Public Comment on Proposed Rule. 8.325.12 NMAC, Medication Assisted Treatment Services in Correctional Settings.
May 8, 2025

My name is Nathan Birnbaum, and I am a family medicine physician in Albuquerque, New Mexico. I served as expert witness for SB425, the statute to which these proposed rules are responsive.

I believe that these rules are a solid foundation upon which New Mexico's criminal legal system can finally begin to expand access to evidence-based addiction treatment. I want to commend the individuals who developed these rules as their overall contents clearly reflect attention to best practices in this field.

The expansion of medication for addiction treatment (or MAT) in the New Mexico Corrections Department (NMCD) will decrease overdoses, stem the spread of infectious diseases, save lives, and improve the safety and stability of families and communities.

In what follows, I will provide overall and then part-specific constructive feedback for these proposed rules.

As a general comment, I believe that these rules should make explicit that the NCMD must offer MAT at facilities even in the absence of counseling or other behavioral health services. Such an approach would be consistent with best practices and data showing that medications such as methadone and buprenorphine reduce risk of death even without counseling services. I worry that without inclusion of such language we may put patients at risk of being denied treatment due to NMCD staffing/hiring issues or outdated approaches to addiction treatment.

In part 12.5A: The implementation date of these proposed rules must be updated to reflect the March 5th legal settlement between Disability Rights New Mexico and the NMCD. Under this agreement, within 90 days of the promulgation of these rules, NMCD must provide for continuity of buprenorphine for individuals who were on it prior to booking in the Department. Including the settlement's implementation dates in part 12.5A will prevent confusion and ensure that treatment is continued as soon as possible for individuals who are taking buprenorphine-based products.

In part 12.9B1 – there needs to be a clear timeframe attached to any preliminary substance use disorder screening during the intake process. Delay of such screening may result in individuals unnecessarily entering withdrawal from their evidence-based treatment in violation of their rights. I would argue that such screening should take place no later than 24 hours after entrance into the NMCD. Such a timelines must be prescriptive given NMCD's history of neither systematically screening for substance use disorder nor providing evidence-based treatment for substance use disorder.

In part 12.9C3 – these rules state that "the decision as to which FDA-approved medication is prescribed, dispensed and administered shall be made by the healthcare provider in consultation with the program participant, taking into consideration security, health and safety level, and community resource availability." The use of "security, health, and safety level" is overbroad and

provides license for abuse by NMCD. What exactly is a “health level”? How does a clinician account for “security” in their prescribing practices? Further, why should a clinician’s judgment be clouded by these non-clinical considerations? For example, it is wholly inappropriate to bring “security” into any discussion around evidence-based treatment. As a clinician, I would not defer to a correctional officer if I was deciding whether to continue a patient’s blood pressure medication or whether to manage their diabetes with insulin or an oral medication. Addiction treatment is no different – the decision about which medication will be most appropriate for a patient should be made between an experienced clinician and the patient. The (Hippocratic) oath of a provider relates to the care of their patients – not an ill-defined measure of “security level.” SB425 was written to guarantee access to all three FDA approved medications for MAT in order to increase treatment flexibility, choice, and provide as much autonomy to patients and their providers as possible. The wording in this section threatens that goal and forces providers into an unacceptable situation of “dual loyalty.”

In part 12.9F4: This clause is written as a mandate to conduct a supervised taper for patients if they are returning to a region or community that “does not have resources available to continue treatment.” The language here is too general and ripe for abuse. What “resources” are being referenced – prescribers of MAT, behavioral health support for people with substance abuse disorder, or both? What criteria will be used to determine if enough resources are available? What is the threshold that NMCD will use to determine if one person deserves treatment at release while another does not? At the patient level, this will lead to relapse and death. People are nearly 130 times as likely to die of a drug overdose in the first two weeks after release from prison when compared to the general population. People will leave NMCD without the support of the medications on which they have come to rely on for stability and cravings reduction, without any physiologic tolerance, and will be set up to fail. This language provides absolutely zero incentive for NMCD to improve its linkage to care services for patients on MAT and will allow the Department to simply wipe its hands of anyone who lives in underserved communities in our state. This cannot be the case. While I absolutely understand that our state is under-resourced, it is the responsibility of NMCD to work hard to link patients to care after release. The NMCD, the Department of Health, State Medicaid and its managed care organizations, and the Healthcare Authority (HCA) should be collaborating on how to expand access to MAT services to our rural and at-risk populations, not creating rules that provide an excuse for potential inaction.

Finally, in part 12.12D, I hope that these rules can better define the measures of evaluation of these MAT programs to allow for parity across each prison in our state. Each prison and evaluation team should know from the start what measures they are responsible for collecting and monitoring. If this is not defined from the start, it will create significant burdens for HCA when it is required to give annual reports to Legislative Finance and the Interim Health and Human Services Committees, respectively. I would recommend the following be included in annual reports (at minimum): an analysis of the impact of such programs on participating incarcerated individuals, including factors such as rate of opioid overdose mortality on reentry before and after correctional MAT programs implementation, behavior infractions, recidivism rates, HIV and hepatitis C treatment rates, programs participation (including information regarding participation among postpartum and breastfeeding participants), and programs retention, among related relevant factors. The following specific data points should also be included in the report: number of

incarcerated individuals assessed to have a substance use disorder; and number of participants in the MAT programs and recidivism rates of those participants.

Thank you for your time and consideration of my comments.

Nathan Birnbaum, MD, AAHIVS
Albuquerque, NM