadequate or provide dated information to the public. For example, CYFD participates in the Child Fatality Review Board, the Maternal Mortality Review, and other child fatality review panels, but these panels lack timely reporting on findings and outcomes. Additionally, the Substitute Care Advisory Council (SCAC), enacted by statute, fulfills a federal requirement from CAPTA requiring states establish volunteer citizen panels to review child welfare policies and practices. SCAC is currently placed within the Regulation and Licensing Department; however, an FY20 SCAC annual report identifies this placement as a liability due to a lack of independence and autonomy. The report identified administrative attachment to the Administrative Office of the Courts (AOC) as a better fit given the deep involvement of the judiciary in child welfare issues.

Roughly 1-in-7 CARA families is receiving substance use treatment services.

There are substance abuse treatment options, like medication assisted treatment (MAT), which CARA families can be referred to and provided on an outpatient basis.

Sixty-three percent of cannabis only cases were not referred to substance abuse treatment while 43 percent of illicit substance use cases were not referred to substance abuse treatment.

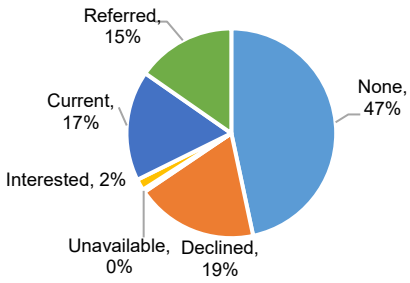
The state is not currently tracking CARA families' utilization of substance use treatment, other service referrals, or longer-term utilization of preventive healthcare. Service referrals on a plan of care are primarily directed to the mother and infant but can also include family members and other caregivers. Although engaging with a plan of care and the supportive services is completely voluntary, half of families with a plan of care are not being referred to any type of substance use treatment by hospital staff, and when hospital staff do refer to substance use treatment services, 2-in-5 families decline those services. There may be certain cases where substance abuse treatment is not required and cannabis use cases may account for a portion of the high number of families not receiving substance abuse treatment. For instance, 63 percent of cannabis only cases were not referred to any type of substance abuse treatment. However, amongst cases who only used illicit substances (excluding all cannabis use) 43 percent were not referred to any type of substance abuse treatment. Barriers to providing substance use treatment to CARA families is the state's lack of substance use treatment provider options, particularly providers that can accommodate a mother with her infant. Currently, the only inpatient treatment programs for pregnant women and mothers with newborns are in Carlsbad, Santa Fe (Santa Fe Recovery), and Bernalillo County (Milagro-FOCUS). The University of New Mexico's support of the UNM Hospital, Milagro, and FOCUS (Family Options Caring Understanding Solutions) provides a model for wraparound substance abuse treatment services for substance-using pregnant and new mothers; however, these programs only serve the Albuquerque metro region (see Appendix E for more detail). However, some substance abuse treatment options, like medication-assisted treatment (MAT) can be provided on an outpatient basis. According to LFC's 2023 *Medicaid Accountability Report*, though MCOs generally meet their contractual standards for "network adequacy," or having enough providers, data suggests clients may be unable to access care when they need it due to insufficient numbers of providers. Additionally, the $20 million appropriated to CYFD in FY23 to expand behavioral health provider capacity had gone unspent as of September 2023.

Almost half of families with a plan of care are not referred to substance use treatment and only 15 percent accept referrals. Hospital staff (e.g., labor and delivery nurses, social workers, care coordinators) are responsible for creating plans of care with mothers and families of substance-exposed newborns and referring them to supportive services. Although services are voluntary, not all identified mothers and families of substance-exposed newborns are referred to substance use treatment.

Only 15 percent of CARA families accept referrals to some kind of substance use treatment. Nearly half of CARA families are not referred to any type of substance use treatment. Nineteen percent of CARA families are referred to some type of substance use treatment but decline services. Seventeen percent of CARA families are already involved in some kind of substance use treatment.

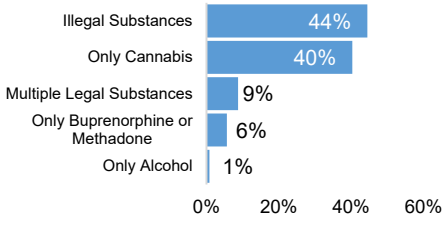
Families often decline referrals to substance use treatment, uptake of other service referrals is mixed, and families are not necessarily being referred to or participating in evidence-based services. The services that families accepted most often were early intervention, home visiting, Women, Infants, and Children (WIC), parenting group, and mental health counseling. Of the families referred to substance use treatment services, 84 percent declined smoking cessation, 80 percent declined 12-step programming, 60 percent declined recovery supports, 56 percent declined MAT, and 51 percent declined substance use counseling. Additionally, referrals to domestic violence services, children's medical services, and infant mental health services were declined at high rates. Hospital staff are still not referring all CARA cases to other supportive resources, which could benefit these high-risk cases. For example, hospital staff could automatically refer all CARA cases to early intervention or evidence-based home visiting programs.[xiv]

Chart 10. Plan of Care Service Referral Type for any Type of Substance use Treatment
2020-2021
(Includes 12-Step Programming, MAT, Recovery Supports, Smoking Cessation, and Substance Abuse Counseling)



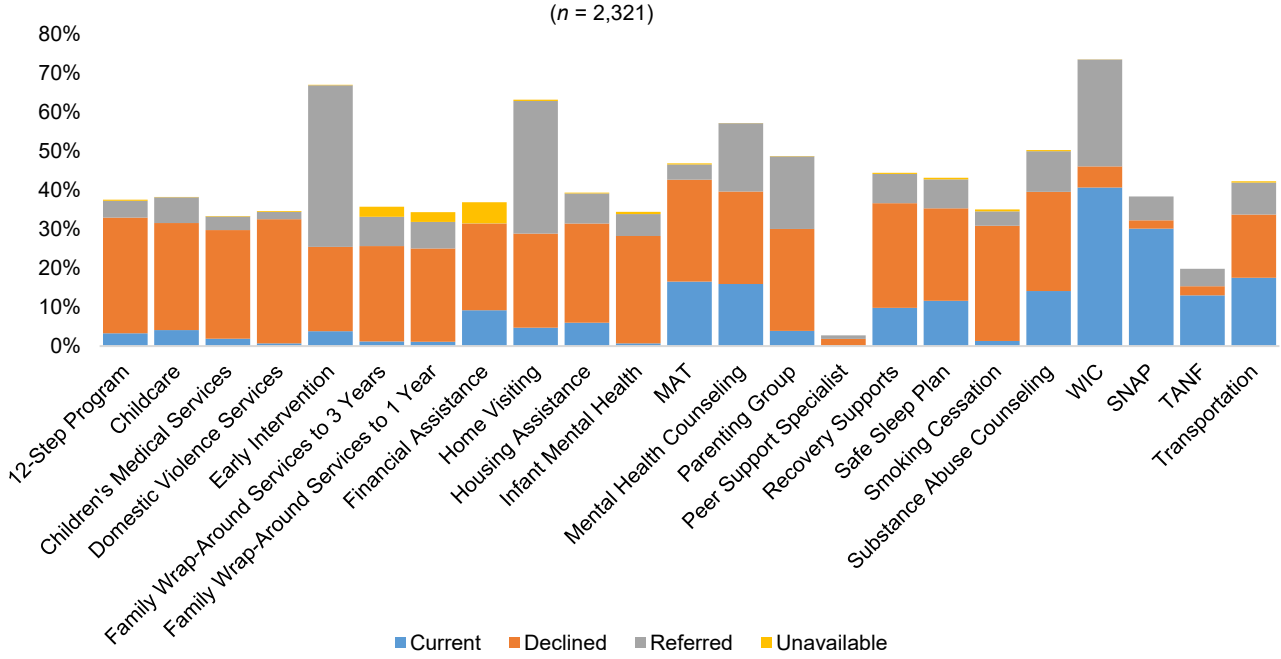
Source: CYFD

Chart 11. Percent of Substance Exposure Types on Plans of Care
2020-2022



Source: DOH

Chart 12. CARA Service Referral Outcomes, New Mexico
2020-2021
(*n* = 2,321)



Source: CYFD

State law does not require CYFD to assess families with substance-exposed infants who decline substance use treatment. State law says the department "may" (but does not have to) conduct a family assessment of whether a child is at risk of neglect or abuse if a family does not comply with their plan of care (Section 32A-3A-13 NMSA 1978). Additionally, all services in a plan of care are voluntary and can be refused by families (8.10.5.9 NMAC). Given 51 percent to 84 percent of families decline referrals to substance use treatment, the Legislature should consider requiring CYFD to conduct a family assessment of families who refuse substance use treatment or do not comply with their plans of care.

A prior DOH evaluation of the implementation of CARA noted families that initially declined a service may request them if the service is explained and follow up is provided. For example, the LFC evaluation team met with hospital staff who noted once families are home and settled with their new baby, they may realize the benefits or be more receptive to accepting the supportive services offered through a plan of care. This indicates a need for continuous follow-up with families to identify service needs, as well as adequately explained services by hospital staff.

Even when families accept services, the state does not regularly track whether families follow through with treatment and services.

One limitation to the state's implementation of its CARA policy is that service utilization is not monitored by CYFD or DOH. Further, DOH noted in its evaluation of CARA's implementation that hospitals and Medicaid MCOs are not tracking this information. MCOs are also only required to report on information outlined in contracts with the Human Services Department (HSD), which is currently family's engagement status with care coordination but not individual services in their plan of care.[xv]

Table 3. Percent of CARA Plans of Care Considered "Successful" Reported by MCOs

MCO	Percent of CARA plans of care considered "successful"
MCO A	0.4%
MCO B	22%
MCO C	92%

Note: MCOs defined "success" differently, varying between overall service utilization or engagement with care coordination.

Source: HSD, MCOs

Infants stay on a plan of care for their first year of life; however, neither statute nor rule define what "successful" completion of a plan of care means. Family engagement in accepted service referrals could be considered one measure of success. MCOs only track service utilization for Medicaid eligible services. When asked what percent of CARA plans of care could be considered "successful," MCOs reported a range of 0.4 percent to 92 percent, but differed in their definitions of successful engagement based on service utilization or engaging with care coordination. In defining successful engagement in a plan of care as utilizing referred services, one MCO reported that, out of 1,764 CARA families, only 29 received a well-child visit (1.6 percent), 19 received housing support (1.1 percent), 62 received baby benefits education (3.5 percent), and 20 engaged in community resource (1.1 percent), for an overall 0.4 percent successful program completion rate.

Families who accept services on a plan of care often do not participate in those services. Among families on a plan of care from 2020-2021, 612 (26 percent) families accepted referrals for home visiting. However, when matched to the state's home-visiting database, only 17 percent were found to be participating in those services[2]. Similarly, 1,045 (45 percent) families received a referral to early intervention services, but only 59 percent ultimately participated in services. In other words, only 4 percent of all families on a plan of care went on to participate in home-visiting services and 26 percent participated in early intervention. Analysis by DOH found that families who accepted a referral for early intervention but did not ultimately participate in services were mostly due to the families being unable to be contacted (37 percent) or not completing the eligibility process (25 percent).

Home Visiting: 17 percent of families who accepted referrals for home visiting on a plan of care go on to participate in those services.

Early intervention (Family, Infant, Toddler): 59 percent of families who accepted referrals for early intervention on a plan of care go on to participate in those services.

Source: DOH

[2] The state home visiting database, managed by UNM, was linked to the CARA portal database by DOH to ascertain the number of CARA participants whose record indicated they were interested, referred, or currently enrolled in a home visiting program. Among 612 records in 2020-2021 CARA cohort that indicated they were interested, referred or currently enrolled in a home visiting program, 102 matched to a home visiting record for 2020-2021. DOH notes this could be an underestimate and may not include all CARA records since their analysis did not include CARA participants who did not accept care coordination or who participated in a non-ECECD funded home visiting program.

The CARA portal database is inadequate for case management and tracking safety and well-being outcome measures. New Mexico's plan of care data is collected in the online plan of care submission portal, developed by the contractor Falling Colors through an HSD Interagency Behavioral Health Purchasing Collaborative Services Agreement and maintained and monitored by both CYFD and DOH through a memorandum of agreement. The initial contract and design for the CARA portal database did not allow providers outside the hospital to access the plans of care online to add information that would document the progress of parent and infant in outpatient services. Currently, only the CARA navigators at CYFD, DOH, and the Early Childhood Education and Care Department (ECECD) can make updates to edit plans of care to indicate additional services referred or accepted. The CARA portal database needs to be updated to add fields to allow updates regarding service engagement for case management.

Appropriate outcome data for infants and families on a plan of care are maintained in numerous databases across multiple agencies, including CYFD disposition data, various health registry databases maintained by DOH, and healthcare utilization data for Medicaid recipients maintained by partner MCOs. To track policy outcomes of interest, the state needs to operationalize their data sharing agreement among DOH, ECECD, HSD, and CYFD to track individual client's healthcare utilization over the first year after an infant's birth. Data needed to link to the CARA portal database for outcome analysis should include statewide central intake, the Family, Infant, Toddler early childhood data system, the prescription monitoring profile, the statewide immunization database, and Medicaid claims data. Integrating data with the CARA portal database would allow meaningful comparisons to be made among families that accept a plan of care and access services, families that refuse plans, and families that drop out of services. In addition to service engagement, longer-term health metrics should be tracked, monitored, and reported, which should include immunization rates, well-child checks completed, health status at 12-months, health status at subsequent well-child checks (e.g., 15 months, 24 months, 36 months), enrollment in prekindergarten, enrollment in special needs programs in school, and custody (e.g., foster care placement, kin placement, birth parent placement).

Potential CARA Policy Outcomes

Safety Outcomes:

- Investigations by CYFD for suspected abuse or neglect
- Substantiated cases of abuse or neglect
- Custody (e.g., foster care placement, kin placement, birth parent placement)

Well-Being Outcomes:

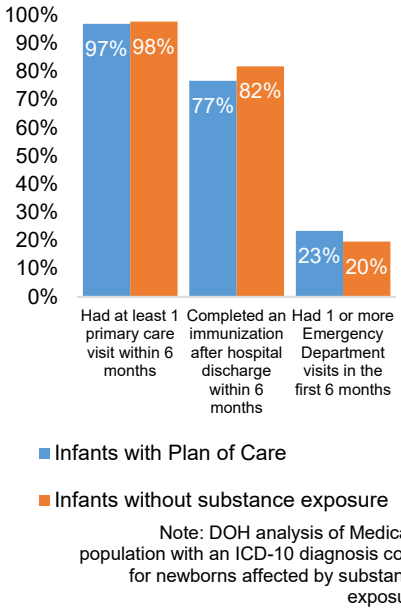
- Engagement in early intervention, home visiting services, or other supportive services
- Engagement in substance use treatment services
- Immunizations
- Well-child checks and health status

Current state statutes and rules do not include procedures for creating plans of care before birth, limiting prenatal supports and case management to CARA families.

Though not federally required, prenatal plans of care are considered a supportive, preventive practice. To identify and engage pregnant and parenting women earlier, communities need to build their capacity to support at-risk families prior to the birth event and child welfare involvement with family-centered services. Substance use during pregnancy has detrimental impacts to a newborn's health, maternal health, and costs to the state. The prenatal period provides a window of opportunity to reduce adverse fetal and neonatal outcomes through treatment of prenatal substance use though many states, including New Mexico, do not require prenatal plans of care.

Early identification of drug use during pregnancy and establishing a plan of care during pregnancy can reduce the amount of time the fetus is exposed to substance use and lead to early substance treatment, making it more likely a newborn will be released from the hospital or birthing center to a safe environment. Programs like UNM's Milagro Perinatal Substance Abuse Program provides this type of intervention and includes prenatal visits,

Chart 13. Infants with a CARA Plan of Care Were Not More Likely to Receive Preventive Care
2020-2021



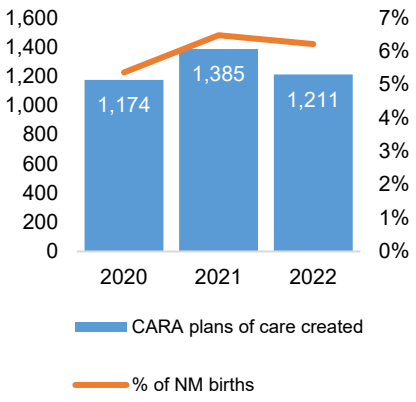
Note: DOH analysis of Medicaid population with an ICD-10 diagnosis code for newborns affected by substance exposure
Source: DOH

maternal fetal medicine consultation, substance abuse counseling, reproductive psychiatry, buprenorphine management, and postpartum services. Creating a plan of care during pregnancy also shifts the process to a potentially less hectic environment, as opposed to creating a plan of care after the birth has occurred when the family is likely exhausted and anxious to be discharged.

Colorado focuses CARA implementation on pregnancy because of "lessons learned" from a perinatal substance use linkage study and policy brief that found plans of care should be initiated prenatally or as soon as prenatal substance use disorder is recognized. Wrapping services around families prenatally holds high promise for making substantial progress on key maternal-infant health and social outcomes, including low birth weight, according to Colorado's perinatal substance study. Infants in their study were 2.8 times more likely to experience low birth weight than Colorado's general population and low birth weight can contribute to higher neonatal intensive care unit admission rates and ongoing health and developmental issues. The study concluded, because birth weight is influenced by factors during pregnancy, initiating a plan of care prenatally might influence this "upstream" outcome to prevent negative "downstream" effects. The study also found newborns involved in child welfare due to prenatal substance use tend to be more medically fragile at the time of birth, admitted to the neonatal intensive care unit at three times the rate of the general population, and at higher risk of infant removal by child welfare.

Colorado passed legislation in 2019 to create a statewide perinatal substance use data linkage project that will link maternal and infant data from the prenatal period with data through one year postpartum. The data will generate population estimates of incident rates and health outcomes for infants impacted by perinatal substance use.

Chart 14. CARA Plans of Care Created



Source: DOH

Table 4. New Mexico and National Rates of Infants with Prenatal Substance Exposure (IPSE) Screened-In, Have a Plan of Care, and Referred to Appropriate Services

	NM	U.S.
Percent of IPSE cases screened-in by CPS	51%	83%
Percent of screened-in IPSE cases who have a plan of safe care	11%	70%
Percent of screened-in IPSE cases who have a referral to appropriate services	10%	67%

Source: Children's Bureau: Child Maltreatment 2021 Report

DOH and CYFD have not evaluated CARA since its first year, limiting information and accountability.

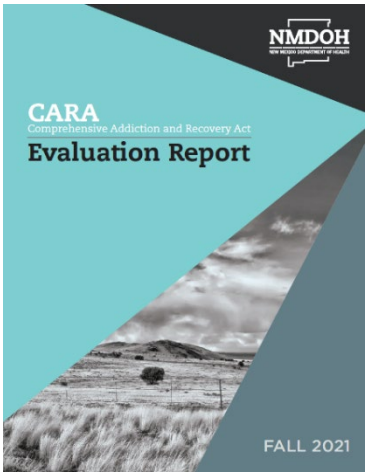
Since its implementation, there have been approximately 1,200 CARA plans of care created each year. In other words, an average of 100 plans of care are created each month and over three plans of care are created every day.

Sixty-one percent of infants born substance exposed were exposed to one substance, while 39 percent were exposed to multiple substances. Fifty-five percent of infants were exposed to only legal substances while 44 percent were exposed to at least one illegal substance. Nearly two-thirds of newborns with a plan of care were exposed to cannabis and 40 percent were exposed to only cannabis.

As reported in the most recent 2021 *Child Maltreatment Report*[3], New Mexico tends to provide a plan of care, refer to appropriate services, and screen in cases of substance-exposed infants referred to CYFD at less than national rates. In the 2021 federal fiscal year, New Mexico reported 286 infants were referred to CYFD as infants with prenatal substance exposure, with approximately half (51 percent) screened in to receive either an investigation or alternative response. Nationally, approximately 50 thousand infants were referred to child protective services agencies as infants with prenatal substance exposure (IPSE) and the majority (83 percent) of those cases were screened in. Of the referred IPSE cases screened in by CYFD, New Mexico reported only 11 percent had a plan of care, compared to 70 percent nationally. Among the

[3] The Comprehensive Addiction and Recovery Act (CARA) of 2016 includes an amendment to CAPTA to collect and report the number of infants with prenatal substance exposure (IPSE), IPSE with a plan of safe care, and IPSE with a referral to appropriate services. States began reporting the new fields with their National Child Abuse and Neglect Data System (NCANDS) submissions in the 2018 federal fiscal year. Although state definitions can differ, state and national NCANDS data reported in the Children's Bureau Child Maltreatment Report presents state and national data about child abuse and neglect known to child protective service agencies in the United States.

screened-in IPSE cases by CYFD, New Mexico reported only 10 percent of cases were referred to appropriate services, compared to 67 percent nationally. What is considered an appropriate service is up to each state and may depend on the needs of the specific case, but could include mental and behavioral health, foster care, substance abuse assessment and treatment, and other programs that facilitate early identification of at-risk children.[xvi]



DOH has not conducted a program evaluation of CARA for the past two years. In fall 2021, DOH conducted an evaluation with existing staff resources on the first year of implementation of the state's CARA initiative.[xvii] The department is working to contract with a health economist for a follow-up CARA economic impact study, though there is not a projected completion date. DOH also recently contracted for a CARA mapping study; however, this report does not provide up-to-date outcomes to assist the Legislature in determining whether CARA is working as intended or not. CARA administrative rule specifies that DOH and CYFD shall collect data relevant to plans of care as needed for evaluation and tracking purposes, but not that the evaluation shall be done. Therefore, to ensure oversight and accountability, administrative rule should be updated to require the agencies to conduct annual evaluations of CARA outcomes, report to the Legislature, and post the evaluations publicly on their websites.

Recommendations

The Legislature should consider:

- Amending CARA statute to require a family assessment or differential response when a report involving a CARA family is made to CYFD;
- Amending statute to require CYFD to conduct a family assessment of families who refuse substance use treatment or do not comply with their plans of care;
- Amending CARA statute to include references to implementing prenatal CARA plans of care alongside references to plans of care developed at birth; and
- Amend statute for the Substitute Care Advisory Council by moving it from the Regulation and Licensing Department to the Administrative Office of the Courts and including a mandate for a minimum number of case reviews that include representative samples of CYFD cases.

The Children, Youth, and Families Department should:

- Promulgate rules requiring hospitals and birthing center staff to report families to CYFD if referrals for substance use treatment for illegal drugs in a plan of care are declined;
- Revise administrative rules and CYFD intake screening procedures and update training to hospital staff and MCO care coordinators to report suspected abuse or neglect to statewide central intake (SCI) when infants are born substance-exposed to illegal drugs and a family declines substance abuse treatment or declines to participate in a plan of care so the agency can assess whether a family assessment or investigation is necessary;
- Promulgate rules requiring hospitals and birthing centers to require a referral to early intervention or evidence-based home visiting for every CARA family;
- Clarify procedures for when positive drug screening results are received after a family has been discharged without a plan of care; and

- Amend rules, CARA plan of care forms, and the online CARA portal to allow for implementation of plans of care during prenatal treatment.

The Children, Youth, and Families Department and Department of Health should:

- Conduct annual evaluations of CARA outcomes, report to the Legislature, and post the reports publicly.

The Children, Youth, and Families Department, Department of Health, Human Services Department, and Early Childhood Education and Care Department should:

- Establish a data-sharing agreement to track CARA service engagement and healthcare utilization over the first year after an infant's birth, which should include the CARA portal database, SCI, the Family, Infant, Toddler early childhood data system, the prescription monitoring profile, the statewide immunization database, and Medicaid claims data.

The Children, Youth, and Families Department, Department of Finance and Administration, and Legislative Finance Committee should:

- Develop Accountability in Government Act performance measures regarding CARA plan of care service referrals, engagement rates, and preventive care metrics; and
- Develop Accountability in Government Act performance measures regarding rate of cases with a CARA plan of care and subsequent investigations and substantiated cases of abuse or neglect.

CARA-Related Case Management, Screening, and Identification of Substance-Exposed Newborns Should be Improved

The implementation of the state's CARA statute has gaps in its process. CYFD assessment and procedures for screening reports of suspected abuse or neglect appear to need to be updated to incorporate CARA cases. According to data provided by DOH, substance-exposed newborns eligible for CARA plans of care are under-identified by up to 40 percent. Engagement in services by families with a plan of care after discharge from the hospital is not monitored. MCOs do not classify families on plans of care at higher levels of care coordination.

New Mexico's CARA law does not include monitoring of family's follow-through with plans of care, a recommended best practice.

Thirteen states, but not New Mexico, require their state's child welfare department to monitor the implementation of plans of care to ensure steps are completed by the parent. New Mexico is one of 42 states that statutorily require healthcare providers to notify the state's child protective services (CPS) when they are involved in the delivery or care of infants who show evidence at birth of having been prenatally exposed to drugs, alcohol, or other controlled substances. While the notification to CPS is required by the federal Child Abuse Prevention Treatment Act (CAPTA), New Mexico is one of only 14 states that have laws or policies that make clear that a notification is not considered a report of child abuse or neglect unless there is evidence of maltreatment or risk of harm to the infant. New Mexico is also one of 10 states that require the child welfare department to collect data required to meet federal and state reporting requirements. However, New Mexico is not one of 13 states that have statute or policies that require the child welfare department to monitor the implementation of a plan of safe care to ensure that the specific action steps are completed.[xviii]

Table 5. Children's Bureau Recommended Best Practices for States Implementing Plans of Care

Recommended Best Practice for Implementing Plans of Care	NM Statute
A notification is not considered a report of child abuse or neglect unless there is evidence of maltreatment or risk of harm to the infant.	✓
On receiving a notification of an infant with prenatal substance exposure, the CPS agency makes an initial assessment to determine whether the infant meets the state's definition of child abuse or neglect.	A report to SCI is required for a CYFD assessment
A plan of care should be developed to address the safety, health, and substance use disorder treatment needs for any infant identified as substance-affected as well as the treatment needs of the parent or caregiver.	✓
A plan of care can be initiated by the healthcare provider at the birth hospital as part of the discharge process to ensure the infant will receive appropriate care in the home.	✓
Plans of care should be designed to meet both the short- and long-term needs of the infant, parent, caregivers, and family with the goal of strengthening the family and keeping the child safely at home.	✓
The child welfare department should monitor the implementation of a plan of care to ensure the specific action steps are completed.	X
Data should be collected in the plan of care to meet federal and state reporting requirements.	✓

Source: Children's Bureau

Best practices for plans of care adopted by other states include monitoring of service referral engagement. Under the current New Mexico CARA statute and rule, families of a substance-exposed newborn are referred to services in a plan of care, but acceptance and participation of services is explicitly voluntary. Because engagement in services is voluntary, there is no provision in statute or rule for care coordinators or CARA navigators to track or monitor engagement and progress in services. Other states laws or policies require monitoring the implementation of a plan of care to ensure the specific action steps are completed, which is considered a best practice by the Children's Bureau.[xix] For example, Arizona statute requires child protective services monitor the progress and participation through monthly in-person meetings.[xx] Delaware established policy that the plan of care coordinator continuously reviews a family's plan of care and ensures the family completes the services to which they were referred. The plan of care coordinators in Delaware are also responsible for how long the plan of care remains in place, the need for ongoing services, and updating of the plan of care as needed.[xxi]

The National Conference of State Legislatures (NCSL) highlighted many of the challenges and barriers to implementing CARA policies and CARA plans of care across states. Challenges included inconsistent substance use screening, referral, and engagement as part of routine prenatal care; inconsistent hospital protocols for identifying and treating infants with prenatal exposure; inconsistent responses by hospitals and protective services to hospital notifications; stigma and perceptions about pregnant women with substance use disorders; lack of understanding of medication assisted-treatment (MAT) for pregnant women; and infants not referred or found eligible for intervention services.

NCSL suggested several strategies for states to overcome these challenges and barriers, including developing consensus definitions of infants affected by substance abuse, partnering with community providers to develop notification pathways for plans of care, implementing plans of care prenatally, using peer specialists to engage women in substance use treatment and other services, and integrating universal screening at birth.

Source: NCSL

Additionally, as statute stands, New Mexico does not have a comprehensive or detailed discharge process for hospital reported substance-exposed infants as opposed to Delaware state statute where a caseworker is required to attend a "predischarge" meeting at the hospital and is required to conduct a safety assessment of the infant's home prior to being discharged from the hospital.

Colorado's policy brief recommends a state intermediary approach to ensure "prevention and treatment services are coordinated, efficient, evidence-informed, and delivered with fidelity to drive outcomes." Use of a state intermediary would allow the state to implement a prenatal plan of care for families not yet involved with the child welfare system, since child welfare cannot become involved with the family due to prenatal substance exposure until after the birth of the substance exposed newborn. The state intermediary can provide support in implementing a plan of care, including supporting training and coaching, monitoring plan-of-care activities, promoting continuous quality improvement, and helping provide triage for emergent needs and challenges that may arise.

The state intermediary plan would facilitate unified data collection from plans of care to assess the quality and impact of plans of care to drive positive outcomes and to determine what evidence-based and community-based practices lead to high return on investments. This recommendation from the Colorado policy brief anticipates CAPTA reauthorization language that would mandate the development and implementation of state monitoring systems for plans of care.

Illinois' Department of Children and Family Services uses a recovery matrix assessment for parents to measure and document progress in recovery for parents of substance-exposed newborns. The National Center on Substance Abuse and Child Welfare advises that plans of safe care could benefit from oversight and management to determine progress toward completion of goals and evolving needs of the infant and family and caregivers.[xxii] To successfully close intact cases involving parents with a history of substance abuse, caseworkers in Illinois must document activities and observations that indicate a parent's progress in substance abuse recovery and the resumption of positive parenting responsibilities using a recovery matrix assessment. The recovery matrix worksheets provide caseworkers and parents with criteria, guidelines, and a visual representation for assessing and discussing a parent's progress in recovery and movement toward case closure over a 12-month period. Within the first year, the caseworker is required to meet with the parent and complete the matrix five times: within 45 days, at the end of 90 days, within six months, within nine months, and within 12 months.[xxiii] New Mexico could implement a similar process for CARA families for monitoring and tracking engagement in treatment services. (See Appendix F for matrix).

HSD and MCOs do not include CARA client service engagement metrics in current MCO contracts. Current managed care organization contracts require care coordinators to focus on meeting timeliness and compliance standards, but not necessarily client outcomes. A health risk assessment (HRA) is conducted for all new Centennial Care members or members who have a change in health condition that requires a higher level of care coordination. In draft versions of Turquoise Care contracts, CARA members are automatically assigned to level two care coordination. The HRA may be conducted by telephone or in-person within 30 calendar days of notification to the MCO. Utilization and claims data is used to identify a member's current and emergent needs related to care coordination. The care coordinator shall document at least three attempts to contact the member. Members identified as not needing a comprehensive needs assessment (CNA) shall be monitored by the care coordination unit. Those members identified as needing a CNA will receive one within 30 calendar days of completion of the HRA. At a minimum, the CNA will assess physical and behavioral health, long-term care needs, risk, and disease management needs and determine a social profile, such as living arrangements and financial resources. Care coordinators will provide for level 2 members the development and implementation of a care coordination plan (CCP), monitoring of the CCP to determine if the CCP is meeting the member's identified needs, annual CNAs, semi-annual in-person and in-home visits with the member 150-180 calendar days after the most recent CNA, two telephone contacts 60-90 calendar days and 240-270 calendar days from the most recent CNA. MCOs provide quarterly CARA reports to HSD, which includes aggregate data related to enrollment and compliance with assessment and contact with families within contractually agreed timeframes. Future contracts with MCO should include requirements for CARA client service engagement and outcome metrics.

Statewide central intake's risk assessment for reports of suspected cases of abuse or neglect with CARA families needs to be validated.

According to CYFD's most recent CAPTA State Grant Program report, hospital staff initially struggled with the change in reporting concerns of abuse or neglect to the statewide central intake (SCI) due to the state's CARA law because they were accustomed to making reports based solely on positive toxicology. Although CYFD reports developing specific screening questions used for CARA cases, they are not reflected in the current *Intake Tool Instruction Manual*, most recently updated June 2023, and have not been validated.

The current Intake Tool Instruction Manual used by SCI intake workers makes no mention of CARA-specific screening questions.[xxiv] The screening manual may contradict CARA statute because the SCI decision tree for response time for all screened-in reports indicates a 24-hour response if alcohol or drug abuse is affecting the child. (See Appendix H for section of decision tree.) CYFD should update SCI intake assessment tools to incorporate procedures for assessing suspected abuse or neglect of CARA families and include referrals to differential response in counties where available for families that are screened out.

Statewide central intake screening questions for a drug- or alcohol-exposed child:

- Was a plan of care created? If not, why not?
- Do they have a care coordinator?
- What support services did they engage in prenatally; what new services were referred and accepted on the plan of care?
- What is the post-discharge housing plan for the newborn and who will the primary caretaker be?
- Have the caregivers been trained on care of newborn, including any special medical care or treatments specific to this child?
- Has there been any specific interactions or have the parents displayed any behaviors that were of concern?

Source: CYFD

Nebraska has made the decision to accept all calls made by medical professionals to the intake hotline if the identified child or alleged child is age 5 or under in order to assess their most vulnerable population.

Source: Nebraska CARA Letter to Hospitals

Reasons Healthcare Providers Should Report Concerns Regarding the Safety of a Newborn on a CARA Plan of Care:

- Parent does not participate in care of the newborn.
- Parent uses substances, or appears under the influence, during hospital inpatient or NICU visits.
- Observed parent action or inaction harms the newborn.
- Domestic violence is evident.
- Parent fails to engage in follow-up treatment for newborn's medical needs.

Source: CYFD

CYFD is not systematically evaluating its process for screening CARA families at SCI. An LFC staff memo sent to the committee in September 2021 notes CYFD has an internal Quality Assurance unit within Protective Services that conducts case reviews based on federal best practices. CYFD Protective Services reports having developed a protocol system to report "serious injuries" or near fatalities to the secretary, chief of staff, and executive management, but no public reporting of these data exist, creating oversight and accountability issues. CYFD should conduct a comprehensive review and validate the CARA-specific screening tool to determine its effectiveness for appropriately screening in CARA infants and unnecessarily screening out CARA infants who later receive subsequent investigations with substantiated cases of abuse or neglect.

New Mexico hospitals are under-identifying substance-exposed newborns by up to 40 percent.

Determination of substance exposure is key to achieving CARA's goal of connecting substance-exposed newborns and their families with treatment options. Once determined as substance-exposed, a plan of care must be developed before the newborn can be discharged from the hospital. This is in line with intended *short-term* CARA outcomes identified in DOH's 2021 CARA evaluation report:

- Hospital staff understand CARA policy and processes to submit plans of care.
- Care coordinators understand CARA policy and processes to provide care coordination and have the capacity to help families.
- Health systems will come into and maintain compliance with the CARA policy.

One of the intended *intermediate* outcomes identified by the same DOH evaluation includes, "Every substance-exposed newborn offered a plan of care if accepted receive a plan of care prior to hospital discharge." Data indicates these outcomes are not being met.

Hospitals differ in their policies regarding universal screening for substances. The National Conference of State Legislatures identified inconsistent substance use screening as a challenge and barrier to CARA implementation across states. DOH notes, "Without universal screening, newborns can suffer from delays in maternal substance use treatment or may not be identified at all." Lack of universal screening can also lead to biased screening, leading to increased or under diagnosis for certain demographics.

Not all newborns exposed to substances received a plan of care according to an analysis of the state's Medicaid claims for 2020 and 2021. Of 2,299 babies identified as substance exposed in 2020 and 2021, 927, or 40 percent, did not receive a plan of care. These numbers lag behind even the first six months of 2020, where 63 percent of neonatal abstinence syndrome (NAS) cases received a plan of care, and 68 percent of newborns effected by opioids received a plan of care.

Hospitals often submit CARA plans of care with missing information, which could lead to insufficient case management. DOH reports the quality of plans of care vary among hospital staff and facilities, with missing contact information, missing MCO information, and unknown service referrals among the common issues. For example, 10 percent of plans of care submitted

How to Screen Pregnant Patients for Substance Use Disorder and Alcohol Use

The American College of Obstetricians and Gynecologists (ACOG) recommends **universal screening** with brief intervention and treatment referrals for cannabinoids, alcohol, club drugs, dissociative drugs, hallucinogens, opioids, stimulants, tobacco, and other compounds, such as anabolic steroids and inhalants.

Following the **SBIRT model** (screening, brief intervention, and referral to treatment), general screening recommendations involve starting a conversation about substance use in a reassuring and compassionate matter.

"Screening" means using a **validated screening tool** to ask questions aimed at understanding the patient's potential substance use. There are several validated screening tools for pregnant women, including 4P's, T-ACE, and CRAFFT for adolescents and young adults.

If the screening tool identifies a risk for substance use disorder, providers should discuss possible strategies to stop and make **referrals to treatment** as appropriate. Under federal law, pregnant women must receive priority substance abuse treatment.

Source: SAMHSA

between 2020 and 2022 did not indicate the birthing hospital of the newborn. Other common fields with missing information included who the newborn was discharged to, what type of substance they were exposed to, and to which services they were referred. Additionally, service referral status can also be misreported with services reportedly being declined even if a family was interested in the service. Incomplete plan of care information could lead to inadequate care coordination and case management.

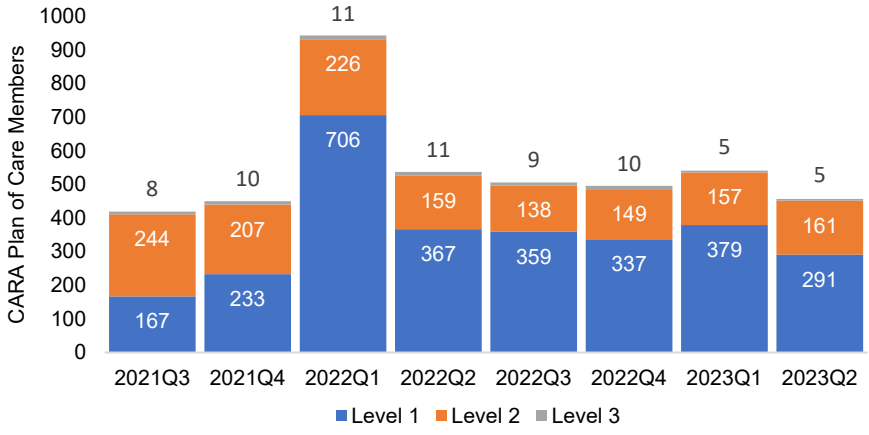
Many CARA families are not aware a plan of care was created for them. DOH reported in their evaluation of CARA that 42 percent of families responding to a survey roughly 11 months after receiving a plan of care indicated they did not know what a plan of care was or had no one talk to them about it in the hospital. An ongoing DOH family survey of CARA families finds 13 percent of families surveyed do not know what a plan of care is despite having one. Fifty-seven percent responded they were not involved in making their plan of care and 27 percent did not receive a copy of their plan of care.

MCO contract provisions under Centennial Care 2.0 do not prioritize CARA families into higher levels of case management.

Under the Centennial Care 2.0 contracts for Medicaid between HSD and managed care providers (MCOs), MCOs assign enrollees with one of three different priority levels for care coordination based on the severity of the members' health conditions or risk indicators. CARA families are automatically assigned to the lowest priority level for care coordination (level one) under Centennial Care 2.0 contracts. Under the new model contract for Turquoise Care, which will replace Centennial Care 2.0, CARA families will automatically be assigned to a higher level of care coordination (level two).

Under Centennial Care 2.0, CARA families are often underprioritized in case management. Medicaid members assigned to care coordination level one do not receive care coordination services but receive annual health risk assessments. Medicaid members assigned to level two care coordination receive care coordination services, such as outreach, the development of a care coordination plan, the coordination of access to covered services as needed (e.g., scheduling appointments, arranging transportation, making referrals), and in-person, in-home comprehensive needs assessments as needed. Medicaid enrollees assigned to level three care coordination receive the most intensive level of coordinated services. Currently under Centennial Care 2.0, most CARA members are assigned to care coordination level one. In the most recent quarter, MCOs reported that 64 percent of CARA members were assigned to level one care coordination and did not receive an in-person comprehensive needs assessment or additional care coordination services.[xxv] By assigning the majority of families on plans of care to level one, Centennial Care 2.0 does not assign them to a high risk group for care coordination services.

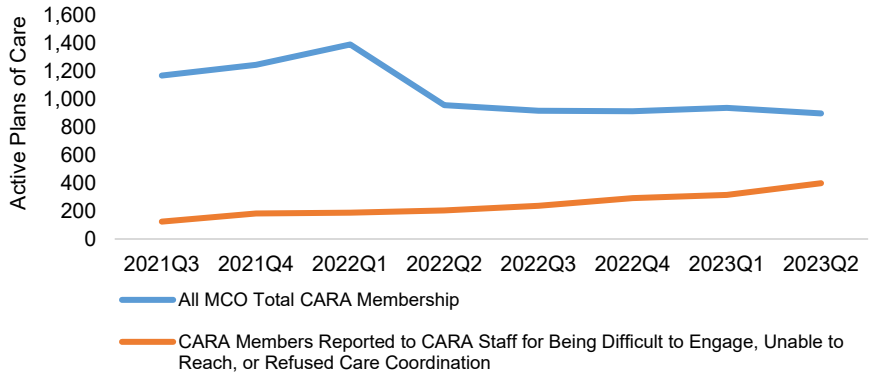
Chart 15. CARA Plan of Care Members Care Coordination Level Assignment



Source: MCO Quarterly Reports

CARA families designated as difficult to engage, unable to reach, and families who refused MCO care coordination have increased. Fewer families are being provided with plans of care and more CARA families are reported to CARA navigators for not engaging with care coordinators. In CARA's implementation year of 2020, there were a total of 1,105 plans of care.[xxvi] In MCO's reports to HSD regarding CARA enrollment and care coordination, CARA enrollment peaked in the first quarter of 2022 with 1,388 clients with a plan of care. In the following quarter, active plans of care managed by the MCOs dropped 31 percent to 955. HSD reported the observed drop is solely attributable to partial hospitalization programs (PHP) removing members who no longer had an active plan of care. MCOs reported 896 plans of care in the most recent quarter. While total CARA membership dropped, the number and percent of CARA clients who refused care coordination, could not be reached, or were difficult to engage increased, according to MCO reports to CARA staff. In its implementation year, MCOs reported that 32.3 percent of families had either not been able to be contacted or refused coordination. In the most recent quarter, MCOs reported 44 percent of families refused care coordination, were unable to be reached, or difficult to engage.[xxvii]

Chart 16. Fewer Families are Being Provided with Plans of Care and More CARA Families are Reported to CARA Navigators for Not Engaging



Source: MCO Quarterly Report

The current CARA portal is not sufficient for comprehensive reporting, case management, and tracking engagement by families, which is out of compliance with statute. Contracts and internal reports indicate the state pays $65 thousand annually for an online CARA portal that is insufficient for monitoring plans of care while the vendor has been unresponsive making system changes. According to a contract between HSD and the Falling Colors Corporation (Falling Colors), Falling Colors provides and maintains an online portal for housing CARA plans of care for an annual maintenance cost of $65.1 thousand per year. The contract states the online portal should have the ability to house plans of care, review plans of care based on different search criteria, and create reports for CYFD staff tracking the number of plans of care and more detailed information about substance exposure, MCO assignment, and plans of care. Despite this investment for an online CARA portal, a 2023 report from the consultant hired by DOH to evaluate New Mexico's implementation of CARA reported the data system was "not sufficient" for comprehensive reporting, case management, or tracking follow-up with families who accept or refuse a plan of care. The consultant's report also noted the data system vendor, Falling Colors, was "unresponsive to requests to make changes." According to DOH, DOH held preliminary planning sessions with Falling Colors to improve the online CARA portal but these efforts have since been paused.

HSD recently directed MCO care coordinators to provide in-person contact to CARA families prior to discharge from the hospital. HSD issued a letter of direction to MCOs in September 2023 that would require MCOs to assign a care coordinator to conduct in-person daily rounds at the five largest metro hospitals in Albuquerque and Las Cruces, identify all infants born substance-exposed, ensure a plan of care has been created by the hospital staff, visit every birth mother or CARA infant with consent to discuss services available for both the mother and infant, and attend any discharge planning with the family and hospital staff (see Appendix K for letter). Healthcare staff that LFC evaluators met with stated that in-person care coordinators available would be beneficial for helping with a warm hand-off and providing a point of contact. However, the letter of direction only mandates in-person care coordination at metro hospitals, which would limit this service in rural areas of the state. HSD should expand their directive to MCOs to provide in-person care coordination statewide.

It is recommended that any service provision be set up through a "warm hand-off" process, to increase the engagement of the family. Warm hand-offs have been found to significantly increase the likelihood of the family engaging in treatment services.

Source: CYFD CAPTA State Grant Program, 2021

A "warm hand-off" is a hand-off that is conducted in person, between two members of a health care team. The warm hand-off establishes an initial face-to-face contact between the person and the new care provider.

The letter of direction also directs MCOs to shorten the timeframes for care coordination contact with CARA families. Contact with the guardian of the infant in the CARA program should occur within 24 hours of the discharge from the hospital. The health risk assessment should be completed inpatient whenever possible and, if not possible, should be completed at the call done within 24 hours. Comprehensive needs assessments should be done in the member's home within seven days of discharge from the hospital. Three attempts to contact the guardian should be made within the first 48 hours of discharge. If the care coordinator is unable to reach the mother and the baby is in the mother's custody, the care coordinator must contact the CARA navigation team.

Recommendations

The Children, Youth, and Families Department should:

- Conduct a comprehensive review of the SCI screening procedures for cases with a CARA plan of care;
- Define a CARA plan of care as successful if families have completed the specific action steps and services agreed to by the family; and
- Require hospital staff or care coordinators to update CARA plans of care with incomplete or missing information.

The Department of Health should:

- Regularly query the state's Medicaid claims data to determine whether cases should require a CARA plan of care.

The Human Services Department should:

- Direct MCOs to regularly query Medicaid billing data for cases with prenatal care or obstetrics and substance use treatment to determine whether cases should require a CARA plan of care;
- Require hospitals to develop policies to universally screen pregnant women for substances using screening, brief intervention, and referral to treatment (SBIRT) or other evidence-based verbal screening tools;
- Codify the requirement from its letter of direction into rule and establish penalties for noncompliance with these rules;
- Direct MCOs to automatically assign CARA clients to a more intensive level of care coordination (level two);

- Hold MCOs accountable for providing in-person care coordination and case management to CARA families through its letter of direction and Turquoise Care contracts;
- Direct MCO care coordinators to monitor completion of specific action steps and services agreed to by the family in the plan of care and notify CARA navigators;
- Revise its contract for the CARA portal to have case management and reporting functionality; and
- Expand its directive to MCOs to provide in-person care coordinators to CARA families statewide.

The Children, Youth and Families Department, Department of Health, and Human Services Department should:

- Identify factors that predict subsequent investigations and substantiated cases of abuse or neglect, such as substance exposure type, acceptance of care coordination, types of services referred, service acceptance rate, and difficult to engage.

Hospitals and birthing centers should:

- Modify internal human resources systems to ensure all appropriate staff receive required CARA training.

CYFD is Requesting More Staff Despite Challenges with Capacity, Duplicative Services, and Unclaimed Federal Funds

Even with 582 vacant positions, CYFD is requesting a budget increase of $38 million from the general fund and 121 positions for FY25. Of this expansion funding, CYFD is requesting an additional $6.2 million in state funding and 35 positions for the creation of a new family services division. CYFD's proposed family services division would include a unit of 20 positions dedicated to CARA and directing families to services, yet CYFD already has 66 positions directing families to support services. At the same time, New Mexico provides over $140 million to MCOs (employing roughly 1,000 care coordinators) to assist patients with complex health needs. Additionally, New Mexico is missing out on federal Families First funding for preventive services for families, including mental health and substance abuse treatment.

CYFD has 582 vacant positions available to potentially dedicate additional staff to CARA oversight. At the start of October 2023, CYFD had a vacancy rate of 26 percent (or 582 vacant positions) out of 2,226 authorized full-time employee positions. The CYFD positions with the highest number of vacancies were caseworkers, social workers, corrections officers, and parole officers. A 2022 LFC report noted CYFD's Protective Service fieldworker turnover rates have ranged from 35 percent to 45 percent over the last several years. Additionally, CYFD reverted $33 million in unspent funding back to the general fund at the end of FY22 (latest data available). In the same year, CYFD transferred $1.4 million out of personnel into other budget categories. These data indicate CYFD has hundreds of positions and millions of dollars available to potentially dedicate toward CARA. CYFD should revise its staffing expansion proposals for FY25 through the reclassification of some of its long-term vacant positions.

To help address chronic turnover and vacancies, CYFD recently completed a workforce development plan in summer 2022. The department has outlined strategies to build up its workforce, including streamlined hiring practices, advanced training for supervisors, enhanced onboarding of new staff, professional development, and addressing salary inequities. CYFD should sustain implementation of its workforce development plan to reduce high turnover and vacancies. In 2020, Oregon's Child Welfare Division completed a vision for transformation centered on three guiding principles: (1) promoting maltreatment prevention, (2) enhancing staff and capacity, and (3) using data for continuous quality improvement. As of September 2023, Oregon's hiring and promotion of caseworkers continued to exceed caseworker losses and caseload ratios were within target ranges. The Legislature should consider providing funding for technical assistance for CYFD to implement research-based hiring practices, such as realistic job previews, reimbursement for social worker licensure fees, uniform rating systems, and exit survey analyses.

When New Mexico was developing its CARA legislation, CYFD and other state agencies reported CARA implementation could be fully funded through federal dollars. When the legislation creating the state CARA law was being developed and debated during the 2019 legislative session, CYFD, DOH, and HSD provided agency analyses of the legislation to LFC staff to include in the fiscal impact report on the legislation. CYFD and DOH did not identify any specific costs related to the implementation of the legislation,

while HSD reported the bill would have some minimal administrative implications for the department. Additionally, CYFD highlighted how the proposal would allow the department to receive $225 thousand in federal Child Abuse Prevention and Treatment Act (CAPTA) funding on an annual recurring basis. Based on this information from the agencies, the fiscal impact report for House Bill 230 indicated the bill would increase federal revenue by $225 thousand each year while having a minimal impact on agency operating budgets.

Table 6. Existing FTE Available to Refer and Connect CARA Families to Support Services

Entity	Staff	Existing FTE
MCOs	Care Coordinators	950*
CYFD, DOH, and HSD	CARA Navigators	3
CYFD	In-Home Services Staff	50
CYFD	Community-Based Prevention, Intervention, and Reunification Staff	6
CYFD	Family Outreach Staff	7
Total		**1,016**

*Note: This number reflects all MCO care coordinators serving the entire Medicaid population. Previous LFC reports have highlighted the need to track and evaluate care coordination outcomes and service utilization outcomes.

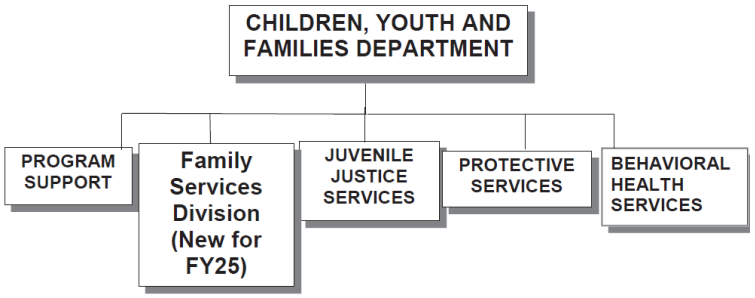
Source: LFC Staff Review of CYFD's FY25 Budget Request Documentation and HSD's Website

CYFD proposed a new family services division that includes 20 employees dedicated to CARA, duplicating existing state staff and MCO care coordinator roles.

CYFD is requesting a budget increase of $38 million from the general fund and 121 positions for next fiscal year, FY25. Of this expansion funding, CYFD is requesting an additional $6.2 million in state funding and 35 positions for the creation of a new family services division. The proposed family services division would cost a total $52 million (including $26 million from the general fund) with 115 positions. Available CYFD documentation does not yet specify the job classifications, specific responsibilities, or geographic locations of the requested additional positions within the family services division, including the positions to work on CARA.

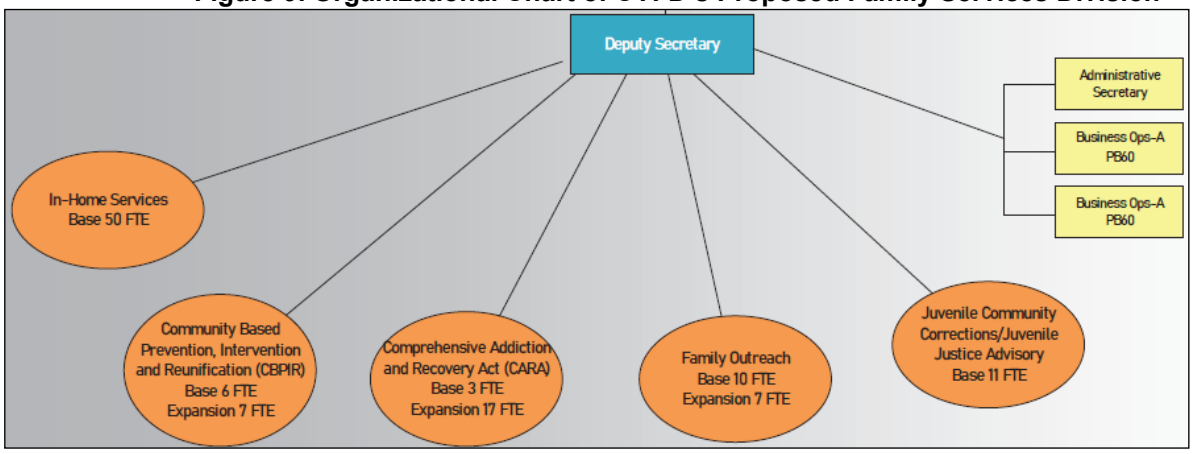
CYFD's proposed family services division would include a unit of 20 staff dedicated to CARA and directing families to services, yet CYFD already has 66 staff directing families to support services CYFD's proposed family services division would dedicate 20 full-time positions (three existing positions and 17 new positions) to monitoring CARA and directing families on plans of care to services, a 567 percent increase in the number of state-level staff dedicated to monitoring and reporting CARA plans of care. However, multiple CYFD programs are already directing lower-risk families to needed services rather than conducting an investigation, an approach called "differential response." For example, CYFD has an "in-home" services unit (with 50 full-time positions) that provides case management and other support services to families at risk of having their children removed because of abuse or neglect. CYFD also has a program called "community-based prevention, intervention, and reunification" that contracts with local providers across the state to deliver case management services to families. Additionally, CYFD has a family outreach program (with 10 full-time positions) that redirects families who do not meet the criteria for an investigation to CYFD's community-based prevention, intervention, and reunification," which contracts with local providers across the state to deliver case management services to families. Additionally, CYFD has a family outreach program (with 10 FTE) which redirects families (who do not meet the criteria for an investigation) to CYFD's community-based prevention, intervention, and reunification program.

Figure 8. Proposed CYFD Organizational Chart For FY25 Appropriation Request.



Source: CYFD FY25 Appropriation Request, Form S-2

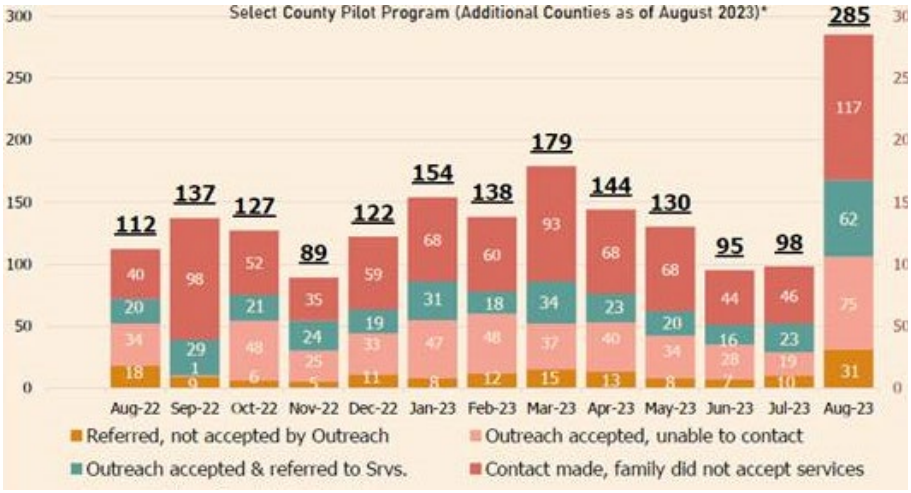
Figure 9. Organizational Chart of CYFD's Proposed Family Services Division



Source: CYFD FY25 Appropriation Request

Existing CYFD divisions referring families to services are grappling with low uptake of services, indicating a need to improve engagement and outcomes rather than increase staff. Existing CYFD programs refer families to support services, but few families are accepting these services. For example, CYFD's family outreach program reached out to 285 families in August 2023 to refer those families to support services. Of those 285 families, 223 families (78 percent) either could not be contacted, refused outreach, or refused services. These data indicate improving family outreach practices and engagement with services would have more of an impact on prevention outcomes than increasing staff. CYFD should focus on improving the implementation of its differential response approach for referring families to prevention and early intervention services.

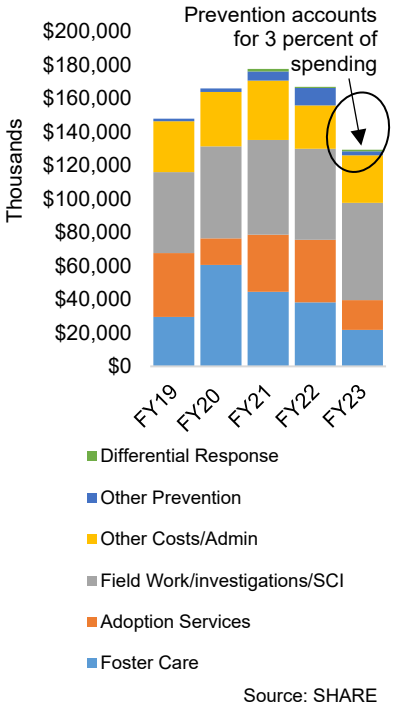
Figure 10. Family Outreach Community Prevention Response



Source: CYFD Desktop Report p.7

Numerous LFC reports have highlighted that rollout of evidence-based differential response is underway but implementation has been slow and its impact is unclear. Though statutorily required, CYFD has flexibility in the application of the program and only the lowest level of response is being implemented. CYFD should expand the program to two additional levels of response for families with greater need. The department recently expanded the program and it is available in Bernalillo, Catron, Lea, Lincoln, Luna, McKinley, Mora, Otero, Rio Arriba, San Juan, San Miguel, Sandoval, Santa Fe, Sierra, Socorro, Taos, and Valencia counties but should continue to expand statewide.

Chart 17. Protective Services Spending Categories
FY19-FY23
(in thousands)



Source: SHARE

The state is engaging in ongoing efforts to expand its community service provider network, such as through the Early Childhood Coalition and the Behavioral Health Collaborative. However, there are many reasons for the low uptake of services, such as inability to access existing services. For example, LFC has reported timely access to needed behavioral health services and an adequate behavioral health provider network is an ongoing challenge. Also, a survey commissioned by the Department of Finance and Administration identified barriers to accessing services, such as lack of knowledge of available programs and stigma about enrolling in programs. However, CYFD spending for prevention efforts accounts for 3 percent of their overall expenditures, and it has yet to expend any of the $20 million appropriated to it in FY23 to expand behavioral health provider capacity.

As CYFD plans to dedicate 20 employees to assist CARA families, New Mexico provides over $140 million to MCOs (employing roughly 1,000 care coordinators) to assist patients with complex health needs. According to the 2022 LFC Program Evaluation, *Medicaid Network Adequacy, Access, and Utilization*, MCOs employ almost 1,000 care coordinators with the goal of working with members with complex healthcare needs to ensure they are receiving needed care. Care coordination services from the MCOs cost $147 million in 2020, including $30 million specifically for behavioral health care coordination. While New Mexico requires care coordination in its managed care contracts with MCOs, previous LFC reports have noted care coordination service outcomes are uncertain and recommended adopting health outcome measures and benchmarks for care coordination services. HSD started to collect some outcome metrics for care coordination in 2022, such as dental visit attendance or follow up after an emergency department visit. Under the draft Turquoise Care contract, MCOs will be required to annually evaluate their care coordination services. HSD and MCOs should include targets and metrics related to CARA and plans of safe care to evaluate care coordination services under the final Turquoise Care contract.

Case Studies Demonstrate Improved Outcomes in MCO Care Coordination

Case Study: Blue Cross Blue Shield of New Mexico piloted to identify more pregnancies early and increase prenatal care, demonstrating MCOs can improve care coordination. A 2021 study documented the results from an 11-month pilot partnership between Blue Cross Blue Shield of New Mexico (BCBS), a Managed Care Organization, and TriCore Laboratories (TriCore), a clinical laboratory operating across New Mexico. TriCore was able to use clinical laboratory data to detect pregnancy early on and identify pregnant Medicaid enrollees with high-risk factors (such as diabetes or advanced maternal age). TriCore provided BCBS with these data insights, which allowed BCBS care coordinators to target outreach and monitor prenatal care. The study found an increase of pregnancies identified within the first trimester and an increase in prenatal screenings. This study indicates that MCOs can take a more proactive approach to make care coordination more proactive, better connect families with needed services, and improve patient outcomes.

Source: American Journal of Managed Care

Case Study: Rio Arriba County has used an outcomes-based approach to funding care coordination which focuses on improvements to patients' health outcomes rather than the delivery of services. Value-based purchasing, broadly defined, refers to initiatives by MCOs to link payments to health care providers with improved performance. Research has associated value-based purchasing incentives with subsequent performance improvements from healthcare providers. The Rio Arriba County Department of Health and Human Services has used an outcomes-based approach to funding care coordination, often with grant funding, which defines success as supporting improvements in clients' health. Rio Arriba County's outcomes-based funding approach for care coordination uses unrestricted grant funding to flexibly provide a full range of services to help patient outcomes and basic needs (housing, employment, etc.). Using behavioral health grant funds, Rio Arriba County invested in harm reduction, case management, and medicated-assisted treatment (MAT) and experienced a decrease in overdose deaths before fentanyl use surged. Rio Arriba County's piloted approach demonstrates care coordination can be funded based on patient outcomes rather than the number of services delivered or activities performed.

Source: Journal of Operations Management

New Mexico is missing out federal Families First funding for preventive services for families, including mental health and substance abuse treatment. In 2018, the federal government enacted the Families First Prevention Services Act allowing states to access federal funds under Title IV-E of the Social Security Act for prevention services grants. States that submit a plan under the Families First Prevention Services Act are eligible to receive funds for preventive services (such as mental health or substance abuse treatment services) allowing "candidates for foster care" to stay with their parents or relatives. CYFD has submitted a Families First plan to the federal government, but it has not been approved. By not having a Families First plan accepted, New Mexico is missing out on federal funds to provide prevention services to families. In FY22, the federal government provided a total of $64.2 million in prevention services funding to states with approved Families First plans. CYFD should prioritize getting a plan Families First plan accepted by the federal government under the Families First Prevention Services Act and use Title IV-E funds for prevention services for families, including mental health and substance abuse treatments.

DOH and HSD have direct oversight over the entities developing plans of care and coordinating care for families. Federal law allows states to choose where to place CARA oversight responsibilities. New Mexico's CARA statute is based on a public health approach to parental substance use, but designates CYFD as the lead agency on CARA responsibilities. DOH has direct relationships with hospitals, birthing centers, and other healthcare providers responsible for developing plans of care and referring families to care coordinators and services. DOH is also already responsible for the care coordination of families with plan of care who are not enrolled in Medicaid. HSD has direct oversight over the MCO care coordinators who connect Medicaid families on plans of care with services. HSD recently issued a letter of direction to MCOs requiring MCOs to improve their care coordination services. Specifically, HSD's letter of direction required MCOs to implement in-person care coordination at the biggest hospitals, shorten time frames for contacting families, contract with a third party to follow-up with hard to engage families, create a billing code for creating plans of care, improve the plan of care form, add new benefits to be covered by Medicaid, and streamline access to home visiting.

Cabinet Secretaries of CYFD, DOH, HSD, and ECECD and the Children's Cabinet identified DOH as the agency most fitting to oversee CARA. In June and July 2023, the Department of Health (DOH) contracted REL Consulting based out of Washington D.C. for $63 thousand dollars to review the current CARA protocols and processes. The consultant met with agency secretaries and staff from DOH, CYFD, HSD, ECECD, Children's Cabinet, and Office of New Mexico Governor. Consultant meetings focused on creating a systems map of the state's CARA process, conducting a gap analysis of existing processes, and identifying key performance indicators.

The consultant's report also identified gaps in federal and state statutory compliance including need for updating the CARA website with information, inadequate monitoring and tracking of plans of care by CARA portal database, gaps in current training, guidelines related to screening tools have not been developed or implemented, and there is not a standard family assessment in place for when families fail to comply with the plan of care. The contractor's report concludes that involved agencies are intentionally taking steps to address gaps in the process and to clearly identify ownership of CARA

Advantages of Placing CARA Oversight in DOH or HSD

Public Health Departments: DOH has a direct relationship with hospitals and birthing centers where plans of care are developed.

Human Services Departments: Human services departments have direct oversight of Medicaid, managed care providers (MCOs) and MCO care coordinators serving Medicaid populations.

Source: LFC

Gap analysis identified statutory compliance issues with CARA implementation:

- Posting information on CARA website,
- Inadequate monitoring and tracking of plans of care,
- Gaps in current training,
- Guidelines related to screening tools have not been developed or implemented,
- Not a standard family assessment in place for when families fail to comply with the plan of care.

The contracted gap analysis highlighted several challenges and opportunities for improvement in the CARA process:

- Need for dedicated staffing,
- Engagement with hospitals and birthing centers,
- Outreach for CARA families,
- Legislation authorizing DOH as the lead agency for CARA,
- Standardization of screening and risk assessment tools,
- Improved data systems for reporting and case management,
- Technical assistance and training for plan of care creation and service referral.

Source: DOH

policies, which the cabinet secretaries determined would be DOH. The Legislature should consider designating the Healthcare Authority as the lead CARA agency if the state is to continue with a public health approach to parental substance abuse. For Native Americans who are enrolled in Medicaid fee-for-service and not in one of the MCOs, and the 10 percent of uninsured population, DOH can still use Centers for Medicare and Medicaid Services to bill through Medicaid.

Recommendations

The Legislature should consider:

- Providing funding for technical assistance for CYFD to implement research-based hiring practices, such as realistic job previews, reimbursement for social worker licensure fees, uniform rating systems, and exit survey analyses;
- Revisiting the differential response statute and making sure there are guardrails to ensure fidelity and timely statewide implementation; and
- Adopting statute that designates the Health Care Authority as the lead agency for CARA following New Mexico's public health approach to CARA.

The Children, Youth and Families Department should:

- Sustain implementation of its workforce development plan to reduce high turnover and vacancies;
- Revise its proposals for staffing expansions in the family services division to not duplicate roles of MCO care coordinators;
- Focus on getting its Families First plan accepted by the federal government under the Families First Prevention Services Act to use Title IV-E funds for prevention services for families, including mental health and substance abuse treatments;
- Focus on improving the implementation of its differential response approach for referring families to prevention and early intervention services; and
- Implement differential response in line with best practices and expand statewide.

The Human Services Department and Medicaid managed care organizations should:

- Include targets and metrics related to CARA and plans of safe care to evaluate care coordination services under the final Turquoise Care contract.

State of New Mexico
CHILDREN, YOUTH and FAMILIES DEPARTMENT

MICHELLE LUJAN GRISHAM
GOVERNOR

HOWIE MORALES
LIEUTENANT GOVERNOR

TERESA CASADOS
INTERIM CABINET SECRETARY

October 26, 2023

Dr. Ryan Tolman, Program Evaluator
Legislative Finance Committee

Mr. Nathan Eckberg, Program Evaluator
Legislative Finance Committee

Mr. Clayton Lobaugh, Program Evaluator
Legislative Finance Committee

Re: ***Comments on CARA Program Evaluation Draft***

Gentlemen:

The New Mexico Children, Youth, and Families (CYFD), Early Childhood Education and Care Department (ECECD), Department of Health (DOH), and Human Services Department (HSD) are collectively disappointed in the overall tenor and tone of the LFC evaluation team's evaluation of the state's CARA law. While shortcomings in the implementation of this law are important to identify and improve upon, we believe that overall, CARA has improved outcomes for hundreds of infants and their families, and that it is a vast improvement upon the almost nonexistent infrastructure that we previously had to meet the needs of this vulnerable population. This report fails to acknowledge the positive outcomes that have occurred in the past four years since the statute was passed. To address misconceptions, it is critical to emphasize that before the CARA statutory changes, no agency routinely received notification of all infants exposed to substances and they only came to the attention of CYFD if a SCI report was filed. With the CARA changes, hospitals are required to notify CYFD about all infants born exposed to substances, not just those where there are safety concerns. Infant mortality rates have also declined every year since implementation.

The report says several times that CARA is not meeting its intended purpose but does not provide data to back this up; in fact, in several places data cited demonstrate positive impacts of NM's CARA approach:

- Infant Mortality is decreasing. Among NM infants born from 2017-2021, infant mortality rates decreased from 5.9 to 4.8 deaths per 1,000 live births. The 2021 infant mortality rate is the lowest rate since 1999 (the oldest publicly available data). Also, as pointed out in this report, the substance-exposed population is a higher risk subset than the general population of infants, yet the infant

mortality in the 2020-2021 CARA group is not statistically different from that of the general population, so that outcome is better than expected.

- Rates of removal are down, and this is reported as if it is a negative outcome when we believe it actually shows the program is working – families are getting support and more families are being kept intact. Lower rates of infant removals are not necessarily indicative that children are more unsafe; as your report acknowledges in a different context, child removals are traumatizing and can lead to worse outcomes than children who are never removed.
- The decrease in the removal rate of infants began before CARA was implemented, and is attributable to many factors, including increased efforts on the part of CYFD to secure supportive services to prevent removal, contracts with community providers to administer intensive home-based interventions, and ongoing development of other services and supports within communities. Still, 27.2% of babies with a Plan of Care who are determined to be a victim of maltreatment are removed and placed into foster care. Babies without a Plan of Care are removed at a much lower rate (19.2% of all substantiated cases). And higher rates of substantiation for babies with a Plan of Care likely means that the "right" referrals are being made and screened in.

While we agree that we would like to see more families who need treatment for a substance use disorder obtain that treatment timely, we recognize that not all families with a Plan of Care require treatment, while others may not have access to these types of formal services, especially at such a crucial time in their lives. Data cited in the report draw broad conclusions about service utilization based on a point-in-time snapshot of what services were offered and accepted by the family, typically very soon after the child's birth and prior to leaving the hospital. Ongoing engagement by CARA navigators and care coordinators likely leads to more families getting the services they need, which are not captured in the dataset used in the analysis.

In the past, LFC's Evaluation Team has encouraged CYFD to devote more resources to prevention efforts. In a 2022 report, the Team asserted that "CYFD may have strayed from the original intent of its founding by removing preventive services as a division and service area." The current evaluation seems to backtrack on this sentiment by suggesting that rules should mandate reporting of suspected neglect or abuse if a CARA family declines substance use treatment or to participate in a plan of care. Declining these services does not constitute abuse or neglect per New Mexico's Children's Code. This type of rule would be a punitive approach that is contrary to the stated purpose of CARA. The report recommends that oversight and coordination of CARA be placed with the Healthcare Authority as the lead agency. DOH is the public health lead agency in New Mexico, not the new Healthcare Authority. Not all public health approaches and services are delivered by the DOH. CYFD, as the lead agency for children's behavioral health and with its new focus on prevention services for families, is well-positioned to effectively coordinate this work. CDC and DOH data show only 54% of births were financed by Medicaid in 2021 (source: CDC Wonder). We disagree with this recommendation.

Studies already show that reporting of abuse and neglect is prone to bias, with overreporting of families of low socioeconomic status and underreporting of families of higher socioeconomic status. Making CARA essentially a Medicaid program would only institutionalize this bias.

One of the most important intents of CARA is to reduce stigma for those struggling with a breadth of challenges that some women and families experience, including those related to substance use and abuse. Building trust between an expectant mother and her doctor is crucial for effective early screening and intervention. We agree with LFC that ideally, prenatal care providers would accurately screen women for substance use or misuse within the larger context of a relational process that builds trust and avoids a punitive approach. By over-emphasizing the potential for abuse or neglect, without a balanced exploration of CARA's benefits to infants and their families, women who struggle with substances may hesitate to be transparent with their healthcare provider or even avoid prenatal care altogether.

Put simply, this report is damaging to families who have successfully followed their Plans of Care; the providers who supported them; and the broader messaging that CYFD is here to help.

There is no doubt that this complex, multi-agency program, implemented during a global pandemic, can be improved. That is what we are committed to doing with the support of the Legislative Finance Committee, their team, other legislators, and public and private partners. We look forward to building this collaborative relationship and continuing to support New Mexico's children and families.

Sincerely,

New Mexico Children, Youth and Families

By: /s/
Teresa Casados, Acting Secretary

Early Childhood Education and Care Department

By: /s/
Elizabeth Groginsky, Secretary

Department of Health

By: /s/
Patrick Allen Secretary

Human Services Department

By: /s/
Kari Armijo, Secretary Designee

Appendix A: Evaluation Scope and Methodology

Evaluation Objectives.

- Examine CARA policy outcomes and services provided.
- Examine barriers, challenges, and successes to CARA policy implementation.
- Examine best practices and alignment with New Mexico CARA statute and rule.

Scope and Methodology.

- Reviewed policy and academic research on CARA implementation, including analysis of other state policies and procedures, and other sources referenced in this report.
- Interviewed and collected data from birthing hospital staff—including doctors, nurses, social workers, and administrators.
- Examined applicable laws, administrative rules, policies, and agency roundtable events.

Evaluation Team.

Ryan Tolman, Ph.D., Project Lead, Program Evaluator
Nathan Eckberg, Esq., Program Evaluator
Clayton Lobaugh, Program Evaluator

Authority for Evaluation. LFC is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conferences. The contents of this report were discussed with Teresa Casados, CYFD Acting Cabinet Secretary, Elizabeth Groginsky, ECECD Cabinet Secretary, Patrick Allen, DOH Cabinet Secretary, Kari Armijo, HSD Cabinet Secretary, and their staff on October 23, 2023.

Report Distribution. This report is intended for the information of the Office of the Governor, Department of Finance and Administration, Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit the distribution of this report, which is a matter of public record.

Jon Courtney, Ph.D.
Deputy Director for Program Evaluation

Appendix B: Fetal Alcohol Spectrum Disorder and Neonatal Abstinence Syndrome Possible Symptoms

Table 2. Fetal Alcohol Spectrum Disorder Possible Symptoms Compared with Neonatal Abstinence Syndrome Possible Symptoms

Fetal Alcohol Spectrum Disorder (FASD)	Neonatal Abstinence Syndrome (NAS)					
Affects as many as 5% of children in the United States	Affects less than 1% of children in the United States					
Caused by drinking during pregnancy	Caused by substance use during pregnancy					
Not caused by exposure during nursing	Not caused by exposure during nursing					
Early intervention can help	Early intervention can help					
Low birth weight	Low birth weight					
Not linked with withdrawal symptoms	Newborn experiences withdrawal symptoms (such as high-pitched cry, restlessness, and/or seizures)					
Microcephaly (the head and brain are much smaller than expected)						
Most effects are not noticeable right after birth	Effects are usually noticeable right after birth					
Possible Effects						
	Alcohol	**Tobacco**	**Opioids**	**Meth**	**Cocaine**	**Cannabis**
Low Birth Weight	X	X	X	X	X	X
Premature Birth	X	X	X		X	
Birth Defects	X	X	X		X	
Changes in Brain Structure and or functioning	X	X	X	X	X	X
Cognitive Effects	X	X	X	X	X	X
Decreased Motor Skills	X	X	X	X		

Source: CDC

Appendix C: CARA Plan of Care Form

CARA POC WTR 2023

If substance use disorder or other factors are interfering with the parents' ability to care for the infant, or if there are concerns that the family does not have adequate supports, a referral shall be made to CYFD Child Protective Services for potential child abuse/neglect. Creating a Plan of Care does not exempt the family from potential investigation by CYFD. Dial #SAFE.

Plan of Care

This 4-page document must be completed before discharge.
Fax to Susan Merrill at NMDOH- (505) 827-5995 or 476-8996

Infant Name:	Admission Date:
D.O.B.:	Discharge Date:
Discharge Address (Street, City, Zip Code):	Discharge Phone:

Infant's Discharge Housing Status (Circle one):
Parental Home Designated Caregiver Home Facility/Shelter
Precariously Housed Foster Home

Biological Parents Discharge Housing Status if different from Infant (Circle one):
Unknown Home (Rented or Owned) Facility/Shelter
Correctional Facility Precariously Housed Homeless

Infant's Insurance Care Coordinator (ICC):	Infant's Primary Care Provider (PCP):
ICC Phone:	PCP Phone:
ICC Fax:	PCP Fax:
Health Insurance Company: _____ Health Insurance Plan: _____	First Appointment Following Discharge: ____/____/____ ____:____ AM/PM

List Household Members over the age of 18 for this infant:

Name	DOB	Relationship to Infant	Contact Information
1.		Mother	
2.			
3.			

For questions or assistance with a plan of care, please contact a CARA Navigator:
CALL or TEXT 505-396-0423 or 505-470-4032
https://sharenm.org/CARA

Infant Name: _____ **D.O.B.:** _____

Other Key Contacts (Optional)

Name	Age	Relationship to Infant	Contact Information
1.			
2.			

Applicable Criteria for Plan of Care: Check all substances to which infant was exposed in utero.

Substance	✓	Substance	✓
Alcohol		Methamphetamine	
Benzodiazepines		Nicotine	
Buprenorphine (Subutex, Suboxone)		Opioids	
Marijuana		Other (Specify):	
Methadone		Other (Specify):	

Support Services (continues on page 3):

Service	Name of Organization / Contact	Current ✓	Referred ✓	Declined ✓	Interested in follow up ✓
12-Step Program					
Childcare					
Children's Medical Services (NM DOH Program for infants with special medical needs or diagnoses)					
Domestic Violence Services					
Early Intervention Family Infant Toddler (FIT) Program Provider Agencies					
Financial Assistance (e.g. TANF, SSI)					
Home Visiting					
Housing Assistance					

For questions or assistance with a plan of care, please contact a CARA Navigator:
CALL or TEXT 505-396-0423 or 505-470-4032
https://sharenm.org/CARA

Service	Name of Organization / Contact	Current ✓	Referred ✓	Declined ✓	Interested in follow up ✓
Infant Mental Health					
Medication-Assisted Treatment					
Mental Health Counseling					
Parenting Group					
Peer Support Specialist					
Recovery Supports					
Smoking Cessation					
SNAP-through ISD					
Substance Abuse Counseling					
WIC-through NM DOH or Tribal affiliation - https://www.nmwic.org/					
Transportation					
Other (Specify):					
Other (Specify):					

Safe Sleep Training Provided prior to discharge from the hospital: ◯ **Yes** ◯ **No**

Has family has been referred to SCI/CYFD Child Protective Services? ◯ **Yes** ◯ **No**

Name of CYFD Caseworker (if applicable): _____

Acknowledgment of Understanding

I understand that information contained in this form will be submitted to the New Mexico Department of Health (DOH) and New Mexico Children Youth and Families Department (CYFD) as required by NM Statute (Children's Code 32A-4-3).

I understand that I may request Care Coordination and/or a CARA Plan of Care for my infant and family even if I have refused these services initially. I understand that I may be contacted by a DOH/CYFD CARA Navigator regarding my experience with CARA.

For questions or assistance with a plan of care, please contact a CARA Navigator:
CALL or TEXT 505-396-0423 or 505-470-4032
https://sharenm.org/CARA

Release of Information/ mlkn"

I hereby authorize the State of New Mexico to obtain pertinent information to include medical, social, and educational information. I understand that the disclosure of pertinent information may include substance use disorder and/or mental health records or information and hereby authorize the disclosure of such records and information. I authorize the State of New Mexico to release information received by organizations referred to in the Support Services section and the following providers identified in the plan of care: Department of Health Children's Medical Services, Family/Caregivers, Primary Care Provider, Insurance Care Coordinator, Children, Youth and Families Department, third party payors.

I also hereby authorize that a photocopy of this authorization be accepted with the same authority as this original. Any person or agency receiving this information will be directed to treat it as confidential and for the sole purpose of collaboration on this plan of care.
This release is valid for two years.

Infant Name: _____ D.O.B.: _____

Caregiver refuses referral for Care Coordination. If they refuse, the plan of care will not be sent to the insurance or Managed Care Organization (MCO). Yes No

Parent Name: _____ Parent Signature: _____ Date: _____

Staff Name: _____ Staff Signature: _____Date: _____

Fax completed form to Susan Merrill, CARA Program Lead at NMDOH Children's Medical Services (505) 827-5995 or 476-8996

For questions or assistance with a plan of care, please contact a CARA Navigator:
CALL or TEXT 505-396-0423 or 505-470-4032
https://sharenm.org/CARA

Appendix D: Introduced CARA Related Legislation, First Session of the Fifty-Sixth Legislature (2023)

Introduced CARA Related Legislation, First Session of the Fifty-Sixth Legislature (2023)

Bill Number	Short Title	Synopsis	Status
House Bill 477	Prenatal Substance Exposure Screening Tool	Would have required prenatal care providers screen each prenatal patient each visit for drug and alcohol use. Results confidential and would not result in CYFD referral but referral to substance abuse treatment.	Not Passed
House Bill 434	Child Rights, Dept. Collaboration & Newborns	Would have shifted many of the responsibilities for overseeing safe care plans to DOH and require DOH to update rules to guide providers in the care of newborns who exhibit symptoms of drug exposure. Would have required CYFD, ECECD, DOH, HSD, and PED to coordinate and collaborate to ensure the sharing of data to improve outcomes, align outcome metrics, share accountability, and demonstrate measurable progress.	Not Passed
House Bill 461	Children's & Families' Rights Act	Would have created three new entities comprising the Office of Children's and Families' Rights, the Provider Advisory Council, and the Child Welfare Innovation Center.	Not Passed
Senate Bill 150	CYFD Plan of Care Failure Assessments	Senate Bill 150 would have amended the existing state statute that established plans of safe care for newborns with symptoms consistent with fetal alcohol syndrome or exposure to other substances. The bill changes "may" to "shall" in several places to mandate CYFD conduct a family assessment in the event of noncompliance with a plan of care. The bill also mandates CYFD refer families to services and mandates investigations in the event a newborn's parents, relatives, guardians, or caretakers decline services or programs offered because of the assessments. In current statute, all three of these actions are elective ("may" not "shall").	Not Passed
House Memorial 52	Study Prenatal Substance Abuse Exposure	Would have asked the Department of Health to convene a task force to make recommendations and study the independent and combined effects of prenatal drug exposure on birth outcomes for children in New Mexico. The task force is charged with analyses, studies, plan development, and reporting.	Not Passed
House Bill 221	Exposure of Children to Certain Drugs	House Bill 221 would have amended existing crimes regarding the abandonment or abuse of a child to apply penalties for exposing a child, in utero, to a Schedule I or II narcotic. Exposure that does not result in a child's death or great bodily harm would be punishable as a third-degree felony (which carries a sentence of three years of incarceration) for a first offense and as a second-degree felony (which carries a sentence of nine years of incarceration) for second or subsequent offense. Exposure resulting in death or great bodily harm would be punishable as a first-degree felony (which carries a sentence of 18 years of incarceration) or, in some circumstances, a first-degree felony resulting in the death of a child (which carries a sentence of life imprisonment).	Not Passed

Source: nmlegis.gov

Appendix E: University of New Mexico Key Programs and Services

CARA Related Clinics and Programs at UNM	Physical location of programs where services are provided	Description of eligible Populations (and location of those populations)	Patients typically enter program or are referred by what means?	Relationship to CARA Implementation	Other Notes (Details of program; barriers or challenges, etc.)
Milagro Clinic	Medical Clinics: UNM Tucker Clinic UNM North Valley Clinic UNM Southeast Heights Clinic	Pregnant and postpartum people with substance use disorder	Self-referral Community providers UNM OB triage UNM Labor and Delivery Incarceration	Potential to be model site if CARA plan creation occurs during prenatal care	Need for integrated social Worker Need for family centered inpatient recovery site for pregnant and postpartum people and their partners/children Access to MOUD/Substance use care for partners. Need for peer support workers/home visiting alternative care models.
UNMH Labor and Delivery (L&D OB Triage (OBT) Women's Special Care (WSC)	UNMH, 4th floor Pavilion	Referrals made to Milagro or FOCUS from L&D, OBT and WSC Primarily manage pregnant persons with substance use disorder (either during labor or management/ initiation of medications for OUD). Postpartum persons may be cared for on WSC.	Self-referral Community providers Incarceration	Potential to be a model site if CARA plan creation occurs during prenatal care	Need for integrated Social Worker Families are afraid of anything to do with CYFD Need for family centered inpatient recovery sites Need for peer support persons (doulas) during labor or hospital admission, with ability to provide continuity of care during pregnancy and postpartum
UNMH Mother-Baby Unit	UNM Hospital, Mother Baby Unit, 3rd Floor Pavilion	Postpartum mothers with h/o drug or alcohol use during pregnancy	Medical provider refers to SW and SW meets with patient who then agrees or not to CARA referral	Majority of newborns are taken care of on MBU and many mothers have h/o substance use during pregnancy	MBU SW is responsible for many other services/floors so does not really have sufficient time to meet with families and make referrals. Families are afraid of anything to do with CYFD.
UNMH Zia Newborn Service	4th Floor BBRP Integrated into NICU	High proportion of newborns with NOWS	At birth from labor and delivery or transfer from Newborn nursey or NICU	High proportion of discharged infants have CARA plan	Lack of capability for dyadic care for NOWs babies

CARA Related Clinics and Programs at UNM	Physical location of programs where services are provided	Description of eligible Populations (and location of those populations)	Patients typically enter program or are referred by what means?	Relationship to CARA Implementation	Other Notes (Details of program; barriers or challenges, etc.)
UNMH Neonatal Intensive Care Unit	4th Floor BBRP	High proportion of newborns with NOWS	At birth from labor and delivery or transfer from NBN or Zia	High proportion of discharged infants have CARA plans	Prior to HB230 implementation, we had systems in place to begin early intervention services and make appropriate/supportive referrals implementing CARA has been an extension of these efforts. Our SW team has operationalized procedures for speaking with families about CARA and making referrals prior to discharge. We have had a high rate of completions and low rate of declines. Challenges include lack of support from MCO's to manage CARAs after discharge and have had to contact Susan Merrill with DOH to re-engage families, concern that we will lose this support once transition out of DOH occurs; As part of informed consent, our team will now be informing parents that CYFD may share their information with law enforcement for welfare checks.

CARA Related Clinics and Programs at UNM	Physical location of programs where services are provided	Description of eligible Populations (and location of those populations)	Patients typically enter program or are referred by what means?	Relationship to CARA Implementation	Other Notes (Details of program; barriers or challenges, etc.)
FOCUS Program	Medical Clinics: UNM North Valley Clinic UNM Southeast Heights Clinic Home- and community-based early intervention services through the UNM Center for Development and Disability, including developmental instruction, speech/language, occupational, feeding, and social work/counselling services Behavioral Health services within the FOCUS medical clinics currently funded by	Families and caregivers for young children (under age 3) who may benefit from intensive multidisciplinary support. About 94% of children served in FOCUS have prenatal substance exposure and most adults seen in clinic have substance use disorder and complex trauma histories Early intervention serves Bernalillo, Sandoval and Valencia counties, though medical services serve outside counties as well.	Referral from Milagro, or at discharge from newborn units at UNM and other local hospitals including Lovelace and Presbyterian. Community referrals, including CYFD referrals.	Nearly all of the newborn patients referred to FOCUS have CARA plans. Currently, the medical clinic receives the CARA plan (although this often requires follow up as the receipt of CARA plan is inconsistent). DOH CMS or MCOs reach out to inquire about families' engagement. Inquiry requests include engagement follow- up for specific medical visits, general engagement, and whether concerns about whether there are concerns about the family/child. We have approx 300-400 families enrolled in FOCUS Program at any point. CARA requests to disclose information have also come to the FOCUS Early Intervention team – clarification on the role of supportive services like home-based Early Intervention in CARA need to be directly clarified = concern about HIPAA/FERPA and engagement.	FOCUS clinic provides medical care for the entire family system, all adults and children in system. Including coordination of specialty medical care. Outpatient treatment of substance use disorder, management of psychiatric co-morbidities with support from Perinatal Psychiatry Providers. Home- and community-based developmental services from early intervention with specialty support from speech/language, social work/counseling, and occupational therapists. Need for additional funding support to sustain early intervention and include case managers/ community health works working within the home/community. Community-based two-generational behavioral health support is supported but not adequately funded via the CDD's Early Intervention contract – needs additional support along with Behavioral health support from faculty and staff therapists for individual therapy and groups—need for sustainability of these positions and component of the program. Concerns for lack of trust in program if perceived to be closely connected to CYFD. Additional concerns regarding HIPAA and FERPA privacy considerations. Worry that families will not engage if aligned with CYFD creating more possible risk than if they are participating in the program.

CARA Related Clinics and Programs at UNM	Physical location of programs where services are provided	Description of eligible Populations (and location of those populations)	Patients typically enter program or are referred by what means?	Relationship to CARA Implementation	Other Notes (Details of program; barriers or challenges, etc.)
School of Medicine Section for Child Safety and Well-Being	Child Abuse Response Team (CART), UNMCH Para los Ninos (PLN) Clinic, Albuquerque Family Advocacy Center Healthy Beginnings Foster Care Clinic (HBC), UNMCH	CART and PLN provide medical evaluations for children for whom there is concern for child abuse/neglect, including symptomatic exposures to controlled/illicit substance. HBC serves as a medical home for children in foster care	Patients are referred by other health care professionals, child protective services (CYFD or tribal), law enforcement, or forensic interviewing services	We often care for children affected by substance exposure in utero, symptomatic substance exposures in infancy/childhood, maltreatment related to active substance use disorders in parents/guardians,	We have minimal funding from the state to support our critical access medical services that are necessary to ensure the state can meet its obligation to adequately respond to child maltreatment. Child Abuse pediatrics is an under-represented specialty. Standard medical reimbursement models are inadequate to support the complex care and coordination provided by our service.
ADOBE Program	Medical Clinics: UNM North Valley Clinic UNM Southeast Heights Clinic Community based navigation, educational liaisons may attend school meetings, UNM Law clinic may see families in their location as well	Adolescents and families with high psychosocial complexity including involvement or risk of involvement in juvenile justice, CYFD, adolescents with substance use or behavioral health needs, families referred by the DAs office for wrap around services, transitional age youth without robust support systems.	JPO, the DA's office, JobCorps, CYFD, community pediatricians, UNM medical providers	Teen parents who may struggled with substance use, older children whose parent may have used substances during pregnancy, families referred by diversion programs for wrap around support	Fully sustainable funding, reimbursement while working with other community wrap-around partners, clinical space, resources to expand ADOBE model state-wide.
UNM Psychology Department Clinic – Alcohol specialty Clinic	1820 Sigma Chi Road Albuquerque, NM 87106	Adults with concerns related to alcohol and other drug use, or family/friends of those who are concerned about the drinking of a loved one.	Self-referral Community providers	CARA implementation could be supported by expanding services for families and those who are pregnant	Training clinic for psychology PhD students (so workforce development component). Also, no insurance accepted, only fee for service with very generous sliding scale

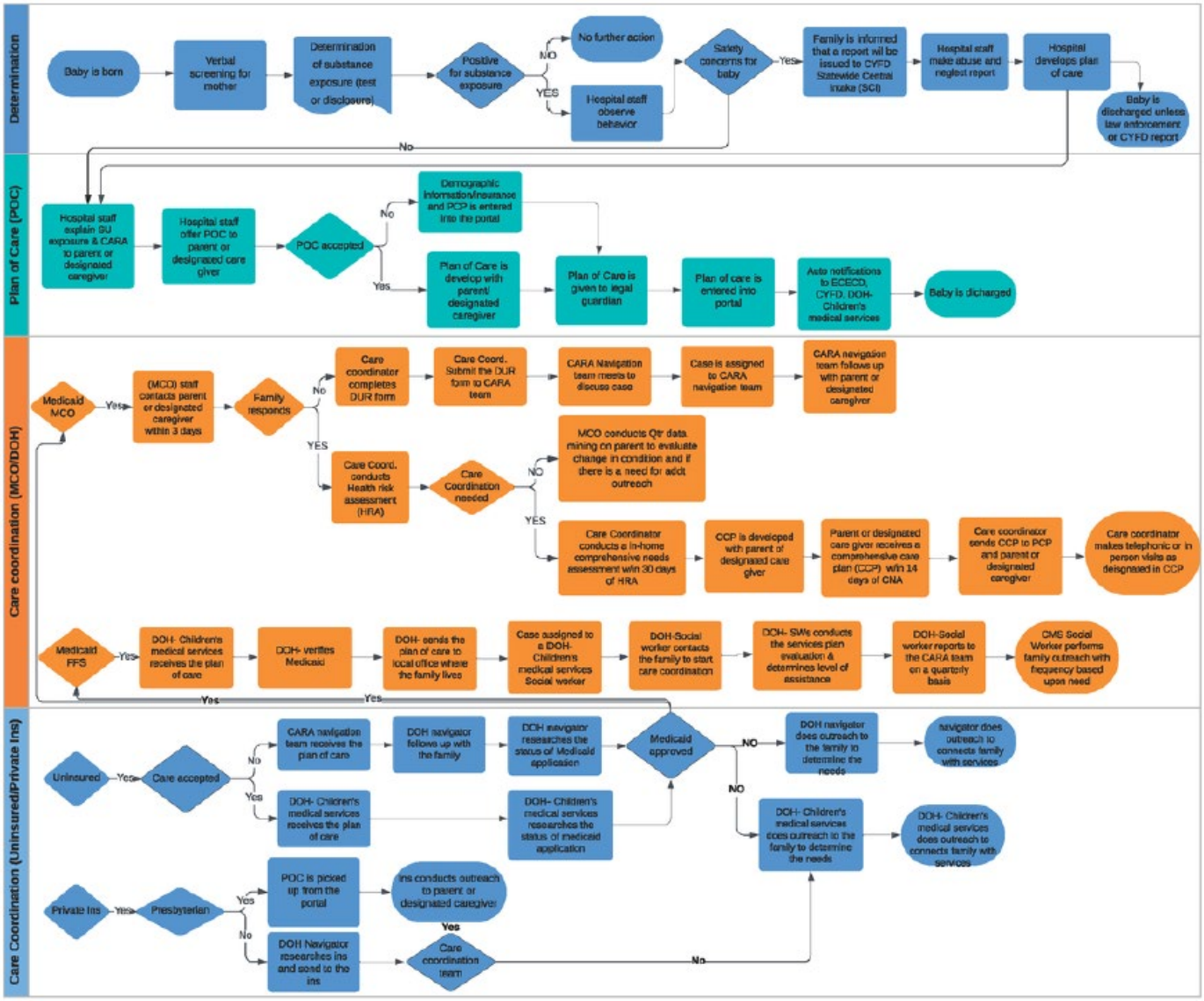
Appendix F: Illinois' Recovery Matrix

Example of Illinois's Recovery Matrix: Baseline Matrix 0 – 45 Days

Substance Abuse Treatment		
Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent: ☐ Continued to use and/or remains in denial of substance abuse/ addiction ☐ Had less than 50% clean urinalysis results ☐ Substance Exposed Infant born subsequent to case opening Date: Other:	Parent: ☐ Failed to consistently meet with caseworker ☐ Completed substance abuse assessment but has not yet followed recommendations or entered treatment ☐ Had more than 50% clean urinalysis results ☐ Self-reported abstinence for consecutive days Other:	Parent: ☐ Entered residential treatment- movement has not been restricted ☐ Entered recommended outpatient treatment ☐ Attending at least 80% of sessions ☐ Self-reported abstinence for the past 30 days ☐ Had all clean urinalysis for past 30 days Other:
Parenting Responsibilities		
Lack of Progress	**Partial Progress**	**Substantial Progress**
Parent failed to: ☐ Be contacted/meet with caseworker ☐ Arrange for immunizations and medical care appointments ☐ Arrange for appropriate child care ☐ Enroll child in Head Start or other early intervention programs ☐ Attend school conferences ☐ Use non-physical forms of discipline Other:	Parent was inconsistently able to: ☐ Be contacted//meet with caseworker ☐ Arrange immunizations and/or schedule medical care appointments ☐ Ensure child's attendance in Head Start and school ☐ Attend school conferences ☐ Arrange for appropriate child care ☐ Use non-physical forms of discipline Other:	Parent consistently able to: ☐ Participate in the development of the Comprehensive Service Plan ☐ Complete all scheduled immunizations ☐ Engage in educational, health and developmental appointments ☐ Arrange/attend routine scheduled medical appointments ☐ Ensure child's attendance in Head Start and school ☐ Use non-physical forms of discipline ☐ Arrange for appropriate caregivers Other:

Source: State of Illinois Department of Children and Family Services.

Appendix G: CARA Systems Map from Contractor's Report

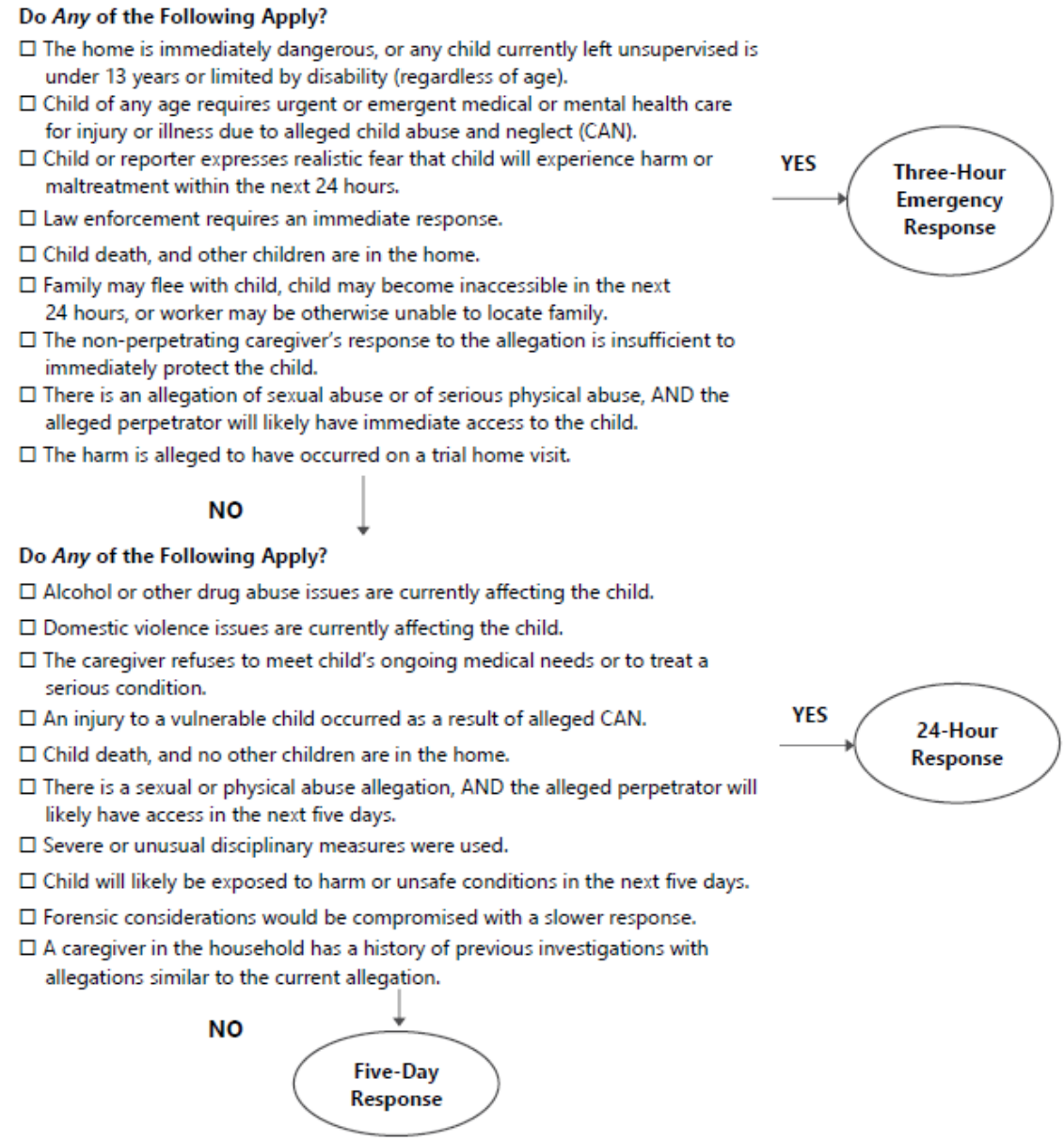


Appendix H: CYFD's Screening Manual Decision Tree Regarding Alcohol or Drug Issues

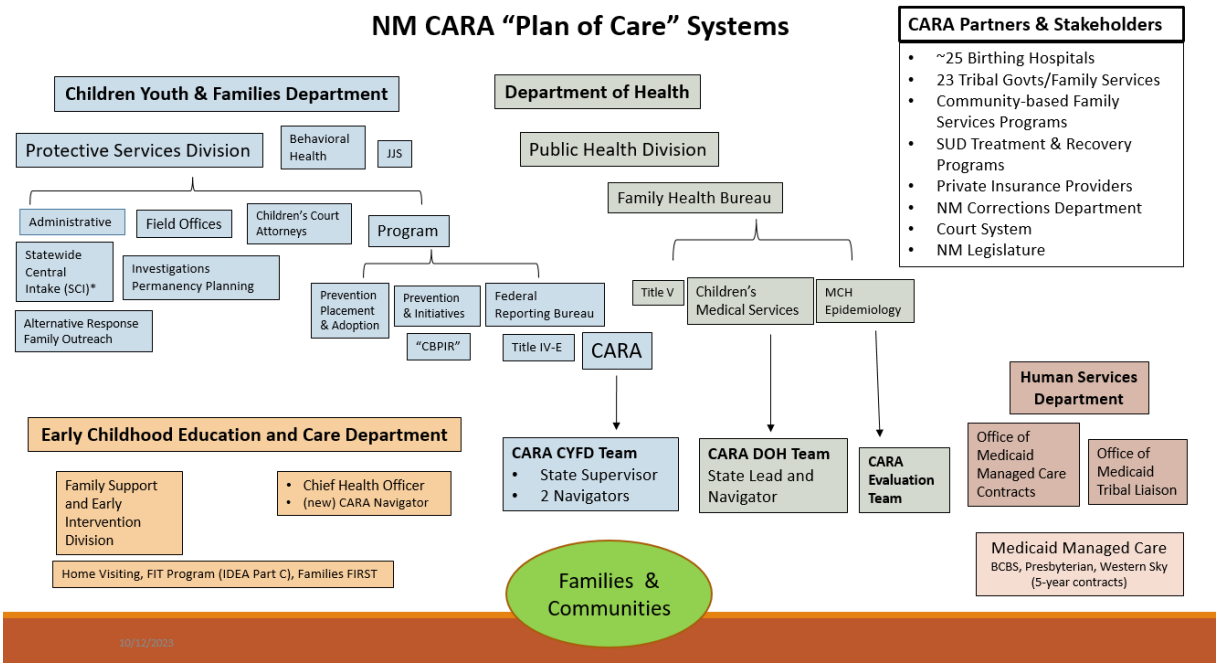
PART II. RESPONSE TIME DECISION

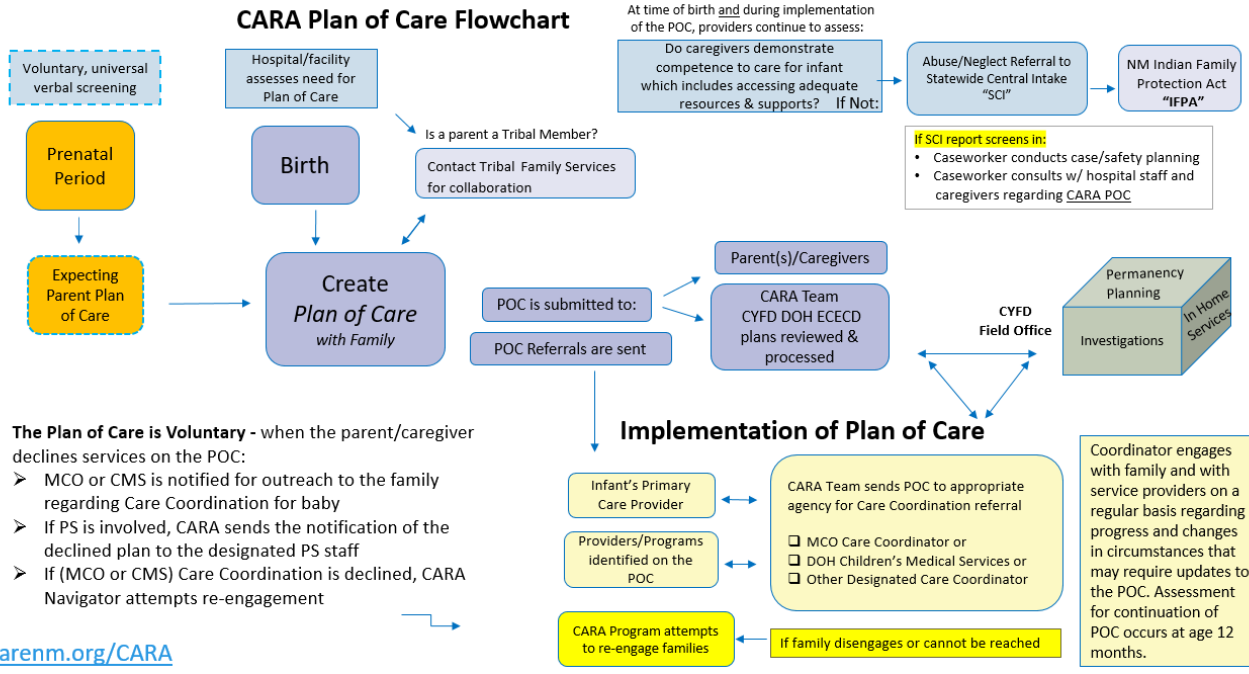
For all screened-in reports, review all items until establishing a response time.

A. DECISION TREE



Appendix I: CARA Plans of Care Training Slides from DOH and CYFD





Appendix J: CARA Family and Expecting Parents Brochure

CARA Plan of Care BENEFITS:

- Support to help all members of the family thrive
- Services are free & culturally responsive to meet your family's needs & traditions
- Offers community connections for your family
- Safe, healthy, developing baby

Who is there to guide and help me through the process?

- Your Healthcare Provider, Doula or Midwife
- Supportive Family Members, Father of Baby, and/or a Partner
- Your Insurance Care Coordinator
- A Peer Support Specialist or Community Health Worker
- Home Visiting Provider (Prenatal or Postpartum)
- CARA Navigator

What does a CARA Navigator do?

The Navigator reviews your Plan of Care. She/he can help you with any questions or concerns you have. The Navigator can assist you to make changes to your Plan of Care when your child's or family's needs change. They can help you connect with a Care Coordinator and other supports such as a Community Health Worker or Peer Support Specialist.

Care Coordination

A Care Coordinator supports your family to access health care and resources to help your family achieve good health. They can help you follow-up with the services on your Plan of Care. Care Coordination is available at no charge through your Medicaid Managed Care Organization (MCO), private insurer, or NM DOH Children's Medical Services.

- In NM, the MCOs are Blue Cross Blue Shield, Presbyterian Health Plan & Western Sky Community Care.
- A Care Coordinator may be available through private insurance also.
- If Care Coordination is not available through your insurance plan, or you have Medicaid Fee for Service, you can receive supportive assistance through the Department of Health--Children's Medical Services (CMS).

Community Health Workers & Peer Support Specialists

A CHW or PSS is a certified person who provides one-to-one support to individuals with substance use concerns. They bring a perspective from their lived experiences and training that promotes empathy and impartiality in their support of clients.

CARA
Plan of Care

Supports and Resources for Expecting and New Parents




WHAT is CARA?

CARA, the Comprehensive Addiction and Recovery Act, is a federal law that was passed in 2016 and adopted in New Mexico in 2019.

CARA requires states to offer supportive services to the families of babies who are born with exposure to substances that can affect their health and development.

These substances can include alcohol, nicotine, marijuana, and medications or drugs, including prescribed substances.

When substance exposure occurs, families can work with their health care provider to create a **Plan of Care**.

HOW does CARA help New Mexico families?

The 2019 CARA Statute (law) in NM amended the rules about reporting abuse/neglect for newborns with substance exposure:

- Health care and other providers are now required to offer families a CARA Plan of Care when a newborn has experienced substance exposure prenatally.
- It is no longer required to report newborn substance exposure to CYFD Statewide Central Intake unless there are specific concerns about the newborn's safety, beyond the substance exposure.

What is a Plan of Care?

- A Plan of Care (PoC) is created by you and your health care provider during your prenatal visits or at the time of your baby's birth.
- The plan helps you identify and access the services you want that will help you care for yourself, your baby and family.
- Other members of your family may participate in the plan of care. This can include fathers, partners, grandparents, or other members of the household.

What if I have older children?
The CARA Program can still help you with the services you and your child may need.

How is CYFD involved with the Plan of Care?

The CARA Program is coordinated by NM CYFD and NM Department of Health.

The CARA Program will receive a copy of your family's Plan of Care in order to assist you to receive the supportive services you want. The Plan of Care is voluntary so you may decline to participate. If you decide to create a plan of care, the plan will only include the information that you want to include.

To learn more about CARA and the Plan of Care Program, please visit:

www.sharenm.org/CARA

Or contact us:

NM Children Youth & Families Department

Milissa Soto
Federal Reporting Bureau Chief
Acting CARA Supervisor
Cell: 505-257-8759/Milissa.Soto@cyfd.nm.gov

Lisa Rohleder, MA, CARA Navigator
Cell: 505-396-0423/Lisa.Rohleder2@cyfd.nm.gov

NM Department of Health
Children's Medical Services

Susan Merrill, LCSW, DOH CARA Lead & Navigator
Cell: 505-470-4032/Susan.Merrill@doh.nm.gov

NM Early Childhood Education and Care Department

Janis Gonzales, MD, Chief Health Officer
Phone:505-469-1742/ Janis.Gonzales2@ececd.nm.gov

Stephanie Becenti, CARA Navigator
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Appendix K: HSD Letter of Direction

HUMAN SERVICES DEPARTMENT

Michelle Lujan Grisham, Governor
Kari Armijo, Acting Secretary
Lorelei Kellogg, Acting Medicaid Director

Letter of Direction #105

Date: **September 25, 2023**

To: **Centennial Care 2.0 Managed Care Organizations**

From: **Lorelei Kellogg, Acting Director, Medical Assistance Division**

Subject: **Care Coordination for Infants Affected by Substance Abuse**

Title: **Care Coordination for Comprehensive Addiction and Recovery Act (CARA) Infants**

The purpose of this Letter of Direction (LOD is to add additional layers of support for infants in the Comprehensive Addiction Recovery Act (CARA) program. These are infants who have prenatal exposure to substances, receive a plan of care within the hospital, and then should continue to receive ongoing wrap-around services once discharged. Care Coordination plays a key role in this program.

Care Coordination Presence in Hospitals

The Contractor is directed to assign members of their Care Coordination team to each of the hospitals identified below:

- University of New Mexico Children's Hospital Level IV
- Lovelace Women's Hospital Level III
- Presbyterian Main Hospital Level III
- Memorial Medical Center Level II
- Mountain View Medical Center Level II

To ensure all eligible CARA infants, birth mothers, and legal guardians are provided the information on the services and supports available, HSD is directing the Contractors to implement the process below:

- Assign a care coordinator to conduct in person daily rounds at each of the facilities above to identify infants admitted to the NICU and the mother/baby unit, who are eligible for care coordination through the MCO.
- The MCO care coordinator will make contact with the staff in the NICU and mother/baby unit, including both social workers and nurses, and obtain a complete list of all Medicaid members that are currently enrolled or presumptively enrolled with the MCO.
- The MCO care coordinator will obtain a complete list of infants identified as enrolled or presumptively enrolled with the MCO and born exposed to substances and ensure that a plan of care (POC) has been written by the hospital staff and submitted through the New Mexico Healthy Families portal.

MEDICAL ASSISTANCE DIVISION | PO BOX 2348 – SANTA FE, NM 87504 | PHONE: (505) 827-3100 FAX: (505) 827-3185

- The MCO care coordinator will visit every birth mother and/or CARA infant's legal guardian identified as enrolled or presumptively enrolled with the MCO in the unit and, with consent, discuss services covered by Medicaid and services available to the member that are not covered by Medicaid, that are available for both mother and infant. Although CARA infants are the focus of this program, every person who has birthed an infant and every infant born who is enrolled or presumptively enrolled in Medicaid should receive an in-person visit from a care coordinator within these 5 hospitals.
- If permitted, the MCO care coordinator will attend any discharge planning rounds and team meetings within the unit to make connections to staff to be fully updated on the healthcare status of mothers and infants enrolled or presumptively enrolled with the MCO.

The MCO care coordinator will inform the infant's parent/legal guardian of the full range of services and resources available and provide the name and contact information of the care coordinator assigned to the infant. Whenever possible, the Contractor shall align the mother's Care Coordination with the infant's Care Coordination, as well as any other family members engaged in Care Coordination with the MCO, by assigning the same care coordinator to all members of the family. When feasible, the care coordinator will perform the Health Risk Assessment (HRA) during this initial contact. Services, supports, and resources that should be offered shall include but are not limited to the following:

- Care Coordination
- Medicaid/Non-Medicaid Home Visiting Programs
- Value Added Services (VAS) such as infant car seats and diapers offered by the Contractor
- Housing supports, Supplemental Nutrition Assistance Program (SNAP), and Income Support
- Substance use disorder counseling and Behavioral Health services
- Referrals and scheduling assistance with a pediatrician/Primary Care Provider (PCP) for both infant and mother.

Care Coordination Teams

The Contractor is directed to have a Care Coordination team dedicated solely to CARA members. No services shall be withheld while waiting for completion of the HRA or CNA. If the infant is in the mother's custody, infant and mother should have the same care coordinator.

Timelines

Contact with the guardian of the infant in the CARA program should occur within 24 hours of the discharge from the hospital. The HRA should be completed inpatient whenever possible and if not possible should be completed at the call done within 24-hours. CNAs should be done in the member's home within 7 days of discharge from the hospital. Three attempts to contact the guardian should be made within the first 48 hours of discharge. If the care coordinator is unable to reach the mother and the baby is in the mother's custody, the care coordinator must contact the CARA navigation team.

Communications

The CARA care coordinators should regularly meet with CARA member assigned pediatricians, hospitals, and home visiting agencies in their community to discuss communication challenges and processes. The care coordinator is required to submit the POC created by the hospital, to the infant's PCP (pediatrician, midwife, or family medicine provider) within 5 business days from receiving notification of a new POC. The HRA and CNA must be submitted to the PCP within 14 business days of discharge. The CARA care coordinator must create a transition plan when the CARA program

ends at the one-year mark for the CARA navigation team to ensure continuity of care for the infant. This must be completed within the 60 days before the graduation date.

Reporting
The CARA infant's parent/legal guardian has the right to refuse Care Coordination for themselves and/or the infant, and the MCO care coordinator should obtain a declination form from the individual refusing Care Coordination in accordance with 4.4.1.5 of the New Mexico Human Services Department Medicaid Managed Care Services Agreement. In addition, the MCO care coordinator will email the CARA DUR Member Form (MAD 902) to the CARA navigator at CARA.CYFD@cyfd.nm.gov.

This LOD will sunset upon inclusion into the NM Medicaid Managed Care Services Agreement.

Attachments:

- **LOD #105 Attachment 1 - Instructions for Completing the CARA DUR Member Notification Form**
- **LOD #105 Attachment 2 - MAD 902 CARA DUR Member Notification Form**

Letter of Direction #105 Attachment 1 - Care Coordination for Comprehensive Addiction and Recovery Act (CARA) Infants

Instructions for Completing the CARA DUR Member Notification Form MAD 902

DUR: Difficult to Engage (DTE), Unable to be Reached (UTR), Refused Care Coordination (RCC)

The CARA DUR Member Notification Form, MAD 902, is utilized to enable communication between MCOs and the CARA Team regarding members who are Unable to be Reached (4.4.2.6.1), Difficult to Engage (4.4.2.6.2), or have Refused Care Coordination (4.4.1.5). Per section 5.13 of the New Mexico Managed Care Policy Manual, notifying CYFD if the mother and/or family/caregiver(s) are DUR is required for CARA members.

Date: The date the form is being submitted to the CARA email address.

Care Coordination Level: Check the appropriate box to specify whether the member is Difficult to Engage (DTE), Unable to be Reached (UTR) or has Refused Care Coordination (RCC).

SCI Report: Check "Yes" or "No" to indicate whether a State Central Intake (SCI) report was filed due to concerns of neglect or abuse of the member.

MCO Reporter: Enter the name, MCO, phone number and email address of the MCO staff member filing the CARA DUR Member Form.

CARA Member Information: Enter the name, Medicaid ID (if applicable), and date of birth of the CARA member who is DTE, UTR, or RCC.

Parent/Guardian Contact Information: Enter the name and all contact information available to the MCO for the parent and/or guardian of the CARA member who is DTE, UTR, or RCC.

Unable to be Reached (UTR) Outreach Attempts: If the CARA member is UTR, enter the dates and times that telephonic or in-person attempts were made to reach the member. Enter the date the UTR letter was sent to the last known address of the member's parent/guardian.
If the member is NOT UTR, leave this section blank.

Difficult to Engage (DTE) Outreach Attempts: If the CARA member is DTE, enter the most recent successful contact date and the subsequent dates and times of unsuccessful contact attempts. Enter the date the UTR letter was sent to the last known address of the member's parent/guardian.
If the member is NOT DTE, leave this section blank.

Refused Care Coordination (RCC) Documentation: If the CARA member is RCC, enter the date the member's parent/guardian refused Care Coordination. Indicate whether the parent/guardian signed a Care Coordination Declination Form.
If the member is NOT RCC leave this section blank.

Additional Information: Enter the member's New Mexico Healthy Families (NMHF) Plan of Care (POC) ID and any additional information relevant to the CARA member's DTE, UTR, or RCC status.

The completed CARA DUR Member Notification Form shall be emailed to: CARA.CYFD@cyfd.nm.gov. Documentation of the submission of the form must be included in the member file.

For CYFD Use: If CARA staff are able to locate UTR members, re-engage DTE or RCC members, or have additional member information helpful to the MCO, CARA staff will complete the applicable sections titled "For CYFD Use". CARA staff will email the form with the additional information to HSD at: HSD-CARA-DUR@hsd.nm.gov.
The updated CARA DUR Member Notification Form will be forwarded to the MCO. Additional outreach by the MCO to the member may be requested by HSD.

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Letter of Direction #105 Attachment 2 - Care Coordination for Comprehensive Addiction and Recovery Act (CARA) Infants

CARA DUR Member Notification Form

(DUR: Difficult to Engage, Unable to be Reached, Refused Care Coordination)

MCOs: Please email this document to CARA Staff: CARA.CYFD@cyfd.nm.gov

Date: _____

Care Coordination Level:

☐Difficult To Engage (DTE-CCL5)
☐Unable to be Reached (UTR-CCL0)
☐Refused Care Coordination (RCC-CCL4)

SCI Report:

Was an SCI Report completed? ☐Yes ☐No

MCO Reporter
Name
MCO
Phone Number
Email

CARA Member Information
Name
Medicaid ID
Member Date of Birth

Parent/Guardian Contact Information:	
Name	
Address:	
Phone	Email

MAD 902 Revised 04/25/2023 Page 1 of 2

Please provide requested information in the appropriate section below:

Unable To Be Reached (UTR) Outreach Attempts
Please include the dates and times of telephonic attempts and any additional methods used to contact member. Date UTR letter sent:

Difficult To Engage (DTE) Outreach Attempts
Please include the most recent successful contact date and subsequent unsuccessful telephonic contact attempts. Date UTR letter sent:

Refused Care Coordination (RCC) Documentation
Please document the date that the member's parent/guardian refused Care Coordination. Did parent/guardian sign Care Coordination Declination form? ☐Yes ☐No

Additional Information
Please include the New Mexico Healthy Families (NMHF) portal Plan of Care (POC) ID. *Example: ZAL-T56-8427*
For CYFD Use: enter additional information as appropriate.
Example: Alternate member contact information, member request to re-engage

Appendix L: NCSL Compilation of State's CARA Implementation

State	State Legislation
Colorado	CO SB 137 (2021) Requires the perinatal substance use data linkage project to utilize data from multiple state-administered data sources when examining certain issues related to pregnant and postpartum women with substance use disorders and their infants.
Connecticut	CT H 6997 (2017) Concerns the well-being of children affected by prenatal drug or alcohol exposure, provides that the Commissioner of Children and Families shall develop and implement policies and procedures in accordance with the Child Abuse Prevention and Treatment Act to secure the health, safety and well-being of infants identified as being affected at birth by drug abuse, withdrawal symptoms related to prenatal drug or alcohol exposure or fetal alcohol spectrum disorder.
Delaware	DE H 140 (2018) Seeks to codify certain sections of the federal law known as the Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Comprehensive Addiction and Recovery Act (CARA), that requires states to have policies and procedures in place to address the needs of infants born with and identified as being affected by substance abuse, withdrawal symptoms, or Fetal Alcohol Spectrum Disorder, including a requirement that healthcare providers involved in the delivery or care of such infant notify the child protection services system. This bill formalizes a uniform, collaborative response protocol for the development of a Plan of Safe Care for infants with prenatal substance exposure and their affected family or caregivers.
Iowa	IA H 543 (2017) Requires a health practitioner involved in the delivery or care of a newborn or infant, who discovers in the newborn or infant physical or behavioral symptoms that are consistent with the effects of prenatal drug exposure or a fetal alcohol spectrum disorder, to report such information to the department of human services in a manner prescribed by rule of the department.
Louisiana	LA H 658 (2018) Establishes an evidence-based pilot project within the Louisiana Department of Health to treat infants with neonatal opiate withdrawal syndrome by providing care options that are safe alternatives to the intensive care unit. The pilot prioritizes maternal access to evidence-based treatment of substance use disorder and practices that minimize harm and improve outcomes in infants.
Nevada	NV S 480 (2017) Requires certain health care providers to notify an agency which provides child welfare services that a newborn infant has been affected by a fetal alcohol spectrum disorder. Requires an agency which provides child welfare services to make certain referrals for services for such a newborn infant and the affected family or caregiver of the newborn infant.
New Hampshire	NH S 549 (2018) Defines plan of safe care. Plans of safe care are for infants affected by neonatal abstinence syndrome or fetal alcohol spectrum disorder.
Pennsylvania	PA H 253 (2022) Establishes task force on the opioid abuse epidemic impact on children to focus on improving the safety, well being and permanency of substance exposed infants and other young children affected by parental substance abuse disorders, provides for membership, duties and responsibilities of the task force, provides that from money appropriated to the Department of Human Services shall be used for making payments to hospitals for making retention and recruitment payments to qualified staff, appropriates funds.
Virginia	HB 1786 (2017) Relating to in utero exposure to a controlled substance.
Wyoming	WY SF 79 (2023) AN ACT relating to public health and safety; requiring health care providers to develop plans of safe care for infants as specified; requiring hospitals to report to the department of family services as specified; providing definitions; requiring rulemaking; and providing for effective dates.

Appendix M: References

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