A. General Background Information

1. Demonstration name, approval date, data analysis

Demonstration Details
Full Name: Medicaid Section 1115 substance use disorder (SUD) Demonstrations
SUD Implementation Plan Approval Date: 05/21/2019
SUD Monitoring Protocol Approval Date: 07/21/2020
Demonstration Approval Period: 01/01/2019 - 12/31/2023
Population: Medicaid enrollees with a diagnosis of substance use disorder
Period analyzed: 01/01/2019 (DY1 Q1) to 03/31/2021 (DY3 Q1)

Monitoring Reports and the COVID-19 Public Health Emergency
New Mexico's Mid-Point Assessment analyzes the first 2 and a quarter years of the demonstration. In this report, the baseline period for the quarterly metrics is the first year (2019) and first quarter (January 1st – March 31st) or for annual metrics, simply the first year (2019). These baseline periods were unaffected by the COVID-19 Public Health Emergency (PHE) and New Mexico did not delay or pause its implementation of the SUD demonstration. Thus, in accordance with CMS guidance (*Implications for COVID-19 For Section 1115 Demonstration Monitoring: Consideration For States*), New Mexico did not adjust their baseline reporting period for this Mid-Point Assessment. However, the arrival of the COVID-19 PHE did result in significant disruption of usual workflows within state government yielding some delays in finalizing of the monitoring reports. Thus, at the time when the Mid-Point Assessment was conducted (April 1- May 31st, 2022), the most recent monitoring reports submitted to CMS were Demonstration Year 3 (2021), Quarter 1 (January 1st-March 31st), which is 1 quarter shy of CMS' request to analyze up to Quarter 2 of Demonstration Year 3 or the official mid-point of this five-year waiver.

2. Description of demonstration's policy goals

New Mexico faces alcohol-related injury deaths 1.6 times the national average, high rates of unintentional drug overdose (opioids, benzodiazepines, methamphetamine), 1.9 times the national average for deaths from suicide, sociocultural issues as related to SUD including domestic violence, crime, poverty, unemployment, and concurrent medical complications of liver disease, mental illness, and SUD-related injuries (e.g., traumatic injuries). New Mexico's efforts to combat SUD have yielded a reduction in the rising overdose trend, from the highest rate in the states to the 13th. Yet this is still relatively high, and NM is unfortunately among the top states for alcohol-related deaths and suicides. New Mexico's Medicaid SUD policies are grounded in a literature-driven framework that SUD is influenced by multiple factors, including stress, environment, genetics, drug-induced effects, and mental health. The SUD waiver is focused on Medicaid beneficiaries with an SUD-diagnosis across all age groups and eligibility categories.

New Mexico's 1115 waiver application supports and focuses its SUD evaluation on the six goals developed by CMS:
1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs
2. Increased adherence to and retention in treatment for OUD and other SUD
3. Reductions in overdose deaths, particularly those due to opioids
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services

5. Fewer readmissions to the same or higher level of care where readmission is preventable or medically inappropriate for OUD and other SUD
6. Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs

To achieve these goals, NM established a SUD Implementation Plan in 2019 and have implemented many of the milestone-specific activities to achieve their goals. In their implementation plan, they described the current state of services and identified implementation action items to establish new services focused on the current gaps in service. The Implementation Plan is based upon American Society of Addiction Medicine (ASAM) levels of care for the continuum of care and is organized by CMS's SUD milestones.

Milestone 1: Access to critical levels of care for OUD and other SUDs

In accordance with their Implementation Plan, New Mexico has expanded access to critical levels of care for SUD. They have implemented all their planned activities within each ASAM level, including detection, outpatient, intensive outpatient, partial hospitalization, withdraw management, and medically managed inpatient withdraw.

Highlights include:

- **Detection**: Expanded training and implementation of SBIRT to physical health locations and adolescents
  - Rise in claims for SBIRT from 2018-2021: 1,878 to 4,845
- **Outpatient and Intensive Outpatient**: Expedited treatment through the Treat First clinical model, addition of crises intervention services via crisis triage centers (ASAM Level 2 withdraw management), and expanded intensive outpatient treatment level of service to OTP.
- **Partial hospitalization**: Expanded eligibility to all ages for those with SUD and expanded definitions such that hospitals with acute psychiatric services can now do partial hospitalization along with an increased reimbursement rate.
- **Withdraw management**: Expanded withdraw management codes for CTCs, RTCs, and IMDs.

Milestone 2: Widespread use of evidence-based, SUD-specific patient placement criteria

- During the first two years of their SUD waiver, New Mexico moved to ASAM level of care guidelines for SUD services and developed a BH policy manual that informs providers of specific placement, staffing, and treatment guidelines for SUD services at each level of care.

Milestone 3: Use of nationally recognized, evidence-based SUD program standards to residential treatment provider qualifications

- The state's Implementation Plan details processes for accrediting adult residential treatment centers within Medicaid to assure compliance with ASAM placement and treatment standards of care for each level.
- The state has delivered ASAM trainings across the state to clinicians funded through State Opioid Response (SOR) grants.

Milestone 4: Sufficient provider capacity at each level of care

- Significant expansion of MAT providers [see **Provider Availability Assessment**]
- Supporting telehealth expansion, particularly in rural regions of the state.
- Expanding counseling and behavioral health support practitioners (e.g., peer support workers and behavioral health counselors).

Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

- Harm reduction (distribution of naloxone, fentanyl test strips; removal of buprenorphine prior authorization)

- Primary Prevention and Provider Education (peer training on OUD, ASAM training, SBIRT integration into physical health setting)
- Prescribing (PDMP best practices, prescribing guidelines in alignment with Support Act, MCO Drug Utilization Review committee)
- Treatment (SUD as eligibility criteria for NMCL HH's, buprenorphine in OTPs, Crisis Triage Centers w/ withdraw management expertise)

Milestone 6: Improved care coordination and transitions between levels of care

- Addition of SUD diagnosis as criteria for enrollment in NM CareLink Health Homes [Milestone 5]
- Planned expansion of HH to 13 previously targeted counties is not yet accomplished
- Planned delegation by MCOs for care coordination to community agencies

B. Methodology

The independent assessor evaluated NM Medicaid's SUD waiver between years 2 and 3 of the demonstration. For all milestones, multiple data sources were reviewed (**Table 1**). For milestones determined to be low risk, we report the critical metric trends and key stakeholder interview findings. For any milestone determined to be medium risk, we provide in-depth analysis from all listed data sources below.

1. Data sources

For each milestone, we reviewed the following data sources and source of collection:

Table 1. Data Sources for Mid-Point Assessment

Data Source	Method of collection
Critical metrics	State's quarterly and annual SUD waiver monitoring reports submitted to CMS
State-specific metrics	State's quarterly and annual SUD waiver monitoring reports submitted to CMS
Implementation Plan action items	State's Implementation Plan for initial action items, as reported by the state and posted to NM's Medicaid.Gov 1115 Waiver page (https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82611)
Interviews with key stakeholders	Qualitative individual interviews were conducted with key stakeholders. These were conducted in partnership with the NM Recovery Project. These interviews utilized the method of brief transcription notes which were integrated into the Findings of this report. The interviewee's [providers, agencies, state contractors, state policy makers, Medicaid MCO leadership, service recipients] were selected for the purpose of 1) identifying progress/success of action items from Implementation Plan, 2) interpreting monitoring report critical metric

	progress, 3) current workforce availability and expansion efforts during COVID-19.
Narrative data from monitoring reports	State's quarterly and annual SUD waiver monitoring reports submitted to CMS (https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82611)
Provider availability assessment data	Milestone 4's assessment of the availability of Medicaid providers at critical levels of care including the New Mexico Recovery Project – a statewide needs assessment (focused on workforce) to verify the availability and access to SUD treatment.

2. Analytic Methods

Monitoring metrics

In accordance with CMS guidance and formulas, we evaluated the monitoring metrics at baseline (DY1 2019, Quarter 1) and at the mid-point (DY3 2021, Q1) to determine if the state is on-track to meet their demonstration targets (**Table 2**).

Table 2. Formulas for metric evaluation

Absolute change	Metric value at mid-point – Metric value at baseline
Percent change	(Metric value at mid-point – Metric value at baseline)/ Metric value at baseline

Provider availability assessment data

We evaluated the state's assessment of availability of Medicaid providers at critical levels of care to determine 1) the state's ability to provide SUD services, 2) availability of services is changing over time in ways consistent with the state's implementation plan, and 3) identify any needs for additional capacity. This assessment was conducted in collaboration with the New Mexico Recovery Project, a statewide needs assessment which occurred during 2021, examining the availability and access to SUD treatment.

Implementation plan action items: Following the state's submission of their implementation plan, no progress reports were submitted. Thus, progress on action items was determined by interviews with key stakeholders (as described below) and review of state legislation.

Interviews with key stakeholders: The independent assessor conducted key stakeholder interviews. The interviewee's [providers, agencies, state contractors, state policy makers, Medicaid MCO leadership, service recipients] were selected by assessor for the purpose of 1) identifying progress/success of action items from Implementation Plan, 2) interpreting monitoring report critical metric progress, 3) current workforce availability and expansion efforts during COVID-19. These interviews utilized the method of brief transcription notes which were integrated into the Findings of this report.

Narrative information from demonstration documents: The state's demonstration documents were evaluated by the independent assessor through text analysis, which was incorporated into Findings, as appropriate.

3. Assessment of overall risk of not meeting milestones

The independent assessor first used an analysis of the critical monitoring metrics to assess the state's risk of not achieving each milestone. Following CMS guidance, the assessor evaluated each milestone as being low, medium, or high risk – as based on percentage of critical metrics within each milestone as trending in the correct direction.

Primary Risk Assessment

Risk Level Thresholds	Low	Medium	High
Percent of critical metrics trending in correct direction for each Milestone: [(# metrics in correct direction/# total metrics) x 100]	> 75%	75%-25%	< 25%

For milestones which contained metrics which did not meet the state's goal (Metric #27, in *Milestone 5* and Metrics #17(1) and #25 in *Milestone 6*), the assessor evaluated additional data: implementation action items achieved, stakeholder feedback, and provider availability assessment.

Secondary Risk Assessment

Risk Level Thresholds	Low	Medium	High
Implementation plan action items for each Milestone [(# action items completed/# total action items) x100]	> 75%	75%-25%	< 25%
Stakeholder feedback (narrative identification of risks causing challenges meeting milestone)	Few stakeholders identified risks; risks can be easily addresses within planned timeframe	Multiple stakeholders identified risks	All stakeholders identified significant risks
Provider availability assessment (state have/expected to have adequate provider availability at critical levels of care)	Availability is adequate	Availability is not yet adequate, but moving in expected direction	Availability is not yet adequate, and is not moving in expected direction

4. Limitations

The primary data source for the Mid-Point Assessment are obtained from internal state workbooks and documents (see Data Collection Tool Appendix) which are subject to the yearly PQA and HEDIS value set changes (per CMS instructions). For one metric, the 2019-2021 overdose death rate, was verified from DOH (from where the metric is calculated before reporting to CMS) as it was reported in an atypical fashion in the workbooks. Additionally, all metrics were confirmed by the assessor team with the analytic team at MAD to confirm data accuracy. Through this work, the assessor did not identify limitations of the data sources. The quantitative analytic methods are straightforward, though calculating percent change for metrics which started at Zero or ended at Zero is mathematically odd (for example, percent change from 0% baseline to >0% at midpoint is undefined mathematically). The qualitative methods are subject to selection of a sample of stakeholders, which the assessor sought a broad array. However, it is possible that selection bias existed.

C. Findings

1. Progress towards demonstration milestones

Monitoring metrics

New Mexico Medicaid has demonstrated strong progress towards meeting demonstration milestones, as demonstrated by their performance on the critical monitoring metrics (**Table 3**). Only three critical metrics demonstrated a discordant trend with the state's goals. These are Metric #25 (Milestone 6): Readmissions among beneficiaries with SUD, Metric #17(1) (Milestone 6): Follow-up after ED Visit for Alcohol or Other Drug Dependence Metric, and #27 (Milestone 5): Overdose death rate.

Metric #27 (Milestone 5). The state experienced a rise in their OUD rate of 38.5% from 0.39 per 10,000 to 0.54 per 10,000 New Mexican Medicaid beneficiaries. This is echoed in the national rise in opioid-related deaths by 31% from 2019 (21.6 per 100,000 standard population) to 2020 (28.3). While NM's rate is above average and the rise between 2019 and 2020 is alarming, the state's 2021 data indicate a flattening in the rate of rise for OUD death rate to 0.59 per 100,000 New Mexican Medicaid beneficiaries. Within Milestone 5, the state is performing as expected on other metrics related to overdose, demonstrating declines in concurrent use of opioids and benzodiazepines (Metric #21) and use of opioids at high dosages (Metric #18).

Metric #17(1) and Metric #25 (Milestone 6). The state monitoring reports demonstrate a rise of 3.4% between 2019 and 2020 for Metric #25, or readmissions among beneficiaries with SUD. The state experienced a decline in the number and percent of MCO members who have a principal diagnosis of Alcohol and Other Drugs (AOD) abuse or dependence and who had a follow-up visit at 31-days (decline of by 38.1%) and 7-days (decline of 31.3%) with a corresponding principal diagnosis for AOD. The state performed well on two other metrics associated with Milestone 6, demonstrating strong performance on follow-up after ED visits for mental health [Metric#17(2)] and initiation and engagement of drug/alcohol treatment (Metric #15). The state does not report on Metric #16, AOD treatment provided or offered at discharge.

Table 3. Findings from Mid-Point Assessment of monitoring metrics

	Monitoring metric rate or count							
Metric #	**At baseline**	**At mid-point**	**Absolute change**	**Percent change**	**State's demonstration target**	**Directionality at mid-point**	**Progress (Yes/No)**	**Milestone risk assessment**
#5	*4,256*	*4,342*	*86*	*2.0%*	*Increase*	*Increase*	*Yes*	*Low*
#7	*323*	*721*	*398*	*123.2%*	*Increase*	*Increase*	*Yes*	*Low*
#8	*9,874*	*10,657*	*783*	*7.9%*	*Increase*	*Increase*	*Yes*	*Low*
#9	*594*	*860*	*266*	*44.8%*	*Increase*	*Increase*	*Yes*	*Low*
#10	*148*	*346*	*198*	*133.8%*	*Increase*	*Increase*	*Yes*	*Low*
#11	*21*	*78*	*57*	*271.4%*	*Increase*	*Increase*	*Yes*	*Low*

#12	*9,647*	*10,901*	*1,254*	*13.0%*	*Increase*	*Increase*	*Yes*	*Low*
#13	*4,349*	*8,525*	*4,176*	*96.0%*	*Increase*	*Increase*	*Yes*	*Low*
#14	*653*	*685*	*32*	*4.9%*	*Increase*	*Increase*	*Yes*	*Low*
#15-I[a]	*24%*	*44.9%*	*20.9%*	*87.1%*	*Increase*	*Increase*	*Yes*	*Low*
#15-I[b]	*39.0%*	*63.0%*	*24.0%*	*61.5%*	*Increase*	*Increase*	*Yes*	*Low*
#15-I[c]	*25.0%*	*50.1%*	*25.1%*	*100.4%*	*Increase*	*Increase*	*Yes*	*Low*
#15-I[d]	*25.0%*	*49.1%*	*24.1%*	*96.4%*	*Increase*	*Increase*	*Yes*	*Low*
#15-E[a]	*0%*	*16.2%*	*16.2%*	*U*	*Increase*	*Increase*	*Yes*	*Low*
#15-E[b]	*0%*	*27.7%*	*27.7%*	*U*	*Increase*	*Increase*	*Yes*	*Low*
#15-E[c]	*0%*	*16.1%*	*16.1%*	*U*	*Increase*	*Increase*	*Yes*	*Low*
#15-E[d]	*0%*	*18.2%*	*18.2%*	*U*	*Increase*	*Increase*	*Yes*	*Low*
#17(1)[a]	***35.7%***	***22.1%***	***-13.6%***	***-38.1%***	***Increase***	***Decrease***	***No***	***Medium***
#17(1)[b]	***21.1%***	***14.5%***	***-6.6%***	***-31.3%***	***Increase***	***Decrease***	***No***	***Medium***
#17(2)[a]	*49.7%*	*55.3%*	*5.6%*	*11.3%*	*Increase*	*Increase*	*Yes*	*Low*
#17(2)[b]	*35.8%*	*42.7%*	*6.9%*	*19.3%*	*Increase*	*Increase*	*Yes*	*Low*
#18	*1%*	*0%*	*-1%*	*-100%*	*Decrease*	*Decrease*	*Yes*	*Low*
#21	*15.8%*	*15.6%*	*-0.2%*	*-1.3%*	*Decrease*	*Decrease*	*Yes*	*Low*
#22	*26.6%*	*27.3%*	*0.7%*	*2.6%*	*Increase*	*Increase*	*Yes*	*Low*
#23	*5.7*	*5.2*	*-0.5*	*-8.8%*	*Decrease*	*Decrease*	*Yes*	*Low*
#25	***8.9***	***9.2***	***0.3***	***3.4%***	***Decrease***	***Increase***	***No***	***Low***
#27	***0.39***	***0.54***	***0.15***	***38.5%***	***Decrease***	***Increase***	***No***	***Medium***
#36	*19.2*	*6.5*	*-12.7*	*-66.1%*	*Maintain*	*Decrease*	*Yes*	*Low*

Table 3 Legend

#15-I[a] Initiation of AOD Treatment - alcohol abuse or dependence
#15-I[b] Initiation of AOD Treatment - opioid abuse or dependence
#15-I[c] Initiation of AOD Treatment - other drug use or dependence
#15-I[d] Initiation of AOD Treatment - total AOD abuse or dependence
#15-E[a] Engagement of AOD treatment - alcohol abuse or dependence
#15-E[b] Engagement of AOD treatment - opioid abuse or dependence
#15-E[c] Engagement of AOD treatment - Other drug use or dependence
#15-E[d] Engagement of AOD treatment - total AOD abuse or dependence
#17(1)[a] Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit
#17(1)[b] Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit
#17(2)[a] Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit
#17(2)[b] Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit
U = Undefined, the mathematical outcome of percentage change with baseline of 0%

Implementation plan action items

The independent assessor evaluated the state's initial Implementation Plan for all the Milestone. The percentage next to the Milestone indicates the percent of the implementation plan action items completed at the mid-point. The total (see **Table 4**) or denominator of the percentage of implementation action items completed excludes those action items which were planned to be completed at a date beyond June 1, 2022. As based on the implementation plan risk assessment, Table 4 demonstrates that Milestones 1-5 meet the criteria for low risk, but Milestone 6 meets high risk criteria.

Table 4. Findings from Mid-Point Assessment of implementation plan action items

Milestones	Percentage of implementation action items completed (# items/total)	Risk Assessment
Milestone 1. *Access to critical levels of care for OUD and other SUDs*	*87% (33/38)*	*Low*
Milestone 2. *Widespread use of evidence-based, SUD-specific patient placement criteria*	*80% (4/5)*	*Low*
Milestone 3. *Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications*	*90% (9/10)*	*Low*
Milestone 4. *Sufficient provider capacity at each level of care*	*100% (7/7)*	*Low*
Milestone 5. *Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD*	*80% (4/5)*	*Low*
Milestone 6. *Improved care coordination and transitions between levels of care*	*22% (2/9)*	*High*

Milestone 5. Within Milestone 5, opioid overdose rate (Metric #27), demonstrated a concerning rise between 2019 and 2020. On review of the Implementation Plan action items for Milestone 5, the state has accomplished most of its action items and is on-target to achieve the remaining items (e.g., MMIS replacement plan). Specifically, the state achieved implementation of prescribing and PMP best practices including PMP delegates, daily reporting from pharmacies, provider feedback report, opioid prescribing guidelines, and limiting prescriptions (90mme, max 7 days for new scripts, refill threshold of 90% before refill). Further, the MCOs developed a standard drug monitoring program for controlled substance utilization and SUD was added to NMCL, yielding care coordination opportunities for those with SUD. Looking to related Milestones, the state continues concerned efforts on opioid prescribing and opioid treatment (Milestone 4) with expansion of providers who deliver SUD services and SUD trainings for peers and prescribers, meeting 100% achievement of their critical metrics. Despite strong progress on the implementation plan action items, the state mirrored national trends towards a rapid rise in OUD-related mortality rates. Given the state's strong performance on the other metrics and the implementation plan, the assessor examined additional data sources [see Stakeholder and Narrative sections below] to better understand potential contributors to rising OUD rates.

Milestone 6. In review of the implementation plan items relation to Milestone 6, two of the nine action items are complete at the mid-point. These include the action items related to expanding NM CareLink Health Homes (NMCL HH) eligibility to those with SUD. CMLM HH program provides integrated care coordination services to Medicaid-eligible adults/children and was previously only available to those with a Serious Mental Illness/Serious Emotional Disturbance diagnosis. This expansion of HH eligibility to those with SUD occurred in Spring of 2021, which also corresponds to the mid-point of the SUD Demonstration. Thus, any improvements related to follow-up and care coordination would not have been realized at the time of this report. The suspended focus on HH expansion may have resulted in decreased focus on coordination of care and related metrics of readmissions (Metric #25) and follow-up after ED visit for SUD [#17(1)]. To gain improved insight into the implementation

plan status, the independent assessor examined additional data sources regarding the state's current priorities for Health Homes and coordination of care [see Stakeholder and Narrative sections below].

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD			
Action item	**Action item description**	**Date to be completed**	**Current status (completed,open, suspended)**
1	*Expand reimbursable services under home visiting initiatives to improve early identification and engagement in treatment for parents with SUD.*	---	*Complete*
2	*Continue and expand PAX Good Behavior Game.*	---	*Suspended*
3	*Add SUD to CLNM admission criteria and expand risk factor education for members with SMI, SED.*	*04/01/2021*	*Complete*
4	*Drug utilization review committee to continually adjust monitoring guidelines.*	*12/31/2019*	*Complete*
5	*Leverage the Medicaid Management Information System (MMyIS) replacement project to achieve the SUD goals that will be developed in the plan.*	*12/31/2019*	*Complete*
6	*Enhance the existing master client index (MCI) to support the state's MMIS replacement.*	*12/31/2022*	*Open (not included in denominator/item # for Table 4)*
7	*Execution and monitoring of the MMIS replacement plan.*	*12/31/2024*	*Open (not included in denominator/item # for Table 4)*

Milestone 6: Improved Care Coordination and Transitions Between Levels of Care			
Action item	**Action item description**	**Date to be completed**	**Current status (completed,open, suspended)**
1	*MCOs delegate care coordination to community agencies.*	*12/31/2024*	*Open*
2	*CLNM Steering committee to establish new requirements for SUD addition to CLNM HHs.*	*06/31/2019*	*Complete*
3	*Submit health home SPA to CMS.*	*07/01/2020*	*Complete*
4	*Solicit potential providers in 13 targeted counties.*	*12/31/2024*	*Suspended*
5	*Evaluate potential health home applications.*	*TBD*	*Suspended*
6	*Educate applicants on health home requirements and provision of additional services expected.*	*TBD*	*Suspended*
7	*Develop reimbursement per facility.*	*TBD*	*Suspended*
8	*Activate HH in 13 counties.*	*01/01/2021*	*Suspended*
9	*Repeat above steps and activate all remaining counties for Health Homes.*	*01/01/2022*	*Suspended*

Stakeholder input

As an additional data source, the independent assessor evaluated stakeholder input to gain additional insight into Milestones 5 and 6. These stakeholder interviews included providers, agencies, hospitals, state contractors, state policy makers, Medicaid MCO leadership, service recipients/patients. In accordance with CMS Technical Assistance guidance on risk assessment (**Table 4**), Milestone 5 is low risk as stakeholders identified minimal risks to continued achievement on metrics of Milestone 5, except for opioid overdose. Milestone 6 is medium risk, with multiple stakeholders identifying risks but did feel these risks could be addressed in the remaining time under the SUD waiver.

Milestone 5. In discussions with provider- and state-level stakeholders, there was a strong level of confidence and consensus the state would continue to achieve expected trends for two of the four metrics -- #18, use of opioids at high dosage in persons without cancer and #21, concurrent use of opioids and benzodiazepines. There was greater concern regarding metric #23, ED use for SUD, as noted reductions in 2020 may have been driven by COVID-related use patterns – in which nationally ED visits declined. Stakeholders felt the risk to rising ED use for SUD could be addressed by several approaches – increased MAT prescribers (particularly in the ED), focus on care coordination, and expanded levels of care other than the ED which offer withdrawal malmanagement services (e.g., CTCs).

In discussion regarding metric #27, overdose death rate, stakeholders across the spectrum of care were interviewed. Given the national rise in OUD-related deaths, no stakeholders were optimistic that the state would be able to reverse the trend of OUD overdose to 2019-levels by 2023. Stakeholders cited the increase in fentanyl-laced oxycodone ("*little blue pills*") circulating in New Mexico as a contributor to rising overdose. They commented on the state's recent efforts to distribute fentanyl test strips as very progressive, as compared to other states. As for providers in acute care, clinicians in New Mexico EDs noted significant efforts in the last year to deploy buprenorphine initiation (e.g., MAT) from the ED, including the New Mexico Bridge Program (https://nmbridge.org) which implements MAT programs in rural EDs and communities across New Mexico. Additionally, both Presbyterian and University of New Mexico are trial sites for a NIH-funded study prescribing two different types of buprenorphine formulations from the ED. An Emergency Physician stated, "*Realizing our ability to address long-standing SUD in the ED flips the sense of hopelessness some SUD patients engender to a sense of opportunity."* To address rising overdose deaths, the New Mexico Department of Health (DOH) has deployed educational opportunities for medical providers on safe prescribing practices and MAT through multiple modalities including Project ECHO. The DOH also provides academic detailing on best practices for treating chronic non-cancer pain and medication assisted treatment. Finally, the New Mexico Board of Pharmacy assists in using the Prescription Monitoring Program to identify patients who may be at risk of drug overdose. All these activities were cited as assisting NM in meeting their milestones for prescribing metrics (e.g., #18 and #21).

Milestone 6. Stakeholder data identified several risks which they felt the state can likely address in the remaining time of the SUD waiver, placing Milestone 6 at a medium level of risk. Metric #15, initiation/engagement of AOD treatment was anticipated by stakeholders to continue to demonstrate robust increases through the end of the waiver. As for Metric #17(1) and (2), follow-up after ED visit for AOD or MH as well as #25, readmissions for those with SUD, stakeholders noted that the New Mexico CareLink Health Homes (NMCL HHs) is designed to address these metrics. NMCL Health Homes are entities that provide care coordination to individuals with high behavioral health needs. In general, MCOs and providers noted, that compared to other states, NM has a robust care coordination system as all beneficiaries are assigned to care coordination if identify medium or high needs on initial risk assessment. This care coordination can be provided by MCO care coordinators or can be partially or fully delegated to community agencies. One stakeholder notes, "*NM appears to be at a higher level with continuity of care for what is offered.*" The state recently expanded eligibility for HH's to any Medicaid beneficiary with an SUD diagnosis – helping them gain access to care coordination services. However, MCO stakeholders noted that beneficiaries with SUD are some of the most vulnerable and face the greatest

challenges in connecting coordination (e.g., inconsistent contact information, difficulty with organizational tasks, concurrent mental health conditions). Those involved in HHs noted multiple factors (e.g., services offered through HHs, workforce availability for follow-up, patient factors such as transportation and poverty) which can contribute to underperformance on these follow-up metrics. Additionally, with SUD as a very recent addition to HH eligibility criteria, it is anticipated by stakeholders this will increase care coordination services for those with SUD. The assessor team interviewed hospital quality directors, finding that:

- *"We [in the ED and psychiatric ED] have been active in trying to identify and capture patients presenting with primary mental health disorder […] Up to this point … our messaging about the use of the CareLink referrals for 7/30 day follow up has been focused on mental health disorders (not necessarily patients with isolated substance abuse). If this is also a priority - and if CareLink feels they have capacity to follow up additional patient load - we could work to broaden the scope of that project*."

Stakeholders at the MCO- and state- level noted that due to COVID-19 and shifting priorities, the planned expansion of HHs was suspended, in part to needing additional resources to deploy this undertaking and in part due to the state placing significant focus on treatment expansion through new levels of care and additional providers. Despite delays in expansion, HHs have slowly gained enrollment year-over-year, even during COVID-19. This may be assisted by HHs offering of walk-in hours for in-person engagement, which allows for easier outreach for care coordination. In New Mexico, there is increased use of peer support workers, with data showing that *"peers are better at this than others"* with respect to linking patients to follow-up. While peers are not captured in the HEDIS measure for ED follow-up, continued use of peers (including the DOH's efforts on a virtual peer hub) may positivity impact patient's ability to obtain follow-up at 7- and 31-days. Telehealth may play an important role in increasing follow-up for the most vulnerable, with MCO feedback noting:

- *"We [MCOs] reported significant increases in telehealth services to all age groups, in urban, rural and frontier counties, and to all populations of SMI, SED and SUD clients. In addition to increased utilization, behavioral health providers around the state are reporting qualitative improvements – a decline in no-shows and cancellations, clients less stressed because they have not had to leave their homes or children, and therapists more informed about their clients because they can see more of their lives."*

Finally, the stakeholders note that the state is maintaining NMCL HH while planning a robust array of treatment services through CCBHCs (Certified Community BH Clinics), which are not yet developed. The current NMCL HH sites are behavioral health agencies that are part of the safety net in New Mexico. In 2016, these agencies had commenced activities to explore CCBHC status prior to implementation of the Medicaid Health Home model. As NM now commences the process of certifying CCBHCs, the current NMCL HH sites are re-examining whether they will also expand direct services to deliver the full CCBHC model of care. Thus, the assessor team specifically queried the state on planned activities related to care coordination for SUD, NMCL HHs, and CCBHCs [see Assessment of Overall Risk and Next Steps sections].

Narrative description from monitoring reports

For all Milestones, but with a focus on Milestone 5 and 6, the assessor team reviewed the narratives in the monitoring reports to determine state achievements. These narrative descriptions add improved understanding of the state's efforts which may not be captured by the metrics, implementation plan, and stakeholder interviews. This adds additional information, as the state's reporting on their overall waiver is slightly ahead of the SUD waiver monitoring reporting. At the time of this assessment, the most recent monitoring report encompasses July 1st-September 31st, 2021, which is year 8, quarter 3 (DY3/Q3) of the state's 1115 Medicaid Waiver/Centennial Care 2.0 demonstration. This corresponds to DY3/Q3

of the SUD waiver demonstration, for which the monitoring report is not yet complete. Review of the DY8/Q3 1115 NM Medicaid Waiver monitoring report provides insight into more recent achievements in SUD not yet reported for the SUD waiver.

Milestone 5. The narratives of the state's monitoring reports describe clear concern regarding opioid overdose and significant investment in multiple strategies for comprehensive treatment and prevention strategies to address opioid abuse and OUD. The reports note that *"New Mexico has made significant advances in recent years in our services to both combat and treat OUD and SUD. However, our rate of overdose deaths continues to rise. The impact of the COVID pandemic related to riskier use conditions such as isolation and the introduction of drugs laced with fentanyl have been tied to the acceleration in SUD related deaths."* As a result, the monitoring narrative states *"Therefore, much of our focus is on increasing the number of agencies and practitioners treating substance use of all types. Alcohol continues to be our highest substance but now with the emergence of fentanyl laced drugs opioid use is increasing and treatment is becoming more difficult."* The reports further highlight the state's continued efforts to implement Crisis Treatment Centers (CTCs), which can provide ASAM level 2 withdrawal management services. The narratives note that provider-specific, cost-based rates are established for the first two CTCs in the state, which began delivering services in SUD DY3 Q3 (not included in this assessment). A third CTC will begin operations by the end of 2022. The state also emphasizes its commitment to expansion of SUD treatment at all levels of care. This includes IOP, CCSS, and treatment for SUD in IMDs. Finally, as a harm reduction technique, the state now distributes fentanyl test strips along with its ongoing efforts on naloxone distribution.

Highlights of state initiatives delineated in the report narratives, in relation to SUD (e.g., Milestone 5) and organized by category:

- Harm reduction
  - Distribution of naloxone and fentanyl test strips
  - Reduced all prior authorizations for buprenorphine
  - Incentivized pharmacists to do counseling and provide Narcan at time of opioid dispersement
- Primary Prevention and Provider Education
  - NM's Office of Peer Recovery and Engagement delivers trainings with a special focus on OUD for peer support specialists to provide recovery services
  - Integrating SUD screening (SBIRT) in physical health provider locations [see Milestone 1]
  - Free ASAM and stigma training, along with ECHO programming (case support) for difficult cases
  - Leveraging health IT infrastructure (and MMIS replacement plan) to address SUD, as demonstrated by NM's strong performance on CMS' Data Quality Atlas Initiative
- Prescribing
  - Nationally recognized PDMP best practices (e.g., delegates, daily pharmacy reporting, EDIE implemented in EDs, NMCL HH)
  - Evidence-based opioid prescribing guidelines (e.g., maximum of 90MME and refill threshold of 90%)
  - Annual reporting measures tracking providers trained through Project ECHO's pain management sessions
  - MCOs' developed a Drug Utilization Review (DUR) committee: a standard monitoring program for controlled substance utilization, meets quarterly, developed enhanced supports for clinician review of patient's history via the PMP
- Treatment
  - Treatment of co-occurring mental health conditions with a primary diagnosis of SUD
  - Addition of SUD to eligibility criteria for our health homes (originally based on SMI and SED)
  - Addition of buprenorphine treatment in our opioid treatment programs (methadone facilities)
  - Newly established Crisis Triage Centers (two, planned expansion to three) with expertise in withdrawal management

- Collaboration between BHSD and NM Department of Health to place telehealth PSWs in EDs, started in 2020
- Expansion of telehealth services, as related to the PHE but also expands access to rural communities
- Implementation of Treat First Approach, allowing rapid engagement of patients in services with concurrent treatment planning

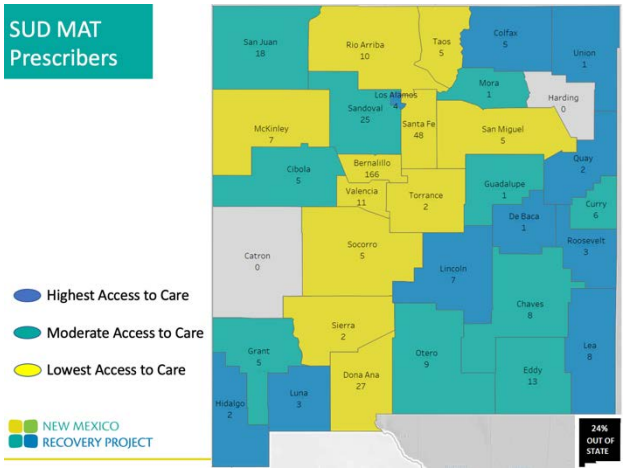
Milestone 6. The narratives note that in the middle of 2021 (DY3 for SUD waiver), CMS approved New Mexico's State Plan Amendment to add SUD to the eligibility criteria for HHs. The narrative states, *"NMCL providers have been serving members with co-occurring SMI and SUD diagnoses, so all have experience in providing SUD services."* To further support efforts to address SUDs, HSD has been working with NMCL providers to help them develop staffing and training plans to ensure members have access to an array of appropriate SUD services. At the mid-point, seven providers deliver coordinated care services at 12 sites to support integrated behavioral and physical health services. However, the narratives note that through COVID-19, *"workforce barriers increased including difficulty retaining staff, high staff turnover, and low morale – which continues to impact outreach efforts*." Despite this, narrative data demonstrates that NMCL HH enrolled did steadily increase 7% between 2019 and 2020 by 7%. Further, COVID-driven telehealth expansion is reported by the monitoring narratives to facilitate engagement of members with virtual services enabling members with transportation barriers to continue to access services.

Milestone 2. While Milestone 2 is low risk by both metric performance and implementation plan achievements, the assessor team did examine any available trends for metric #5, IMDs for SUD, given the importance of achievement in this metric for overall waiver success and in expanding care delivery for SUD. A review of the Centennial Care DY 8 (SUD waiver DY3), shows IMD claims for beneficiaries with SUD (metric # 5) was 2, 916 (Q1), 3,531 (Q2), and 2,738 (Q3) – yielding a total of 9,185. This is very reassuring, as these three quarters alone surpasses the SUD Waiver DY2's metric #5 performance (4,342).

Milestone 3. CMS technical assistance guidance notes that progress on this milestone will be assessed based on data described in milestones and in workforce assessment. The monitoring report narratives contain helpful information on activities towards Milestone 3: *Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications.* During the DY8 of Centennial Care, the state continued their work with nine new providers in completing the Adult Accredited Residential Treatment Center (AARTC) application. The narrative states, *"Four of the nine providers under review are at the initial stages of the application process and are submitting required documentation for review. Four providers are working through rate development and one provider has received approval of interim rates and has begun the process of contracting with the Managed Care Organizations (MCOs) for reimbursement."*

Provider availability assessment

As part of the Mid-Point Assessment, the independent assessor conducted a provider availability assessment. New Mexico has a longstanding shortage of behavioral health providers, including medication assisted treatment prescribers. Despite the programmatic efforts described in Milestone 5 and that Milestone 4 is low risk (MAT prescribers), New Mexico added only slightly over 100 prescribers (447 to 554) between 2018 to 2020. This gradual rise in MAT prescribers, as measured by CMS metrics, is also noted at the DOH-level. New Mexico's efforts to date have been heavily focused on training and expanding prescribing ability (e.g., X-waiver, stigma training). However, these significant efforts have not translated to a dramatic rise in clinicians prescribing – so while the number of clinicians with X-waivers may have risen significantly in New Mexico in the last few years, this is not reflected in their actual prescribing of MAT. This low number of MAT prescribers is a risk to NM's ability to prescribe medications to reduce opioid-related overdose within New Mexico. This limited availability of active MAT prescribers – which is present across both urban and rural regions (**Figure**: SUD MAT Prescribers) – provides context for the states' progress towards demonstration milestones, particularly with respect to Milestone 5 and its metric #27, opioid overdose rate.



The provider availability assessment of this Mid-Point Assessment was conducted in collaboration with the recently concluded New Mexico Recovery Project (NMRP). The NMRP, conducted during 2021, was a collaborative lead by New Mexico Department of Human Services Medicaid Assistance Division and the Behavioral Health Services Division with an overall goal of expanding the number of SUD providers statewide. This 18-month assessment grant had two aims – to conduct a needs assessment to verify the availability and access to SUD treatment and to increase SUD workforce capacity through education, training, and technical support to providers. While the NMRP identified may strengths in the ability for NM Medicaid to delivery SUD services, the key findings in the conduct of their needs assessment a limited and underprepared workforce and administrative burden which decreases access to services.

The limited workforce is manifested across behavioral health within New Mexico and is a longstanding challenge. NM faces shortages within all categories of BH clinicians including prescribers, psychologists, counselors, social workers, and nurses. Additionally, NM faces shortages in all levels of treatment including outpatient, intensive outpatient, community-based services, residential treatment, crisis care, and inpatient care. However, one area of significant expansion is with certified peer support workers to expand capacity within BH workforce. The assessor evaluated the 2021 New Mexico Workforce Report as part of their provider availability assessment, finding multiple recommendations to the state and Medicaid program as related to peer support, including:

- Add peer support services as a covered benefit for behavioral health conditions for all health plans
- Expand the scope of services reimbursed by NM Medicaid for certified peer support specialists to allow work in non-specialized behavioral health settings, such as food banks and senior centers, to facilitate engagement, coordination, and referral to BH care
- Use the Treat First approach to allow peer support workers to provide reimbursable services in EDs so they can deliver Medicaid services without a treatment plan

2. Assessment of overall risk of not meeting milestones

As based on CMS Technical Assistance and as illustrated by the data contained within this report, NM's risk on the milestones is as follows:

- Milestone 1-5: low risk
- Milestone 6: **medium risk** (at the mid-point)
  - 50% of the monitoring metrics trending in the expected direction
  - 22% of the implementation plan action items achieved

The assessor found significant achievement in the implementation plan action items related to Milestones 1-5, which is evidenced by these milestone's related metrics trending in expected directions at the mid-point. Specifically, the state placed significant emphasis on activities related to Milestones 1-5, focusing on expanding services at each level of care (Milestone 1), evolving to ASAM level of care guidelines at each level of care (Milestone 2), training and certifying ARCTs (Milestone 3), and expanding prescribers (Milestone 4), and treatment and prevention strategies for SUD (Milestone 5). This is evidence that the state's efforts are having an appreciable and positive impact. The state has expended significant effort in the advancement of Milestone 5, but are facing a devastating national trend, likely related to COVID-19, of rapid rise in opioid overdose deaths. The state is in the vanguard of harm reduction, including distribution of fentanyl test strips but could make further efforts to improve their performance (which is increasing, but minimally) in treatment of SUD in IMDs.

Milestone 6 performance is concerning, though the assessor team notes that a lack of implementation plan achievements correlates to higher risk of metric non-achievement. The assessor met with the state to review the findings of this report (May 2022). In this meeting, the state provided feedback that many items in Milestone 6's implementation plan were outdated and potentially reflected a previous administration's goals and targets. The current focus has shifted from HHs to CCBHCs – which represents a critically important effort to expand access to a broad array of centralized treatment services. The state was very responsive to recommendations by the assessor regarding either continued support and expansion for HH's care coordination process or building in care coordination aspects to the CCBHCs to address under-performance in ED readmissions and follow-up after ED visits for SUD. The state noted that the implementation plan has not been reviewed since it was originally written and was highly responsive to suggestions to update the implementation plan action items for Milestone 6 in relation to the state's increasing focus on CCBHCs.

Table 5. Summary of Mid-Point Assessment of overall risk of not achieving demonstration milestones

Milestone	Percentage of monitoring metric goals met (# metrics/total)	Percentage of implementation action items completed (# items/total)	Key themes from stakeholder feedback	Risk level	For milestones at medium or high risk, independent assessor's recommended modifications	State's responses and planned modifications
Milestone 1: Access to Critical Levels of Care for OUD and SUDs	*100% (7/7)*	*86% (33/38)*	*"Medicaid covers everything from SBIRT to Peer Support Workers."* *"The state has done a fine job meeting needs with existing Medicaid codes."*	*Low*	*None*	*None*
Milestone 2: Use of Evidence-based, SUD specific Patient Placement Criteria	*100% (2/2)*	*80% (4/5)*	*"In NM we use the ASAM continuum tool and are standardizing that and paying for integration of this with EHR tools for everyone in the state to do this to assess gaps over time.*	*Low*	*None*	*None*
Milestone #4: Sufficient Provider Capacity at Critical Levels of Care Including Medication Assisted Treatment for OUD	*100% (2/2)*	*100% (7/7)*	*"NM is better positioned than the majority of states in terms of SUD service delivery across the continuum of care e.g. prevention, intervention and treatment."*	*Low*	*None*	*None*
Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	*80% (4/5)*	*80% (4/5)*	*"The state's opioid overdose rate is facing a rapid rise, consistent with the national trends, driven by the COVID-19 pandemic."*	*Low*	*Continue efforts to initiate MAT in ED settings with warm handoffs to community programs*	*State will continue to use SAMHSA State Opioid Response funding to train providers and support NM Bridge system*
Milestone #6: Improved Care Coordination and Transitions Between Levels of Care	***50% (2/4)***	***22% (2/9)***	*"Due to shifting priorities, the state has not expanded health homes as planned"*	***Medium***	o *Update Implementation Plan to reflect planned actions for NM Care Link, including focusing on SUD population with hospitals* o *Strategic planning on CCBHCs and how this will improve care coordination and care transitions* o *Consider peer expansion in EDs to conduct warm hand-offs to follow-up for SUD treatment*	o *State will conduct strategic planning surrounding care coordination and follow-up.* o *State will update implementation plan to reflect new action items on CCBHCs, Health Homes, and care coordination activities to address transitions of care, particularly after acute care event (ED or hospital visit)*

Milestone #3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications. Per technical assistance, CMS will assess progress on this milestone based on data described in milestones and in workforce assessment.

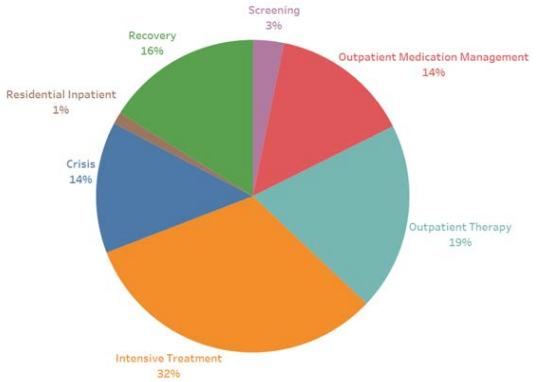
3. Assessment of state's capacity to provide SUD services

- *Adequacy of state's capacity at the midpoint.* At the time of the Mid-Point Assessment, the state has a broad of behavioral health services array (**Figure**: System of Care for SUD treatment and recovery services). However, longstanding workforce challenges limit the effectiveness of the state's efforts. Through New Mexico's 1115 SUD waiver, the state has implemented additional services, leveraging their existing IMDs to treat SUD as well as policy changes and trainings designed to expand practitioners who can deliver SUD services.

Summary of state's capacity to treat SUD:

- Significant focus on MAT provider expansion
  - NM Medicaid can now be billed by community behavioral health agencies for services provided by trainees if supervisory requirements are met. This addresses the most cited barrier (lack of reimbursement for trainees) to independent licensure.
  - Expanded practitioners who can deliver SUD services (e.g., trainees under supervision, peer support workers)
  - ED-based: NM Bridge program, which supports the implementation of buprenorphine induction in our Emergency Departments with a referral network in place.
  - Office-based: MAT ECHO, which provides education on SUD treatment for office-based providers and support for complex cases.

System of Care for SUD treatment and recovery services



- Supporting telehealth expansion
  - Trainings on MAT include specific information about telehealth prescribing (outpatient focused)
  - Hands-on mentorship for rural providers seeking a DEA waiver
- Expanding counseling and behavioral health support practitioners
  - Accelerated training and certification of peer support workers, and their introduction across the spectrum of agencies and the emergency departments
  - The introduction of behavioral health counselors in primary care agencies, and primary care practitioners in behavioral health agencies
- Expanding locations for crisis treatment beyond the ED
  - Two Crisis Triage Centers established in 2021

Stakeholder input on capacity

In addition to seeking stakeholder input to assess Milestone risk, the assessor team also conducted stakeholder interviews in collaboration with the New Mexico Recovery Project. Stakeholders at the provider-level (providers, hospitals, agencies, MCOs) recurrently noted that SUD workforce is a long-standing, difficult to address issue in New Mexico which is a risk facing improved performance on OUD-related mortality (Metric #27). Stakeholders noted *"Addiction, psychosis, dual diagnosed and serious mental health-our state is lacking this expertise."* Despite this, most of these stakeholders indicated the state was in the "*vanguard*

of harm reduction," noting a variety of mechanisms by which to reduce overdose deaths (e.g., distribution of naloxone and fentanyl test strips) and expand services and workforce for SUD treatment. Illustrative quotes include:

- *"The state is proactive when it comes to new initiatives such as: building a provider network, support for MAT training and certification, and the Treat First Model."*
- *"NM is better positioned than the majority of states in terms of SUD service delivery across the continuum of care, such as prevention, intervention and treatment."*

Stakeholders also note that while the state has made significant and impressive efforts on provider training for clinicians to obtain the X-waiver (through the State Opioid Response Grant), the next focus should be on implementation – such that prescribers are encouraged to integrate the practice of prescribing MAT routinely. This is evidenced by a persistently gradual increase in MAT prescribers despite the state's robust effort on trainings. Some stigma still exists however, specifically, *"Lack of knowledge in the community among medical and behavioral health providers who continue to resist MAT. They believe that internal strength is the only way that introducing medication is wrong."*

- *Any changes to state's capacity.* Each milestone demonstrates expansion in the state's capacity to treat OUD. In activities related to Milestone 1, the state has expanded access to treatment across all ASAM levels of care. For example, there was a rise by 123% for early intervention (metric #7), a 45% increase in IOP/partial hospitalization (metric #9), a 134% increase in residential/inpatient services (metric #10), and 270% increase in withdrawal management (metric #11). Milestone 2, which focuses on IMDs, also demonstrated trends in the state's expected direction, though more modest overall. Both the state and provider stakeholders noted this was likely due in part to COVID-related capacity constraints; at the peak of COVID in New Mexico, most hospitals were over 130% capacity. These capacity constraints have been slow to ease, given NM's significant nursing shortage – which dramatically reduces the number of available beds for treatment, even while the COVID-related patient surges have declined. Nonetheless, a slow and gradual increase of SUD treatment in IMDs is anticipated (see Narrative Report section, Milestone 2). The COVID-19 pandemic has driven much needed expansion of telemedicine, which is has increased access and stakeholders' note: *"Telehealth has been big for us … we can have staff provide services to more clients*" and "*Telehealth helps with rural areas that are lacking services and helps clients who lack transportation."* <u>In review of the available data both in Table 1 and in the provider availability assessment, the assessor team did not identify any decreases in the state's capacity, rather that NM is increasing the number of agencies and practitioners treating all SUD types.</u>

- *Any identified needs for additional capacity*. NM is expanding number of agencies and practitioners treating SUD, but capacity is chronically challenged by a limited workforce. *The assessor recommends to the state several areas for improved workforce capacity, many of which the state is already engaged:*
  - Shift focus from training to implementation of MAT prescribing (e.g., NM Bridge and associated SOR-grant activities)
  - Expand CTCs (ASAM Level 2 withdrawal management)
  - Support ED clinicians in prescribing MAT
  - Expand peer support for SUD – guiding patients from initiation (in ED or hospital) to outpatient appointment
  - *Expand peer support for SUD in outpatient settings with evidence-based modalities such as Seeking Safety and Motivational Interviewing*

- *Provide toolkit to NM agencies to support expansion of peer support activities to promote recovery from substance use disorders*
- *To expand access to methadone maintenance treatment during evenings and weekends*
- *To offer training in MAT to advance practice nurses, physician assistants and residents during their training so that they are prepared to offer MAT at the beginning of their careers*
- *To offer training and clinical consultation to MAT providers who are prepared to see special populations including pregnant women and transitional age youth*

4. Next steps

For the New Mexico 1115 SUD Waiver, the areas of risk for the state reside within Milestone 6's metrics and implementation action plan activities. The metrics at risk include SUD readmissions and follow-up after ED visit for SUD. These two metrics rely on improved coordination of care, to prevent readmissions and to link to follow-up after ED treatment. To date, the state has focused on NMCL HHs to achieve coordination of care, but due to shifting priorities during the COVID-19 pandemic which was accompanied by rising rates of overdose. In response, the state has focused on rapid expansion of harm reduction and treatment – which partly informs the focus on CCBHCs while still maintaining, but not expanding, NMCL HHs. It is anticipated that the addition of SUD to HH eligibility (which occurred contemporaneously to the mid-point of the waiver) will improve access to care coordination through HHs. Given that follow-up after ED visit for those with mental health (the primarily population served by HHs) is demonstrating trends in the expected direction, there is reason to assume the state will experience gains in their SUD population similarly. The state has recently focused on CCBHCs, to bring a robust array of wrap-around BH services to their Medicaid beneficiaries. These are exciting and important plans, but at present it is not clear how care coordination will be addressed through the planned CCBHCs. Following the assessors' meeting with the state, the assessors propose the following list of activities to address deficiencies of improving demonstration performance:

The state will:

- *Determine strategic goals for HHs and CCBHCs – to assure that coordination of care is directly addressed (readmissions, ED follow-up)*
- *Leverage state's existing health IT infrastructure (e.g., ED Information Exchange) to facilitate care coordination after ED visits for SUD, as they now do for MH (SMI/SED) visits via NMCL HHs.*
- *Disseminate to hospitals, EDs, and CTCs the new eligibility for patients with SUD's to participate in NMCL HHs*
    - *Educate hospital's discharge planners, care coordinators*
- *Leverage state's efforts on peer expansion to assist in navigation (a highly evidence-based activity) to avoid readmissions and improve timely follow-up after SUD hospitalization or ED visit*
- *Update the State's Implementation Plan, (written in 2019) in accordance with these activities as described above – and task routine updates of the implementation plan to a Medicaid staff member*.

Attachments

- *Independent assessor description (see attachment)*