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May 8, 2024

Human Services Department
Office of the Secretary
Attn: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, NM 87504-2348

RE: Proposed rule 8.325.12, “Medication Assisted Treatment Services in Correctional Settings”

On behalf of the Vital Strategies Overdose Prevention Program, we write to offer input on the Human Service Department’s (“Department”) proposed rule to govern the delivery of medication assisted treatment (MAT) for substance use disorder (SUD) in correctional facilities. Vital Strategies is a registered 501(c)(3) nonprofit organization headquartered in the United States with a mission to support strong public health systems around the world. The Overdose Prevention Program works in various U.S. states, including New Mexico, to catalyze data-driven solutions for an equitable and sustainable reduction in overdose deaths and access to care for people with SUD.

The country’s overdose crisis continues unabated, with data from the Centers for Disease Control and Prevention (CDC) showing that overdose deaths surpassed 100,000 last year alone.[1] Treatment for opioid use disorder (OUD) with agonist medications buprenorphine and methadone[2] is most effective at reducing overdose and serious opioid-related acute care relative to other treatments, such as naltrexone or inpatient detoxification or residential services.[3] Agonist medications for OUD are associated with an estimated mortality reduction of 50% among people with OUD, supporting the conclusion of the National Academies of Sciences, Engineering, and Medicine in 2019 that “[t]he verdict is clear: effective agonist medication used for an indefinite period of time is the safest option for treating OUD.”[4]

The enactment of 2023 New Mexico Senate Bill 425 and the proposed rules implementing the legislation are major milestones for advancing overdose prevention in New Mexico. Vital Strategies commends the state on these noteworthy achievements, which will undoubtedly save lives, and offers these recommendations to further clarify and strengthen the proposed rules.

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[1] Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2023.
[2] Also referred to throughout as “MOUD,” meaning medications for opioid use disorder. MOUD is synonymous with medication assisted treatment (“MAT”) and medications for addiction treatment.
[3] Wakeman SE, Larochelle MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. JAMA Network Open. 2020;3(2):e1920622.
[4] National Academies of Sciences, Engineering, and Medicine. Medications for opioid use disorder save lives. (Leshner AI, Mancher M, eds.). Washington, DC: The National Academies Press; 2019.

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I. Harmonize the use of key words and ensure readability.

Vital Strategies recommends that the Department ensure consistency in the use of key terms throughout the rule. For example, proposed NMAC 8.325.12.7(Q) offers a definition of "program participant," but in numerous provisions of the proposed rule, "participant" is used instead of "program participant."[5] There is also inconsistency in how the proposed rule and the Notice of Rulemaking refer to the issuing agency. Whereas proposed NMAC 8.325.12.1 refers to the New Mexico Health Care Authority, proposed NMAC 8.325.12.12(D) and the Notice of Rulemaking refers to the Human Services Department.

We also urge the Department to consider modest changes to promote readability, including conventions around capitalization of proper nouns and consistent use of abbreviations.

II. Clarify language outlining effective dates.

The Notice of Rulemaking provides that "the Department proposes to *implement* this rule September 1, 2024" and then specifies December 31, 2025 and June 30, 2026 as *effective* dates for specific required services in correctional facilities operated by the New Mexico Corrections Department (NMCD).[6] These effective dates mirror corresponding dates in the authorizing statute for the proposed rule,[7] but proposed NMAC 8.325.12.5 states that the effective date is September 1, 2024 "unless a later date is cited at the end of a section."[8]

These divergences beg the question of precisely which provisions of the proposed rule will go into effect on September 1, 2024, and for which correctional facilities. It is also unclear whether a facility with a *currently* operational program for medication continuation or initiation will be subject to the standards in the proposed rule as of September 1, 2024, relative to the later effective dates in proposed NMAC 8.325.12.5(A)-(B) and 8.325.12.9(B)(3). As currently drafted, Vital Strategies is concerned that correctional facilities may withhold necessary care because they interpret the rule's substantive provisions as having no effect until December 31, 2025.

Clarity on these points is essential for facilities that will be subject to the final rule and the numerous stakeholders throughout New Mexico committed to promoting access to care for

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[5] *See e.g.,* proposed NMAC 8.325.12.9(C)(5) or 8.325.12.10(B(3)(d)(iii).
[6] Emphasis added.
[7] NMSA 24-1-5.11(D)(2)-(3).
[8] Only proposed NMAC 8.325.12.9(B)(3) specifies such a later date.

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SUD in prisons and jails.[9] We also point out that denial of medication treatment for SUD in correctional facilities constitutes illegal disability-based discrimination.[10]

Vital Strategies also recommends language in this section and throughout that reinforces the voluntariness of all program services. In that vein, proposed NMAC 8.325.12.5(B) could be revised to read "By June 30, 2026, NMCD operated correctional facilities *shall offer medication-assisted treatment to all people who are incarcerated in state correctional facilities and in need of medication-assisted treatment.*" This revision would mirror the language of the authorizing statute, make clear that these services are voluntary, and eliminate the otherwise undefined and ambiguous term "qualified."[11,12]

III. Refine or expand the definitions for key terms.

a. *Proposed NMAC 8.325.12.7(B) ("Clinical assessment")*

We recommend consulting the definition for "assessment" in the Legislative Analysis and Public Policy Association's (LAPPA) *Model Access to Medication for Addiction Treatment in Correctional Settings Act.*[13] This is a broader term which encompasses the collection of information beyond strictly clinical data.

b. *Proposed NMAC 8.325.12.7(C) ("Community-based provider")*

An entity that provides SUD treatment services in the community is not mutually exclusive with an entity that provides SUD treatment services in a correctional facility. We suggest a revised definition that accommodates providers that offer services in both kinds of settings: an entity

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[9] For instance, the March 2024 settlement agreement between Disability Rights New Mexico and NMCD includes terms that specifically invoke the effect date of this rule. Order and Settlement Agreement at 5, Disability Rights New Mexico Inc. v. Tafoya Lucero, et al., No. 1:22-CV-00954-WJ-JFR (D.N.M. Mar. 5, 2024) ("Within 90 working days of the effective date of the final rules in § 24-1-5.11(B), Defendants agree to implement a pilot program to provide buprenorphine treat regimens for inmates entering the NMCD's custody that are currently receiving MOUD under the supervision of a qualified, licensed medical provider until NMCD fully implements the continuity program under § 24-1-5.11(D)(2)."). Available at https://storage.courtlistener.com/recap/gov.uscourts.nmd.482010/gov.uscourts.nmd.482010.59.0.pdf

[10] Federal courts and DOJ have made clear that discrimination based on an individual's lawful use of medications, including MOUD, constitutes illegal disability-based discrimination. *See* U.S. Department of Justice Civil Rights Division. The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery. 2022. Available at https://archive.ada.gov/opioid_guidance.pdf. *See also* Legal Action Center. Cases Involving Discrimination Based on Treatment with Medication for Opioid Use Disorder. 2022. Available at https://www.lac.org/assets/files/Cases-involving-denial-of-access-to-MOUD.pdf (summarizing numerous legal challenges to the denial of MOUD in correctional settings over the past 5+ years).

[11] NMSA 24-1-5.11(D)(3).

[12] The term "qualified" also appears in proposed NMAC 8.325.12.9(G)(2).

[13] Legislative Analysis and Public Policy Association (LAPPA). Model Access to Medication for Addiction Treatment in Correctional Settings Act. 2020. Available at https://legislativeanalysis.org/wp-content/uploads/2021/03/Model-Access-to-Medication-for-Addiction-Treatment-in-Correctional-Settings-Act-1.pdf

that provides substance use disorder (SUD) treatment in the community rather than, *or in addition to*, a correctional facility.[14]

c. Proposed NMAC 8.325.12.7(D) and (E) ("Correctional facility" and "County detention facilities")

1. The definitions of "Correctional facility" and "County detention facilities" are specific to adults, which we recognize aligns with the definition of "correctional facility" in the authorizing statute.[15] However, we note that overdose death rates have increased dramatically among young people in New Mexico in recent years.[16] MAT is considered the standard of care to treat adolescents with opioid use disorder according to the American Academy of Pediatrics, the Society for Adolescent Health and Medicine, and the American Society of Addiction Medicine.[17,18,19] Vital Strategies recommends that the Department consider how the final rule could promote access to evidence-based SUD treatment for youth in juvenile detention facilities.

2. The proposed rule defines "Correctional facility" differently than the authorizing statute.[20] While the definitions appear initially similar, there are important differences that require

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[14] Where the rule directs referral of program participants to a community-based provider, we recommend that lower-barrier outpatient settings be the default. Please note our comments on proposed NMAC 8.325.12.9(E)(3) to this effect.
[15] NMSA 24-1-5.11(E)(1)("'correctional facility' means a prison or other detention facility, whether operated by a government or private contractor, that is used for the confinement of adult persons who are charged with or convicted of a violation of a law or ordinance").
[16] Between 2019 and 2021, the number of overdose deaths among young people 0-24 in New Mexico more than doubled. KFF. State Health Facts: Opioid Overdose Deaths by Age Group 1999-2021. Available at https://www.kff.org/statedata/collection/opioid-epidemic/.
[17] American Academy of Pediatrics. Medication-Assisted Treatment of Adolescents with Opioid Use Disorder. 2016. Available at https://publications.aap.org/pediatrics/article/138/3/e20161893/52715/Medication-Assisted-Treatment-of-Adolescents-With?autologincheck=redirected ("The American Academy of Pediatrics (AAP) advocates for increasing resources to improve access to medication-assisted treatment of opioid-addicted adolescents and young adults.")
[18] Society for Adolescent Health and Medicine. Medication for Adolescents and Young Adults with Opioid Use Disorder. Journal of Adolescent Health. 2021;68(3): 632-636 ("All adolescents and young adults with opioid use disorder should be offered medication for opioid use disorder as a critical component of an integrated treatment approach that includes pharmacologic and non-pharmacologic strategies.")
[19] American Society of Addiction Medicine. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. 2020:58; Accessed May 7, 2024. https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline ("Clinicians should consider treating adolescents who have opioid use disorder using the full range of treatment options, including pharmacotherapy.")
[20] Proposed NMAC 8.325.12.7(D) defines correctional facility as "[a] state prison or county detention facility, whether operated by a government or private contractor, that is used for the confinement of adult persons." By comparison, the definition in NMSA 24-1-5.11(E)(1) is "a prison or other detention facility, whether operated by a government or a private contractor, that is used for confinement of adults persons who are charged with or convicted or a violation of a law or local ordinance." Comparing the two, Vital Strategies highlights the inconsistency between "adult persons" versus "adult persons who are charged with or convicted of a violation of a law or an ordinance" and "state prison or county detention facility" versus "state prison or other detention facility."

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reconciliation in the final rule. Vital Strategies urges the Department to define "correctional facility" as broadly as possible to maximize the number of people with SUD who are able to receive evidence-based treatment during any episode of confinement, detention, or incarceration.

3. The definition of "county detention facility" in proposed NMAC 8.325.12.7(D) and definition of "correctional facility" in proposed NMAC 8.325.12.7(E) conflict. More specifically, proposed NMAC 8.325.12.7(E) defines "correctional facility" to include "county detention facility" and specifies that such a facility may be operated by a "government or private contractor," while the definition of "county detention facility" in proposed NMAC 8.325.12.7(D) is limited to detention centers operated by "a local government." We propose that the Department define these terms to ensure expansive provision of services, regardless of whether a county detention facility is operated by a private contractor or a local government. A revised and expanded definition under NMAC 8.325.12.7(D) that resolves this conflict could read:

   > *A state prison or other detention facility, whether operated by a government or private contractor, that is used for the confinement of adult persons.*

4. Vital Strategies recommends that the Department add a definition of "incarceration," which is a term appearing throughout the authorizing statute and in many substantive components of proposed NMAC 8.325.12.[21] However, some provisions of the proposed rule, such as proposed NMAC 8.325.12.9(B)(3), refer to "inmates *or detainees,"* which is arguably broader.[22] We therefore propose that the final rule broadly define "incarceration" to include *any* type of confinement or detention.

d. Proposed NMAC 8.325.12.7(F) ("Discharge Planning")

"Discharge planning" does not appear anywhere else in the proposed rule, although "discharge services" appears in proposed in proposed NMAC 8.325.12.9(F). We emphasize the importance of conformity between defined terms and the language of the final rule as a whole.[23]

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[21] NMSA 24-1-5.11.
[22] Emphasis added.
[23] There are other instances of this kind of inconsistency. For example, there are numerus references to "treatment program" and "program" throughout the rule but this is not defined in proposed NMAC 8.325.12.7. Similarly, proposed NMAC 8.325.12.9(A) outlines requirements for a "facility," which is not a defined term (the defined terms are "correctional facility" and "county detention facilities," respectively).

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e. *Proposed NMAC 8.325.12.7(I) and (J)*
("Medication for opioid use disorder (MOUD)" and "Medication-assisted treatment (MAT)")

The proposed rule includes definitions for both medication for opioid use disorder (MOUD) and medication-assisted treatment (MAT) and collapses these two terms in a single heading proposed NMAC 8.325.12.9(C). Vital Strategies believes that the inclusion of both these terms and their merging in this way will cause confusion in the final rule, particularly since MAT can be defined and understood as inclusive of MOUD. However, the final rule's definition of MAT should more closely reflect the authorizing statute: "medication-assisted treatment means the use of federal food and drug administration-approved prescription drugs for the treatment of substance use disorder."[24] **Defining MAT as necessarily being used "in combination with counseling and behavioral therapies" is inconsistent with NMSA 24-1-5.11(E)(2) and is also a significant departure from federal and other authoritative guidance discouraging the conditioning of medication treatment on receipt of counseling.**[25,26] Indeed, although some patients may benefit from more intensive counseling supports in conjunction with medication, evidence does not support policies mandating that patients receive counseling.[27,28,29,30]

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[24] NMSA 24-1-5.11(E)(2). Proposed NMAC 8.325.12.7(S), which defines "screening", is only place that "dependency" appears in the entire rule, despite numerous program requirements ostensibly intended to address the substance dependence (e.g., proposed NMAC 8.325.12.10(B)(3) covers withdrawal management).

[25] *See* Substance Abuse and Mental Health Services Administration. Low Barrier Models of Care for Substance Use Disorders. *Advisory.* Publication No. PEP23-02-00- 005. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2023. Available at https://store.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-pep23-02-00-005.pdf ("If desired by the individual, counseling can teach new ways to make healthy choices and handle stress. While counseling should be offered to patients, the provision of medication should not be contingent upon participation or engagement in a set counseling schedule.")

[26] *See also* American Society of Addiction Medicine. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. 2020:37; Accessed May, 7 2024. https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline ("A patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacological treatment of opioid use disorder, with appropriate medication management.")

[27] Centers for Disease Control and Prevention. Linking People with Opioid Use Disorder to Medication Treatment: A Technical Package of Policy, Programs, and Practices. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Department of Health and Human Services, 2022. "Engaging in social supports or behavioral health interventions alongside MOUD does not consistently improve treatment outcomes and may not be an appropriate requirement or pre-requisite for MOUD."

[28] Weiss RD, Potter JS, Fiellin DA, et al. Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence: A 2-Phase Randomized Controlled Trial. Arch Gen Psychiatry. 2011;68(12):1238–1246.

[29] Fiellin DA, Pantalon MV, Chawarski MC, Moore BA, Sullivan LE, O'Connor PG, Schottenfeld RS. Counseling plus buprenorphine-naloxone maintenance therapy for opioid dependence. N Engl J Med. 2006 Jul 27;355(4):365-74.

[30] Fiellin DA, Barry DT, Sullivan LE, Cutter CJ, Moore BA, O'Connor PG, Schottenfeld RS. A randomized trial of cognitive behavioral therapy in primary care-based buprenorphine. Am J Med. 2013 Jan;126(1):74.e11-7.

f. Proposed NMAC 8.325.12.7(H) and (U) ("Healthcare practitioner" and "Substance use disorder treatment")

Vital Strategies recommends that the Department modify the definitions for "healthcare practitioner" and "substance use disorder treatment" to ensure that that the listed types of professionals and settings are understood as inclusive and not exhaustive.[31]

g. Proposed NMAC 8.325.12.7(V) ("Tapering guidelines")

The definition of "tapering guidelines" appears to be a definition of tapering. We suggest that "guidelines" be removed for clarity.

h. Proposed NMAC 8.325.12.7(Y) ("Detoxing")

"Detoxing" is an outdated and stigmatizing term and should be eliminated or replaced.[32]

IV. Address ambiguities and enhance provision of services in the required program elements.

a. Screening and referral (proposed NMAC 8.325.12.9(B)).

The final rule should ensure that appropriately qualified medical personnel are responsible for key aspects of the protocol(s) for screening, assessment, and referral. To illustrate, proposed NMAC 8.325.12.8(B)(1) stipulates that "[a] preliminary SUD screening shall be administered" but not by whom. For smaller facilities with limited staffing capacity, this may be accomplished by custody and/or facility staff with appropriate training and oversight by a qualified clinician or by having qualified healthcare practitioners conduct screening remotely through telemedicine.[33]

Proposed NMAC 8.325.12.9(B)(1)(a) and (B)(2)(a) both invoke "best practice and accepted general SUD guidelines" but these terms are not defined in proposed NMAC 8.324.12.7, nor do they have a commonly understood meaning. Vital Strategies suggests replacing this language with "evidence-based practices consistent with current scientifically-based tools, protocols, or guidances for SUD treatment

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[31] These changes would be consistent with, e.g., the language in proposed NMAC 8.325.12.7(E)(5) ("Reentry services…shall include, *but not be limited to*:") (emphasis added).

[32] For example, SAMHSA opted to remove outdated and stigmatizing language in its recent revisions to 42 CFR Part 8. *See* 89 Fed. Reg. 7541 ("Further to this, the terms `maintenance' and `*detoxification*' reference outdated terminology that has potentially hindered adoption of evidence-based treatments for OUD. The amended title reflects current medical terminology and highlights that OUD is a chronic, treatable condition.") (emphasis added).

[33] *See, e.g.*, American Society of Addiction Medicine. Proposed Framework for The ASAM Criteria, Fourth Edition Volume 3: Correctional Settings and Community Reentry. Accessed May, 7 2024. https://rb.gy/7j0zfq (**"**A smaller jail or prison with fewer resources may fulfill this expectation [of screening] by having custody and/or other facility staff receive training and supervision to perform this screening or by having healthcare professionals conduct screening remotely via telemedicine.")

and services."[34] It is important that the final rule incorporate reference to valid and authoritative clinical resources while also leaving space for a growing research base and the emergence of future standards, e.g., around care for stimulant use disorder.

Vital Strategies urges the Department to revise proposed NMAC 8.325.12.9(B)(2)(b) so that it does not inadvertently reinforce a treatment approach based chiefly on abstinence rather than holistic wellness and patient treatment goals. To that end, the Department should delete the word "cessation."[35]

b. Medications (proposed NMAC 8.325.12.9(C)).[36]

In reviewing proposed NMAC 8.325.12.9(C) as a whole, we have identified several changes that would better promote individualized and patient-centered care consistent with New Mexico law and federal anti-discrimination protections.

1. Medication provision and selection.

As currently drafted, proposed NMAC 8.325.12.9(C)(3) requires healthcare providers to consider broad, ambiguous, and explicitly non-medical criteria when determining which FDA-approved medication to prescribe, dispense, and administer, potentially undermining the responsibility of correctional facilities to ensure access to *all* FDA-approved medications for the treatment of SUD. The decision of which medication a program participant receives must be based on an individualized ***medical*** assessment made by a licensed healthcare provider in consultation with the participant. "Security" and "safety level" within a correctional facility simply do not square with this type of assessment and should be eliminated by the Department in its final rule.

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[34] Examples of such tools would be the American Society of Addiction Medicine's (ASAM) clinical guidelines, SAMHSA's numerous Treatment Improvement Protocols (TIPS), as well as resources specific to correctional settings, such as those from the National Commission on Correctional Health Care.

[35] This adjustment would make proposed NMAC 8.325.12.9(B)(2)(b) more consistent with the definitions section, and also reflect the broader shift toward low-barrier treatment approaches. *See, e.g.*, Substance Abuse and Mental Health Services Administration. Low Barrier Models of Care for Substance Use Disorders. *Advisory.* Publication No. PEP23-02-00- 005. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2023. Available at https://store.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-pep23-02-00-005.pdf

[36] Vital Strategies queries whether "MAD" in this section heading is a typographical error. Note also our comments on proposed NMAC 8.325.12.7(I) and (J) above. Regardless of whether the Department ultimately elects to go with medication-assisted treatment, medication for addiction treatment, or something else, it must take care that proposed NMAC 8.325.12.9(C) does not function to exclude medications that may be approved by the FDA in future for the treatment of substance use disorders.

Additionally, and in the same vein, it is not clear to us why proposed NMAC 8.325.12.9(C)(3)(a) is specific to "OUD medication." The substantive provisions in (C)(3)(a)(i)-(ii) appear equally applicable to other SUD medications. Proposed NMAC 8.325.12.9(C)(4) raises similar concerns, as we do not see a justification for confining this provision to MOUD relative to medications for SUD generally.

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Additionally, while we acknowledge that "community resource availability" may be a factor in an individualized medical assessment, e.g., a program participant may prefer to receive buprenorphine relative to methadone to treat their SUD because there is not an OTP in their home community, the assessment of this factor must be individualized and responsive to program participant needs and preferences. In other words, under no circumstances may a correctional facility cite a lack of community resource availability as a basis for not offering a particular medication as part of its overall program. In our 5+ years of experience working toward expanded medication treatment for SUD in correctional facilities, limited community treatment capacity comes up time and again as a barrier among prisons and jails to implementing these lifesaving services.

We therefore strongly urge the Department's final rule remove these criteria as bases for determining which medication a participant receives. A revised NMAC 8.325.12.9(C)(3) could read simply: "*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.*"

2. Medication dosage.

Proposed NMAC 8.325.12.9(C) should be revised to include language around determination of medication dosage, whether at initiation or for longer-term maintenance. Whereas there are protections around the *type* of medication in proposed NMAC 8.325.12.9(C)(1) and (C)(3), there are no corresponding protections as to the *dose*. Setting and adjustment of medication dosage must be based on an individualized medical assessment made by a qualified healthcare provider in consultation with the program participant. This is important for the Department to address, as arbitrary dosage limits are a common problem, particularly for agonist mediations buprenorphine and methadone to treat OUD,[37] and policies which restrict dosages based on factors other than an individualized medical assessment violate federal anti-discrimination laws.

3. Medication changes.

In proposed NMAC 8.325.12.9(C)(3)(a), we advise that the Department substitute "shall commence" with "*may* commence, *only* if" to emphasize that transferring to a different medication is an elective and voluntary process for which basic safeguards must be in place. In addition, the Department could

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[37] *See, e.g.*, Substance Abuse and Mental Health Services Administration. Low Barrier Models of Care for Substance Use Disorders. *Advisory.* Publication No. PEP23-02-00- 005. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2023. Available at https://store.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-pep23-02-00-005.pdf (Part of a low barrier treatment approach is flexibility, including that "[m]edication dosage and duration of therapy are individualized.")

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modify (C)(3)(a)(i) to read "the new medication is deemed medically necessary by a *qualified* healthcare practitioner *and the program participant consents to the change*" and (C)(3)(a)(ii) to read "the program participant elects to commence the new medication*, the new medication is FDA-approved to treat the program participant's SUD, and a qualified* healthcare practitioner *does not identify any absolute contraindication to the change*."[38]

Even where a program participant elects to switch medications, they should always retain the choice to return to their original regimen or another option. Furthermore, someone who discontinues a medication should always retain the choice to re-initiate that or another regimen, including periods of treatment interruption of any duration due to time spent in a local jail or other detention facility. The Department should integrate language to this effect in the final rule, which could fit in this section and/or proposed NMAC 8.325.12.9(G) on program participant safeguards.

4. Response to medication.

Proposed NMAC 8.325.12.9(C)(5) would be improved by the replacement of "progress on" with "response to" because patient response to SUD treatment is not linear and the word "progress" implies that there should be forward motion of some kind at each provider assessment. We also suggest that the Department consider substituting "direct that" with "recommend that" to better align with patient-centered care that is always fully voluntary and reflects the patient's treatment goals.

c. Therapeutic services (proposed NMAC 8.325.12.9(D)).

Vital Strategies recommends that the Department consider adding a definition of "individualized treatment plan" in proposed NMAC 8.325.12.7 or, alternatively, offering additional detail in proposed NMAC 8.325.12.9(D)(1) on what such a plan includes. The definition of "care plan" in the recently revised federal regulations governing OTPs may serve as a starting point for the Department to consider.[39] Regardless of what the components of an individualized treatment plan, it should be underscored in the Department's final rule that such a plan is jointly agreed upon with the individual program participant.[40]

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[38] These modifications would center patient decision-making absent any serious medical contraindication that is identified by a qualified healthcare practitioner. Our suggestion to delete "authorized to prescribe the [new] medication" reflects the fact that methadone cannot be prescribed to treat SUD.
[39] *See* 42 CFR § 8.2 ("Care plan means an individualized treatment and/or recovery plan that outlines attainable treatment goals that have been identified and agreed upon between the patient and the [ ] clinical team, and which specifies the services to be provided, as well as the proposed frequency and schedule for their provision").
[40] *See, e.g.*, Substance Abuse and Mental Health Services Administration. Low Barrier Models of Care for Substance Use Disorders. *Advisory.* Publication No. PEP23-02-00- 005. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2023. Available at https://store.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-pep23-02-

Vital Strategies applauds proposed NMAC 8.325.12.9(D)(2)'s protection against the withholding of medication treatment where there is a lack of available counseling services. However, we urge the Department to strengthen and expand this protection and offer the following revision:[41]

> *(2) Group and individual counseling services with clinical support and supervision shall be provided where available. Treatment services, to include medication, shall not be withheld in the event of the lack of availability of counseling services or when a program participant declines to participate in available counseling services.*

We also recommend that the Department consider the addition of an analogous and standalone protection for program participants who decline *any* available ancillary service, not just counseling.[42] For consistency with this evidence-based orientation to SUD treatment and related services, the Department should also modify proposed NMAC 8.325.12.9(D)(3) to specify that any engagement with peer support is *voluntary.*[43]

d. Reentry (proposed NMAC 8.325.12.9(E)).

The Department's proposed requirements around reentry services would benefit from several points of clarification and elaboration. For a program participant serving a longer sentence (e.g., 10+ years) who enters treatment relatively early on in their incarceration, how would the requirement to initiate reentry planning "upon entry" to the treatment program actually operate? We encourage the Department to provide more concrete guidance as to when and how correctional facilities should begin reentry planning for program participants. In our view, a reasonable requirement would be to begin reentry planning 180 days prior to release for program participants who initiate treatment at least one year

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00-005.pdf ("Respecting individual autonomy and through a shared decision-making informed consent process can enhance treatment adherence, promote a sense of autonomy, and improve overall outcomes.")

[41] Both group *and* individual counseling services should be provided when possible. As currently drafted, there is nothing stopping correctional facilities from opting to offer group counseling services and nothing else, even where individual counseling services would be feasible.

[42] This could be accomplished with the addition of the following language in proposed NMAC 8.325.12.9(D): *Treatment services, to include medication, shall not be withheld in the event that a program participant declines or refuses to participate in any ancillary service.* The inclusion of this safeguard will align with SAMHSA's recommendation that "[t]reatment engagement conditions or preconditions should not be placed on the patient," including any requirement that an individual receive multiple services simultaneously or receive treatment for co-occurring conditions. *See* Substance Abuse and Mental Health Services Administration. Low Barrier Models of Care for Substance Use Disorders. *Advisory.* Publication No. PEP23-02-00- 005. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2023. Available at https://store.samhsa.gov/sites/default/files/advisory-low-barrier-models-of-care-pep23-02-00-005.pdf

[43] It is not clear what the difference is between "qualified peer support workers" and "certified peer support workers." Proposed NMAC 8.325.12.7 includes definitions for "certified peer support workers" (12.7(A)) and "peer support workers" (12.7(P)) but not "qualified peer support workers." We also direct the Department's attention to the same question as to proposed NMAC 8.325.12.9(E)(2).

before their anticipated release date. For individuals who enter a treatment program less than one year before their projected release date or for whom the duration of confinement is unknown, reentry planning at the very outset is a reasonable requirement.

We also identified several other points needing clarification for this section. In proposed NMAC 8.325.12.9(E)(2), the requirement for peer workers to "be engaged" with the reentry process is vague. Likewise, it is not clear to Vital Strategies what the distinction is between proposed NMAC 8.325.12.9(E)(3) and (4). As we understand these two provisions, they could be consolidated into a single requirement that anyone who meets criteria to receive MAT is referred to a community-based provider upon release, regardless of whether they received medication treatment while incarcerated. Furthermore, we recommend that the default be referral to outpatient community-based providers, which will tend to be lower-barrier and easier to access for program participants returning to their communities. However, program participants should have the option for referral for other kinds of community-based providers. This could be accomplished with the following revision: "Facilities shall ensure referral to an outpatient, community-based provider; provided, however, that a facility shall provide a referral to an inpatient, residential, or other community-based provider upon the request of a program participant."

Finally, we propose that the Department enhance the comprehensiveness of resources outlined in proposed NMAC 8.325.12.9.(E)(5)(c) to include referral to harm reduction services and legal services.

e. Transitional services (proposed NMAC 8.325.12.9(F)).

Transitional and discharge services are an essential opportunity to reduce the vulnerability of people leaving correctional facilities to fatal overdose and other negative health outcomes. Vital Strategies recommends that proposed NMAC 8.325.12.9(F)(2)(c) be modified to also include provision of a 30-day supply of buprenorphine products, as well as any other prescribed and over-the-counter medications and necessary durable medical equipment. As in some other jurisdictions, obtaining buprenorphine at a pharmacy can pose challenges in New Mexico because of inadequate stocking and other issues.[44] Recognizing that program participants may encounter these kinds of challenges in their home communities, a 30-day supply of medication at discharge would reduce the likelihood of interruptions in

[44] Lowerre, K. (2023). Buprenorphine Access at NM Pharmacies: Fall 2022. NMDOH.

treatment and give program participants more time and flexibility to identify a reliable option to fill a buprenorphine prescription in their community.[45]

Proposed NMAC 8.325.12.9(F)(3) and (4) are specific to medications for opioid use disorder (MOUD), although these provisions outline services that should be provided as to any medication for addiction treatment. Here and elsewhere throughout the rule, we request that the Department ensure that required program elements are not inadvertently confined to MOUD and instead encompass all current and future medication options for the treatment of substance use disorders.

We also urge the Department to revisit proposed NMAC 8.325.12.9(F)(4) and add language specifying that discontinuation of medication in this scenario should be a last resort. Correctional facilities should first exhaust alternatives to medication discontinuation (e.g., such as the program participant switching to another medication or exploring telehealth options) *and* program participant preferences must also be integrated into a tailored approach. To illustrate, a patient may be okay with traveling a long distance from their community to access methadone at an OTP. Even absent these recommended additions, the Department should offer more guidance in the final rule on what it means for a community or region to "not have resources available to continue treatment."

f. Program participant safeguards (proposed NMAC 8.325.12.9(G)).

Vital Strategies commends the Department's inclusion of safeguards for program participants in the proposed rule and respectfully offers the following suggested enhancements and/or additions:

1. Add protections against program exclusion, program expulsion, or other punitive responses with respect to drug screens that are positive for illicit drug use or that are negative for prescribed medication(s);
2. Add a protection against program exclusion or expulsion with respect to administrative or disciplinary segregation;
3. Add a protection against punitive or disciplinary changes in medication type or dosage;
4. Add a protection against denial of services based on brief interruptions in MAT, including interruptions of any length caused by confinement in a local jail;
5. Prohibit the establishment of any minimum length of treatment as a condition of being considered for medication continuation;

[45] It is also worth noting that the New Mexico Board of Pharmacy recently amended NMAC 16.19.6 to include language regarding the distribution of a take-home supply of medication to "an inmate upon release to avoid interruption in prescribed treatment." NMAC 16.19.6.30(C)(4)(b).

In proposed NMAC 8.325.12.9(G)(2), “qualified” is vague and the Department should clarify or eliminate this term in its final rule.

Denying or discontinuing a medication regimen for a program participant should *never* occur as a form of disciplinary action. If the circumstances in proposed NMAC 8.325.12.9(G)(5) are retained in the final rule, they should be made more exact and should apply to program services generally, not merely medications:

> *Program services shall not be denied to any eligible program participant as a form of disciplinary action unless:*
>
> *(a) The disciplinary action is in response to verified misconduct directly related to program participation;*
>
> *(b) The verified misconduct poses a direct and significant threat to the safety of the program participant or other individuals in the correctional facility;*
>
> *(c) The verified misconduct is in violation of written policy that has been provided directly to the program participant;*
>
> *(d) Other less restrictive measures to address the verified misconduct have failed and this process has been documented;*
>
> *(e) The program participant’s verified misconduct is not the result of coercion by peers or staff.*

It is also critical that correctional facilities institute basic due process protections for program participants who are accused of misconduct related to their participation in the program. At minimum, all program participants should receive a copy of written policies and rules of participation in the program, including what constitutes misconduct that may be the subject of disciplinary action. Where misconduct related to program participation is alleged, there must be a good faith effort by the correctional facility to verify whether it occurred. Grievance procedures should also be prominently displayed and communicated to participants on an ongoing basis. Program services must not be denied to program participants during the pendency of any investigatory or grievance process.

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V. Policies should safeguard participants' rights and address commonly cited challenges regarding MAT/MOUD in corrections.

Vital Strategies recognizes the value of established policies and procedures on medication diversion because this is a commonly cited challenge for MAT programs in correctional settings.[46] However, components of this the proposed rule could be clarified. For instance, the meaning of "addressing consequential strategies for diversion" in proposed NMAC 8.325.12.10(B)(1)(c) is ambiguous. We also suggest that this section of the rule be more prescriptive to ensure that there are uniform guardrails around facility responses to diversion. At minimum, the final rule should expressly state that alleged or actual medication diversion may never result in medication discontinuation in the first instance.

The reference to NMSA 31-3-11 in proposed NMAC 8.325.12.10(B)(2) is confusing because that statute is directed at courts' consideration of an individual's pregnancy or lactation status when determining bail. We suggest that the Department confirm whether this is an appropriate reference point for the development of policies and procedures on the screening and treatment of pregnant individuals.

Complex polysubstance withdrawal is the most likely to lead to mortality or other serious morbidity among people who are incarcerated,[47] but proposed NMAC 8.325.12.10(B)(3)(a) only refers to COWS or its equivalent in screening for needs around withdrawal management. The Department should amend this provision to make clear that policies and procedures for withdrawal management must encompass withdrawal from substances other than opioids as well, regardless of whether it occurs in conjunction with withdrawal from opioids.

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[46] We also note that although diversion is a commonly cited challenge for MAT programs in correctional settings, our experience suggests that this problem is not as acute as widely believed. *See* Vital Strategies. A Snapshot of Medication Diversion Among 6 Jails Expanding Access to Agonist Medications for Opioid Use Disorder (MOUD) in Pennsylvania. 2022. Available at https://www.vitalstrategies.org/resources/a-snapshot-of-medication-diversion-among-6-jails-expanding-access-to-agonist-medications-for-opioid-use-disorder-moud-in-pennsylvania/. Moreover, diversion where it occurs is often driven by barriers to access and unmet need for treatment, i.e., those who are using diverted buprenorphine are doing so for therapeutic reasons. *See* Cicero TJ, Ellis MS & Chilcoat HD. Understanding the Use of Diverted Buprenorphine. Drug and Alcohol Dependence. 2018;193:117-123.

[47] Bureau of Justice Assistance. Managing Substance Withdrawal in Jails: A Legal Brief. 2022. Available at https://bja.ojp.gov/doc/managing-substance-withdrawal-in-jails.pdf ("In addition to the complexities generated by comorbidities, recent trends in drug use and composition make effective withdrawal management even more difficult. More cases of overdose deaths involving co-occurring use of opioids with other depressants (benzodiazepines or alcohol) or with stimulants (methamphetamine or cocaine) are being reported.")(internal citations omitted).

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VI. Ensure necessary training and education are informed by expert input and occur on an ongoing basis (proposed NMAC 8.325.12.11).

As currently drafted, proposed NMAC 8.325.12.11(C) and (D) outline training, education, and technical assistance requirements for which correctional facilities are responsible. Vital Strategies believes that the development and dissemination of these materials would more appropriately be the responsibility of NMCD, not individual correctional facilities. This would support uniformity of key curriculum and technical assistance materials, and likely simplify the process of offering trainings to staff from multiple correctional facilities simultaneously. Moreover, the development of training and technical assistance on SUD and educational materials aimed at stigma reduction should occur in consultation with health-focused agencies, such as the Department and NMDOH.

VII. Data collection and record keeping should enable robust monitoring and evaluation, including the identification of racial/ethnic inequities.

Vital Strategies is heartened by the inclusion of provisions on reporting, evaluation, and recordkeeping in the proposed rule. Robust data collection and evaluation are essential to assessing the impact of these services, including potential gaps and priorities for future programming. We note that although proposed NMAC 8.325.12.12(D) ostensibly applies to the reports from NMCD that are submitted each year to the Department, this is not entirely clear from the current language. We recommend that each type of report described in proposed NMAC 8.325.12.12—including (A) from the Department to the legislature; (B) from NMCD to the Department; and (C) from county correctional facilities to an unspecified recipient—contain clearly enumerated required elements. Moreover, required elements should include data on demographic information sufficient to identify any inequities in treatment access or outcomes within correctional facilities and data on treatment discontinuation (including the reasons for discontinuation).

The authorizing statute for the proposed rule provides that the Department and NMCD must report to the legislature on "the establishment and operation of mediation-assisted treatment programs in *correctional facilities*," which is defined statutorily as inclusive of county correctional facilities.[48] Thus, NMSA 24-1-5.11 does not mandate provision of MAT in county correctional facilities but where such a facility *does* operate a MAT program, reporting can be required under the current rule consistent with

[48] NMSA 24-1-5.11(C)(emphasis added). The statute defines correctional facility as "a prison or other detention facility, whether operated by a government or private contractor, that is used for confinement of adult persons who are charged with or convicted of a violation of a law or an ordinance." NMSA 24-1-5.11(E)(1).

existing law, i.e., there is no need for an additional statutory mandate as contemplated by proposed NMAC 8.325.12.12(C).

Finally, we encourage the Department to require correctional facilities to submit their standard operating procedures and policy documents to ensure substantial compliance with this rule. Further, the Department should consider whether the final rule should outline the consequences for non-compliance with its provisions. Regardless of whether the Department adopts these changes, all policies and reporting should be made available to people in custody.

Vital Strategies thanks the Department for its consideration of our input. Should you have any questions, please do not hesitate to contact jrwan@vitalstrategies.org.

Sincerely,

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