F I S C A L I M P A C T R E P O R T

SPONSOR HHHC **ORIGINAL DATE** 3/5/19 **LAST UPDATED** **HB** 290/HHHCS

SHORT TITLE Opioid Agonist Therapy for Inmates **SB**

ANALYST Edwards

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY19	**FY20**		
$0.0	$3,000.0	Nonrecurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY19	FY20	FY21	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	$0.0	Unknown	Unknown	Unknown	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

Related to House Bill 43, House Bill 290, House Bill 342, and Senate Bill 205.

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
Department of Health (DOH)
Children, Youth and Families Department (CYFD)
New Mexico Corrections Department (NMCD)

SUMMARY

Synopsis of Bill

The House Health and Human Services Committee Substitute for House Bill 290 requires the Behavioral Health Services Division (BHSD) of the Human Services Department to conduct a two-year pilot program to test the effectiveness of providing opioid agonist therapy to inmates who were on such therapy at the time of their incarceration. The pilot shall be conducted in correctional and jail facilities in San Juan, Rio Arriba, and Santa Fe counties.

BHSD is required to measure the effectiveness of the pilot and report to the Governor and the interim Legislative Health and Human Services by November 1, 2019 and November 1, 2020.

House Bill 290 appropriates $3 million from the general fund for expenditure in FY20 and FY21 to HSD to fund the pilot program. Ay unexpended or unencumbered balance at the end of FY21 shall revert to the general fund.

FISCAL IMPLICATIONS

HSD states:

> $3 million is appropriated from the general fund to the Human Services Department for expenditure in FY20 and FY21 to fund the pilot. Any unexpended or unencumbered balance remaining at the end of FY21 shall revert to the general fund.
>
> It is unclear if the $3 million appropriation is sufficient for a pilot of this scope. The pilot would include three detention centers and one penitentiary: Rio Arriba County Adult Detention Center, Santa Fe County Detention Center, San Juan County Adult Detention Center, and NMCD's Penitentiary of New Mexico (Santa Fe). HSD does not have estimates for how many inmates over a two-year period would participate in the proposed pilot, which would require data on how many inmates at each facility have a diagnosed [opioid use disorder] OUD and are taking buprenorphine or methadone at the time of incarceration. Complicating the matter is the fact that some inmates in short-term detention may be on long-acting injectable and therefore not need treatment during their brief detention.
>
> BHSD does currently fund a pilot to provide methadone (but not buprenorphine) for inmates at Albuquerque's Metropolitan Detention Center. Combined cost for FY18 and FY19 was $1.342 million for 1,296 distinct clients. These clients were not limited to those who came into the facility already under treatment; therefore, it is difficult to extrapolate cost figures for the pilot.
>
> Part of the $3 million appropriation would be used to cover the following staff positions, which would cost $75,838 annually x 2 FTE = $151,676 x 2 years = $303,352:
>
> 1) One FTE program manager to create and implement the pilot in coordination with the facilities, and collect data/evaluate effectiveness;
> 2) an additional FTE within the State Opioid Treatment Authority at BHSD, which oversees the heavily-federally regulated and intensive licensing/certification requirements for new methadone programs. There are currently 16 Opioid Treatment Programs (OTPs) providing methadone therapy in NM; in addition to licensing requirements, expansion of four more OTPs would require increased fidelity monitoring and significantly more technical assistance.
>
> Part of the $3 million would likely be needed to cover start-up costs for providers to set up services in the facilities of the pilot.
>
> Federal rules prohibit Medicaid from paying for health care services provided to inmates so there is no fiscal implication for the Medicaid program.

NMCD analysis explains the bill, if passed, would likely result in harm to some inmates and therefore to expensive litigation, as more fully discussed below in the significant issues section, the substitute would have a substantial fiscal impact on the NMCD.

SIGNIFICANT ISSUES

HSD submitted the following analysis:

> Without sufficient data on the target population, BHSD cannot estimate the needs and numbers of inmates who would be served at each pilot site and therefore whether funding and provider are sufficient.
>
> Methadone is technically an opioid replacement therapy rather than an opioid agonist. HSD suggests amending the bill's language to encompass methadone.
>
> Including the language "consistent with patient preference" on p2, line 6 implies that inmates would be able to dictate their dosage. It is important that the individual's dosage prior to incarceration be maintained when incarcerated to avoid withdrawal. This decision should be made by the appropriate clinician.
>
> The pilot may run into problems with provider capacity, particularly for methadone treatment. Federal law requires licensing/certification at every new site, even if a provider is already a licensed OTP. Certification of OTPs to deliver MAT with methadone and counseling can take six to twelve months and requires a certain level of provider capacity to implement MAT requirements, which include proper storage, oversight and dispensing of methadone, as well as monthly counseling. The correctional facilities would need to provide appropriate space for safe storage for medication, as well as for treatment, including medication management and counseling services.
>
> The treatment provider in the correctional facility may not be the provider the inmate was using prior to incarceration, requiring active coordination between the two providers. The pilot at the ABQ Detention Center has shown there to be challenges related to provider coordination.
>
> There are two concerns regarding the measures of effectiveness of the pilot program:
>
> 1) Many people will not "graduate" from opioid treatment but be maintained at a dose that enables them to refrain from opioid use. Using graduation for treatment as a measure of effectiveness implies that medication maintenance is a mark of failure, rather than successful stabilization.
> 2) Given the rapid turnover of inmates in county facilities, it would be difficult to track what happens to some inmates after they are released if they do not remain in treatment, and therefore to draw any conclusions about the success of the pilot based on incomplete data.

NMCD explains:

> The department's position is that allowing buprenorphine or methadone use for NMCD inmates while in NMCD custody, even on a pilot project basis and even in a limited number

of prisons, could jeopardize prison safety and security. It would introduce highly sought after drugs into these prisons; enable illegal drug use; enable the selling or bartering of this drug in prison as a means to control other inmates or staff; and increase the likelihood of disturbances in prisons due to inmates acting out under the influence of drugs or engaging in fights with other inmates or staff surrounding the selling, bartering or use of this or any similar drug. Further, when inmates and staff are injured in prison because of disturbances surrounding the presence of this drug, expensive lawsuits are likely to be initiated. Additionally, having buprenorphine and methadone available in any NMCD prison would give staff ample opportunity to take it and personally use it while on or off duty, or take it and sell it to inmates or on the street.

The NMCD's inmate medical services provider does not utilize these drugs, but does utilize around the clock drug rehabilitation services, along with dietary supplements and other pain medications which are not opioid-based, to humanely assist NMCD inmates in the detoxification process when needed. These protocols utilized by the NMCD's medical services vendor comply with the medical standard of care for correctional settings, and also comply with all relevant American Corrections Association ("ACA") standards. All of NMCD's prisons are ACA accredited.

The substitute if passed would place the NMCD and its medical provider in a difficult situation. The medical provider hired by the HSD would in many cases end up providing medications or treatment inconsistent with the treatment being provided by the NMCD medical provider. It could result in treatment mistakes or inconsistencies which endanger inmates' health and wellbeing. Two different medical providers providing treatment to the same subset of NMCD inmates at some of NMCD's prisons does not meet the community standard of care, and again jeopardizes the health of these inmates.

When the HSD medical contractor wants to provide buprenorphine or methadone to one or more NMCD inmates and the NMCD medical contractor does not believe such treatment is medically warranted or safe, what is the NMCD supposed to do—follow the expertise of its contracted medical provider or the expertise of the HSD contractor? And yet if an inmate is harmed by this conflicting scenario, it is likely to be the NMCD and not the HSD or its medical provider which will be sued or face civil liability.

DOH analysis explains:

The HHHC substitute for House Bill 290 addresses the situation in which an individual receiving Medication-Assisted Treatment for opioid use disorder is placed in a detention facility and does not have access to treatment.

Although New Mexico's national ranking for drug overdose deaths has fallen in recent years, the actual number of overdose deaths in New Mexico from 2015 to 2017 has remained around 500 deaths a year and continues to be a major public health concern.

Medication-Assisted Treatment is one of the most effective forms of treatment available for opioid use disorder. Medication-Assisted Treatment has been shown to lower rates of illicit drug use, lower risk of overdose, lower rates of drug-related crime, and increase engagement with many other essential forms of healthcare. Providing Medication-Assisted Treatment in jails and prisons would bring health care in New Mexico's

correctional facilities in line with current medical standards for the treatment of this medical disorder and improves the likelihood that incarcerated persons will engage in care in the future. It would also decrease the likelihood of relapse, problem opioid use, and risky opioid use after release. It is among the Centers for Disease Control and Prevention's 2018 Evidence-Based Strategies for Preventing Opioid Overdose provided by the Centers for Disease Control and Prevention (see page 22).

A study conducted among nearly 300 incarcerated persons in Rhode Island concluded that forced withdrawal from methadone upon incarceration (among those who were receiving methadone prior to incarceration) reduces the likelihood that an individual will engage in care after release. Forced withdrawal is required in correctional facilities where Medication-Assisted Treatment is not available (Rich JD, McKenzie M, Larney S, et al. Methadone continuation versus forced withdrawal on incarceration in a combined US prison and jail: a randomized, open-label trial. *The Lancet.* 2015; 386(9991):350-359. doi:10.1016/S0140-6736(14)62338-2).

A study conducted in Baltimore found that incarcerated individuals who received methadone stayed in treatment for an average of 166 days in the year following their release, whereas those who received only counseling but not Medication-Assisted Treatment engaged in treatment for an average of 23 days following release and were more likely to test positive for opioids at 12 months after release (Kinlock TW, Gordon MS, Schwartz RP, Fitzgerald TT, O'Grady KE. A randomized clinical trial of methadone maintenance for prisoners: results at 12 months postrelease. *J Subst Abuse Treat.* 2009;37(3):277-285. doi:10.1016/j.jsat.2009.03.002).

Within one year of initiating its new Medication-Assisted Treatment program in all state adult correctional facilities, the state of Rhode Island observed a 60 percent decrease in the proportion of recently incarcerated individuals who suffered a fatal overdose. The state also observed a 12 percent overall decrease in overdose fatalities compared to the previous year, which can be attributed to the deaths prevented by the prison's Medication-Assisted Treatment program (Green TC, Clarke J, Brinkley-Rubinstein L, et al. Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. *JAMA Psychiatry*. 2018;75(4):405- 407. doi:10.1001/jamapsychiatry.2017.4614).

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

HSD explains House Bill 290 is related to House Bill 43 and House Bill 342, which require BHSD to create, implement and evaluate a framework to address the behavioral health needs of adult and juvenile offenders with behavioral health diagnoses in county and local correctional facilities (state facilities were struck from House Bill 43 in the HHHC).

This bill is also related to Senate Bill 205, which would increase the Medicaid reimbursement rate to OTPs, and House Bill 298 which would remove the funding contingency for providing naloxone to inmates with Opioid Use Disorder upon release.

TECHNICAL ISSUES

HSD suggests the following:

Add “and opioid replacement” after opioid agonist on p.1 line 22

Add “or opioid replacement” after opioid agonist on p.2 line 4

Add “and opioid replacement” after opioid agonist on p.2 line 9 and on line 11.
Strike “~~a~~” on p.2 line 9 and add a “s” to provider on line 10.

Add “or opioid replacement” after opioid agonist on p.2 line 25.

Add “and opioid replacement” after opioid agonist on p.3 line 5.

p. 2, line 6 delete ~~patient preference and~~

Remove the specific measures of effectiveness to allow BHSD to determine appropriate measures. P2 line 13, add a period after program and delete ~~in assisting~~; Delete lines 14-17.

OTHER SUBSTANTIVE ISSUES

BHSD states “there would be a significant expansion of BHSD’s administrative duties to create and implement this pilot. BHSD would need a program manager to create, implement, collect data and assess this pilot and an additional State Opioid Treatment Authority (SOTA) staff to handle the increased workload created by expansion of opioid treatment programs from 16 to 20. BHSD would likely need to issue an RFP to determine which providers would be selected to provide services for the pilot.”

ALTERNATIVES

NMCD suggests the following:

NMCD proposes an alternative pilot program that focuses on inmates with identified opioid use disorders (OUD) who qualify for medication assisted therapy (MAT) and are preparing to release from prison. The pre-release facilities for NMCD are the Northwest New Mexico Correctional Facility (NWNMCF) in Grants, NM (Cibola County) and the Springer Correctional Center (SCC) in Springer, NM (Colfax County). NWNMCF serves male inmates; SCC serves female inmates. Inmates from other NMCD facilities are generally transferred to these pre-release facilities during the approximately two year period prior to release to prepare them for re-entry back to the community. Inmates with OUD who are identified by behavioral health staff as candidates for MAT through the use of standard evaluation instruments and inmate history of inability to abstain from opioid use would be initiated on Vivitrol or methadone during the final 3 months of incarceration at the pre-release facility and then transferred to community providers (e.g., community-based methadone programs) for continuation of MAT upon release). MAT would be provided in the pre-release facility by a contracted and licensed methadone or Vivitrol provider who would also work with prison case managers, probation and parole and Medicaid managed care organization (MCO) representatives to assure transition of the inmate back to the community, to include coordinated MAT service in the community. Compliance with the MAT treatment plan in the community would become a condition of parole, and non-compliance would constitute parole violation.

Additionally, the pilot could be constructed as an evaluation where inmates with OUD who are deemed candidates for the program could be randomly assigned to the treatment group or the control group. Treatment group participants would be enrolled in the MAT program at the pre-release facility and control group participants would receive standard services that already exist in NMCD prisons. Each group would then be followed longitudinally to determine if initiating MAT in New Mexico prisons decreases re-arrest and recidivism among the treatment group compared to controls. If money could be appropriated to help the NMCD provide the treatment for the pilot project, this would facilitate the pilot project.

This pilot project would help determine if MAT is really effective in NMCD prisons, and would allow the NMCD to limit the use of MAT drugs to only two prison instead of all or a larger number of its prisons. This would also enable the NMCD to work on separate protocols to try to maintain prison safety and security at the two pilot project (pre-release) facilities where MAT drugs are used for only treatment group inmates, while the numerous other NMCD facilities would continue not providing MAT to their inmates.

TE/gb/sb/al