COMMENT 1

Public Comment to the New Mexico Health Care Authority
Re: Implementation of SB 42 and Alignment with FFPSA
By: Bryce Pittenger, LPCC
To: HCA
Date: 4/7/2026

I am writing to provide a clinical and systems-informed perspective on the implementation of Senate Bill 42, particularly as it relates to substance-exposed newborns and Plans of Safe Care. My perspective is informed by my 30 years of experience in New Mexico's behavioral health system, by my work in other states, and by my former role as Director of Children's Behavioral Health at the New Mexico Children, Youth and Families Department (CYFD), where I oversaw system design, implementation, and accountability within the state's behavioral health continuum.

While SB 42 was designed to align New Mexico with the federal Family First Prevention Services Act (FFPSA), early implementation indicators raise concern that current practice may be producing outcomes that are inconsistent with both the intent of FFPSA and well-established developmental science.

FFPSA is grounded in a clear principle: children should remain safely with their families whenever possible, and removal should be a last resort. For infants, this principle is especially critical. The first year of life represents a foundational period for attachment, and even short-term separations—particularly when prolonged without clear pathways to reunification—can result in lasting developmental and relational harm. From the perspective of the mother, this time is essential for bonding and overcoming inherent challenges, both of which create competency and commitment to parenting.

Recent reporting indicates that substance-exposed newborns are, in some cases, remaining in state custody for extended periods with limited evidence of timely reunification. If accurate, this suggests that implementation may be increasing the likelihood and duration of separation during the most sensitive developmental window. This is not a neutral system outcome—it is one with known and preventable consequences. The first 1000 days of life are the most critical and form the neural pathways for life.

At the same time, expanded identification, reporting, and follow-up requirements appear to be increasing system entry without a parallel, immediate expansion of in-home, family-centered supports. As a result, surveillance and compliance mechanisms may be functioning as a front door to custody, rather than as pathways to stabilization.

Plans of Safe Care are central to this concern. When implemented as intended, they should serve as engagement tools that connect families to meaningful supports. However, when operationalized primarily as compliance or monitoring instruments, they risk accelerating system involvement and, in some cases, contributing to removal rather than preventing it.

Additionally, the phased timeline for prevention services creates a structural gap: families are being identified and monitored now, while the services designed to stabilize them are not yet fully available. This misalignment places both families and frontline systems in an untenable position and increases the likelihood of defaulting to removal in the absence of viable alternatives.

From both a clinical and policy perspective, this trajectory is concerning. For infants, time is not neutral. Prolonged separation during the early attachment window is associated with long-term impacts that are difficult—and costly—to remediate. A system that inadvertently contributes to these outcomes, even with good intent, requires immediate course correction.

To better align implementation with FFPSA and protect infant well-being, I respectfully recommend the following:

- Establish clear guidance that Plans of Safe Care are engagement and support tools—not compliance mechanisms—and monitor their use accordingly.
- Accelerate access to in-home, dyadic, and substance use treatment services so that removal is not used as a substitute for unavailable care.
- Track and publicly report infant-specific outcomes, including time to reunification and duration of custody for children under one year of age.
- Reinforce, through policy and practice, that removal is a last resort—particularly for substance-exposed newborns where safety can be managed with appropriate supports.
- Ensure that prevention infrastructure is implemented at the same pace as identification and reporting requirements to avoid unnecessary system escalation.

New Mexico has an opportunity to build a system that is both accountable and developmentally informed. Doing so will require close attention to how policy is experienced in practice, particularly for infants, where the margin for error is small and the consequences are profound. Thank you for your consideration and for your continued work to improve outcomes for children and families across the state. It’s all about the babies! And their caregivers.

COMMENT 2

Mondragon, Tabitha, HCA

From: Adrien Lawyer <adrien@tgrcnm.org>
Sent: Tuesday, April 7, 2026 2:46 PM
To: HCA-madrules
Subject: [EXTERNAL] Comment on CARA Directive

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While CARA can be seen as a supportive tool, we are concerned that, currently in New Mexico, implementation of these federal guidelines is being used for family surveillance and separation, not support.These actions effectively create a pipeline to child protective services for parents and children through the use of 72-hour automatic newborn holds, ongoing compliance monitoring of families, and unnecessary long-term custody battles and court processes.

At TGRCNM, we believe that the following language will better serve families and children in New Mexico:

8.3.2.7 Definitions
P. (3) "POSC non-compliance" means [an intentional] failure by the infant's family or caregivers to take a required POSC action or to accept a POSC referral identified as necessary for infant safety and well-being.
[(a) POSC non-compliance shall not be determined when barriers to completion are due to lack of access to services, transportation, housing instability, or other socioeconomic factors.]
S. (1) "Safety family assessment" means a comprehensive assessment prepared by the children youth and families department to determine the needs of a child and the child's parents, relatives, guardians, custodians or caregivers, including an assessment of the likelihood [imminent danger] of:
(a) Imminent danger to a child's well-being;
(b) The child becoming an abused child or neglected child;
(c) The strengths and needs [the inability] of the child's family members, including parents, relatives, guardians, custodians or caregivers, with respect to providing for the health and safety of the child.

(5) "Substance-exposed infant" means an infant under one year [90 days] of age for the purposes of this rule who was exposed in utero to a substance that has the potential to impact the health or development of the infant, including an illicit substance such as fentanyl, methamphetamine or heroin, prescribed medication such as opioids, methadone, buprenorphine, or legal substances including alcohol, tobacco, and marijuana. A substance-exposed infant is a substance-exposed newborn as otherwise defined in state law.
8.3.2.9
B. Infants are identified as substance exposed as evidenced by toxicology results [verified by 8.3.2.9 D.] or mother [pregnant person] as interpreted by a clinician, or when the mother [pregnant person] discloses [long term] substance use [or substance use disorder] during pregnancy. [Disclosure of substance use by a pregnant person shall not trigger mandatory reporting, testing, or POSC without clinical indication]

D. Meconium, cord, and other lab toxicology shall be ordered as determined by clinicians when the results will impact the clinical or medical management of the child [to verify toxicology reports and pregnant parent disclosure]. They shall not be done without indication and discussion with the child's parents or guardians with the exception of a medical emergency. [8.3.2.9 NMAC – N, xx/xx/xxxx]

8.3.2.10

When an infant in New Mexico has been identified as substance exposed, a plan of safe care POSC must be created by the hospital, birthing center, or perinatal provider who receives this information. All providers at hospitals, birthing centers, or providers who perform perinatal medical visits, must [shall] be routinely, verbally screening for substance use disorder in pregnant, birthing, and postpartum people and developing POSC when identifying substance use in pregnancy. [Screening shall be voluntary, conducted with informed consent, a may be declined without penalty, reporting, or impact on care] If the POSC has not been developed in the prenatal period, it must be created prior to [within seven days of] discharge from the hospital. Providers should access the CARA supports system portal (CSSP) to identify if a POSC has already been created. If not, these providers are required to create the POSC upon identification of the substance use. To the extent permitted by applicable federal and state privacy and confidentiality laws, including HIPAA and 42 C.F.R. Part 2, notification of the active POSC shall be shared with the following parties either in a physical copy, telecommunication or an electronic version within a reasonable timeframe but within no less than 24 hours [within seven days of] of discharge.

(1) The child's primary care provider.

(2) The child's parent, relative, guardian or caregiver.

(3) The CARA navigator/care coordinator.

(4) If the child's parent, relative, guardian, custodian, or caregiver is a tribal member or resides on tribal land, the respective nation, pueblo, or tribe's responsible entity as identified by tribal leadership.

(5) If there is CYFD involvement due to submission of a statewide central intake (SCI) or a family assessment, the respective staff from CYFD will receive a copy from the CARA navigator if they are not able to access the POSC via the CSSP.

[B Information collected through CARA and POSC processes shall remain confidential within the healthcare system and not be shared with law enforcement, shall not be entered into the child youth and families department database without informed consent.]

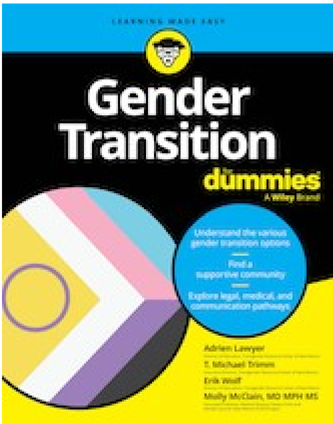
[C]B. Plans of safe care [must be reviewed with the birthing parent in the appropriate language for understanding and] should be signed [without coercion, threat, or implied penalty] by the parent, relative, guardian, or caregiver and the provider. This can be discharging hospital staff, the birthing center staff, or the perinatal provider who created the POSC. When parents, relatives, guardians, or caregivers refuse to sign the POSC that is considered POSC non-compliance and the provider shall initiate a referral to CYFD SCI to request a family assessment.

D. Emergency department or urgent care deliveries: In situations where a delivery occurs before transfer can occur to a birthing facility, the staff in the emergency or urgent care department shall initiate a POSC if the family qualifies for one based on verbal screening [and upon verification of toxicology with meconium results. Emergency circumstances shall not waive requirements for informed consent except in cases of immediate, life-threatening medical necessity].

8.3.2.11

A. (4) (e) In-utero exposures: If an infant is exposed to any substances during pregnancy, all exposures shall be documented in the POSC. Documentation of exposures includes exposures occurring during the timeframe in which the mother may not have known she was pregnant, and all substance exposures, including, but not limited to tobacco, fentanyl, heroin, methamphetamine, cocaine, alcohol, marijuana (medical or recreational), and medication assisted therapy such as methadone and buprenorphine.

Adrien Lawyer
Co-Director & Co-Founder
Transgender Resource Center of New Mexico
Author, Gender Transition for Dummies
Pronouns: he, him, his
Why list my pronouns?
www.tgrcnm.org
505-440-3402
adrien@tgrcnm.org
1515 4th St NW
Albuquerque, NM 87102



COMMENT 3

April 8, 2026

New Mexico Health Care Authority
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
Via email: HCA-madrules@hca.nm.gov

RE: NMAC rule 8.3.2., *Family Health and Well Being, Plan of Safe Care for Substance-Exposed Infants.*

Secretary Armijo,

The New Mexico Department of Health is submitting the following comment relating to the CARA program:

- The rule should clarify the identification and process for "high priority" CARA cases. High priority cases are those where the infant has been born substance exposed to fentanyl, methamphetamine, cocaine or polysubstance exposure that includes one of the aforementioned items.

Thank you for your consideration.

Gina M. DeBlassie
Cabinet Secretary, NM Department of Health

COMMENT 4

Mondragon, Tabitha, HCA

From: Francheska Sevy Gurule <sevy.gurule@gmail.com>

Sent: Wednesday, April 8, 2026 1:57 PM
To: HCA-madrules
Subject: [EXTERNAL] SB42 draft rules suggestions

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My name is Dr. Francheska Gurule. I am double board certified in family medicine and addiction medicine and completed a fellowship in Maternal, Child and Reproductive Health. I have been caring for pregnant people with substance use for over 10 years. I am one of New Mexico's few perinatal substance use experts and have a robust understanding of best practices for caring for families affected by substance use, including evidence based and compassionate approaches that center harm reduction, promote patient-centered care and autonomy, and reduce stigma. The draft rules for SB42 have many flaws and need to be revised to reflect the original intent of SB42, which is to support families whose child has been born substance exposed rather than penalize parents who are working towards recovery despite generations of trauma, structural barriers, stigma, inadequate resources, and the shortcomings of healthcare systems and government agencies.

My suggestions are as follows:

1. The draft rules do not incentivize recovery and acknowledge success. When a parent is stable in recovery taking lifesaving medications for opioid use disorder like Methadone or Buprenorphine, a POSC should be optional. The draft rules currently define substance-exposed newborn as babies who are exposed to methadone and buprenorphine among a list of other substances. If our government and HCA intend to leverage the POSC as a helpful tool for supporting families, it is reasonable to offer a POSC to families stable in recovery. But if the intent is instead that the POSC is used as a database for CYFD and a tool to separate families they should NOT be included in the definition for substance exposed babies. The downstream effects of surveillance, punishment for noncompliance, and stigma are unacceptable.
2. In states that promote mandatory reporting of substance use and equate it to child abuse, or criminalize substance use in pregnancy, we have lower rates of SUD treatment, lower rates of prenatal care, higher rates of neonatal opioid withdrawal, higher rates of overdose, higher rates of congenital syphilis, and many other negative consequences. We cannot perpetuate harm for families in recovery. Understanding the risks of punitive policies, these rules need to take a step further and explicitly state that substance use does not equate child abuse.
3. Screening and testing recommendations need to reflect national standards. ACOG, a leading organization providing guidance for these clinical scenarios recommends screening at the first prenatal visit. Screening at every visit is redundant and creates a burden of work for providers. Screening should be recommended in prenatal care and during the delivery hospitalization as recommended by the Alliance for Innovation on Maternal Health. This draft rule should also take a stronger stance against the illegal, inequitable and unethical use of urine drug testing. Many New Mexico hospitals perform urine drug testing on pregnant people without consent, with unclear clinical indication and for reasons that are purely legal or criminal in nature. The HCA should send a clear message to providers that urine drug testing without clinical indication and consent is not only unacceptable, but illegal as outlined by the Supreme Court in Ferguson v City of Charleston (2001).

4. This draft rule mandates a referral to a substance use treatment program. There will be many individuals who require a POSC, who do NOT need a referral to a substance use treatment program. For example, a person who has rare cannabis use in the early stages of pregnancy prior to knowing she is pregnant will qualify as someone needing a POSC as outlined by these draft rules. Required substance use treatment is not only medically unnecessary, but could lead to family separation if the parent does not comply. A lot of substance use treatment is appropriate within the scope of primary care or even the departments of health. Not everyone needs a specialized treatment program. In fact, studies suggest people would prefer to get SUD treatment in their primary care home. It reduces stigma. Also many parts of our state do not have adequate resources for substance use treatment. Until New Mexico, meaningfully invests in the infrastructure of rural healthcare, we cannot expect that many rural families will be able to comply with these rules. This will risk disproportionate family separation and aggravate the rural inequities that already exist in our state.

5. Finally, the POSC should be a tool that supports families with meaningful, practical, no-barrier resources. These draft rules place a disproportionate emphasis on how the tool will be used by and entangled with CYFD involvement. The draft rules spend a lot of time discussing the many pathways to CYFD involvement and not enough time talking about how the POSC will be accountable to the families. How does the state intend to make this tool beneficial for families? A useful tool will not be linked to CYFD. It will not be accessible by CYFD without explicit consent from the parent. It cannot be a safe tool if it is being weaponized as a database that CYFD has unrestricted access to. There is a comment about families who do not have phones… shouldn't we instead be brainstorming how to support that need? A phone is a low cost and important resource that should be supplied to families with a POSC. In the current iteration, these POSC do not realistically meet the needs of families. We need investment in family centered rehab options, we need housing, we need rural access to MOUD and treatment priority policies. When we cannot meet their needs with the POSC, it becomes obsolete and we should not force them on families. Families should reserve the right to decline a POSC if it is not valuable. Cara navigators should be well trained allies for these families, sources of supports, not branches of the CYFD system.

As a perinatal substance use expert, as someone who has repeatedly witnessed the journey of recovery and the resources needed to stabilize families, as someone who has taken every opportunity to learn about evidence based practices, I am more than happy to consult on these draft rules if the HCA is willing to make a POSC a safe and effective tools for families and will avoid weaponizing the POSC as a tool for CYFD surveillance and family separation.

In solidarity with families affected by substance use,
Francheska Gurule, MD

(This statement is solely mine and not the views of my employer.)

COMMENT 5

Mondragon, Tabitha, HCA

From: Susan Merrill <susanmerrill773@gmail.com>
Sent: Wednesday, April 8, 2026 2:33 PM
To: HCA-madrules
Subject: [EXTERNAL] Upcoming hearing on CARA Rules
Attachments: TITLE 8 SOCIAL SERVICES CHAPTER 3 FAMILY HEALTH AND WELL-public comment.docx

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Hello, I am attaching the rules in word format, with my comments in red. I am concerned as it is unclear about who will follow up and train facilities, including licensed birthing centers? I see that there is mention of facility navigators, are they responsible? I am also very concerned about the 'automatic' referral for someone using THC for example. This needs to be assessed and then determined through a referral to an expert to determine if this use is in fact ;cannabis use disorder'. Not every person who is using a substance is in need of rehab or treatment, but in fact probably needs a further discussion around depression and/or anxiety and how to better support them. This new law falls short of providing that direct support that may be needed and 'assumes' that everyone will need treatment.
Also, how are people who are in treatment and doing well continued to be supported by a POSC?

Thank you for allowing me to comment, Susan Merrill

TITLE 8 SOCIAL SERVICES CHAPTER 3 FAMILY HEALTH AND WELL-BEING PART 2 PLAN OF SAFE CARE FOR SUBSTANCE-EXPOSED INFANTS 8.3.2.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA). [8.3.2.1 NMAC – N, xx/xx/xxxx] 8.3.2.2 SCOPE: New Mexico health care authority, New Mexico managed care organizations (MCOs), private insurance, children, youth and families department (CYFD), department of health (DOH), early childhood education and care department (ECECD), primary care providers, hospitals, birth centers, supportive services providers, perinatal providers, substance-exposed infants, birthing parents and their families, and caregivers.

[8.3.2.2 NMAC – N, xx/xx/xxxx] 8.3.2.3 13 NMSA 1978. STATUTORY AUTHORITY: Sections 9-8-6 NMSA 1978; 27-2-12 NMSA 1978; and 32A-3A [8.3.2.3 NMAC – N, xx/xx/xxxx] 8.3.2.4 DURATION: Permanent. [8.3.2.4 NMAC – N, xx/xx/xxxx] 8.3.2.5 EFFECTIVE DATE: July 1, 2026, unless a later date is cited at the end of a section. [8.3.2.5 NMAC – N, xx/xx/xxxx] 8.3.2.6 OBJECTIVE: The objective of this part is to establish standards and procedures for identification of substance-exposed infants; development, implementation, and monitoring of plans of safe care; coordination among state agencies, licensed facilities, and medicaid contractors; data reporting; and training.

[8.3.2.6 NMAC – N, xx/xx/xxxx] 8.3.2.7 DEFINITIONS: A. Terms beginning with the letter “A”: “Active efforts” mean a series of affirmative, active, thorough, complete, and timely actions aimed at maintaining or reuniting children with their families. This standard is higher than “reasonable efforts”, which mainly involve service referrals. Active efforts require agencies to actively engage and assist families in overcoming barriers to services. Key aspects of active efforts include actively helping parents obtain services rather than just providing referrals, ensuring efforts are culturally appropriate and involve collaboration with the child’s tribe, working in partnership with the family and tribe, tailoring efforts to each family’s specific needs, meticulously documenting all efforts, and initiating these efforts promptly and continuing them throughout the case.

B. Terms beginning with the letter “B”: “Birthing facility” means a licensed hospital that provides labor and delivery services or a licensed birth center.

C. Terms beginning with the letter “C”: (1) “CARA navigator” means an individual designated by the New Mexico HCA or its designee or contractor. A CARA navigator receives plans of safe care and notifications of substance-exposed infants and provides care coordination services for infants, parents, and families impacted by substance exposure. For purposes of Section 32A-3A-2(C) NMSA 1978, a CARA navigator serves as the care coordinator for substance exposed newborns under this part and is distinct from care coordinators employed by medicaid managed care organizations who perform the care-coordination functions required under 8.308.10 NMAC. (2) “CARA navigation program”

means a program overseen directly by the New Mexico Health Care Authority or its contractor that provides navigation services to CARA infants and families, including support for facility CARA navigators in birthing hospitals and other participating facilities.

(3) “CARA supports system portal” means the electronic record of care owned and managed by HCA to provide statewide access to plans of safe care and related documentation supporting care coordination efforts for CARA families within the CARA navigation program.

(4) navigator.

(5) “Care coordinator” means, within the context of the CARA program, a CARA “Caregiver” means child’s parents, relatives, guardians, custodians or caregivers in the household who provides care and supervision for the child.

(6) “Clinician” means a physician, midwife, physician assistant, nurse practitioner, or other prescribing provider licensed to interpret lab results and prescribe medication.

(7) “Comprehensive Addiction and Recovery Act (CARA)” means federal legislation signed into law in 2016 (Pub. L. 114-198, 130 Stat. 695).

D. Terms beginning with the letter “D”: [RESERVED]

E. Terms beginning with the letter “E”: [RESERVED]

F. Terms beginning with the letter “F”: “Facility CARA navigator” means an employee or contracted representative who has on-site presence at birthing hospitals or birth centers.

G. Terms beginning with the letter “G”: “Guardian” means a person appointed as a guardian by a court or by a Native American nation or tribal authority.

H. Terms beginning with the letter “H”: (1) “Health care professional” means a physician, physician assistant, nurse practitioner, nurse, licensed social worker, midwife or other relevant professionals who provide health care treatment to expectant or new parents or infants. (2) “Home visiting” means engagement with a program that delivers a variety of information, educational, developmental, referral and other support services for eligible families who are expecting or who have young children under the age of five. Home visiting programs provider services that promote parental competence and early childhood development by optimizing the relationships between parents and children in their home environment.

I. Terms beginning with the letter “I”: [RESERVED]

J. Terms beginning with the letter “J”: [RESERVED]

K. Terms beginning with the letter "K": "Key household member" means any individual who lives at the infant's discharge address who is 18 years or older and provides care for the infant listed on the plan of safe care.

L. Terms beginning with the letter "L": [RESERVED]

M. Terms beginning with the letter "M": (1) "Managed care organization (MCO)" means an entity that contracts with the HCA to deliver covered Medicaid services to enrolled members, including to assist the state in meeting the requirements established under Section 27-2-12 NMSA 1978. (2) "Member" means a person enrolled in medicaid or a medicaid managed care organization.

N. Terms beginning with the letter "N": "Navigation services" means activities performed by a CARA navigator to receive and review POSCs and notifications, coordinate referrals, document actions, and follow up with families and providers.

O. Terms beginning with the letter "O": [RESERVED]

P. Terms beginning with the letter "P": (1) "Parent" means a biological or adoptive parent with a constitutionally protected liberty interest in the care and custody of the child, or a person who has lawfully adopted a Native American child pursuant to state law or tribal law or tribal custom. (2) "Plan of safe care (POSC)" means a written plan co-created with the birthing parent and family by a health care professional or care coordinator intended to ensure the immediate and ongoing safety and well-being of a substance-exposed infant or to provide perinatal support to a pregnant, birthing, or postpartum person with substance use disorder by addressing the treatment needs of the child and any of the child's parents, relatives, guardians, custodians or caregivers to the extent those treatment needs are relevant to the safety of the child. (3) "POSC non-compliance" means a failure by the infant's family or caregivers to take a required POSC action or to accept a POSC referral identified as necessary for infant safety and well-being. (4) "Primary care provider (PCP)" means a physician, nurse practitioner, physician assistant, or certified nurse-midwife who provides, supervises, and coordinates primary health care for the member, initiates referrals as needed, and maintains continuity of care. (5) "Private insurer" means a private insurance company from which an employer or an individual purchases a health insurance policy.

Q. Terms beginning with the letter "Q": [RESERVED]

R. Terms beginning with the letter "R": [RESERVED]

S. Terms beginning with the letter "S": (1) "Safety family assessment" means a comprehensive assessment prepared by the children, youth and families department to

determine the needs of a child and the child's parents, relatives, guardians, custodians or caregivers, including an assessment of the likelihood of: (a) imminent danger to a child's well-being; (b) the child becoming an abused child or neglected child; and (c) the strengths and needs of the child's family members, including parents, relatives, guardians, custodians or caregivers, with respect to providing for the health and safety of the child. (2) "Safety" means freedom from present or impending serious harm.

(3) "Screening brief intervention referral to treatment (SBIRT)" means an evidence based model designed to identify, reduce and prevent problematic substance use or misuse and co-occurring mental health disorders as an early intervention approach. SBIRT includes a universal verbal screening specific to age, a face-to-face brief intervention for positive screening results, and a referral to behavioral health services if indicated.

(4) "Service provider" means any state or community agency working with CARA families as identified in the plan of safe care (POSC).

(5) "Substance-exposed infant" means an infant under one year of age for purposes of this rule who was exposed in utero to a substance that has the potential to impact the health or development of the infant, including an illicit substance such as fentanyl, methamphetamine or heroin, prescribed medication such as opioids, methadone, buprenorphine, or legal substances including alcohol, tobacco, and marijuana. A substance-exposed infant is a substance-exposed newborn as otherwise defined in state law.

(6) "Statewide central intake (SCI)" means the unit within the children, youth and families department protective services division (CYFD PSD) whose responsibilities may include but are not limited to receiving and screening reports of alleged child abuse or neglect and prioritizing and assigning accepted reports to the appropriate county office for investigation.

T. Terms beginning with the letter "T": [RESERVED]

U. Terms beginning with the letter "U": [RESERVED] V. Terms beginning with the letter "V": [RESERVED]

W. Terms beginning with the letter "W": [RESERVED]

X. Terms beginning with the letter "X": [RESERVED] Y. Terms beginning with the letter "Y": [RESERVED]

Z. Terms beginning with the letter "Z": [RESERVED] [8.3.2.7 NMAC – N, xx/xx/xxxx] 8.3.2.8 CARA PROGRAM: The overall objective of the New Mexico's comprehensive addiction and recovery (CARA) program is to ensure the safety and well-being of infants. The CARA

program also provides support and resources for families experiencing substance use disorder to keep families together when that option is safe for the infant. Need for a CARA plan of safe care (POSC) may be identified during prenatal care, during the delivery episode, or after a child is born.

This section should be restated to-https://www.nmhealth.org/about/phd/fhb/cara/

The DOH page better matches the Federal Rule as well. This section does not match what is on the web, for DOH and HCA CARA pages. The focus is on both, the safety and well being of the infant, and providing appropriate supports to the affected caregivers. This is to include any caregiver for the newborn (with whom the newborn resides).

[8.3.2.8 NMAC – N, xx/xx/xxxx] 8.3.2.9 IDENTIFICATION OF SUBSTANCE-EXPOSED INFANTS: A. Providers must be using an evidence-based verbal screening brief intervention with referral to treatment (SBIRT) model at all prenatal or perinatal medical visits and live births to identify substance use in pregnancy.

Screening when appropriately used will identify what is needed to make the referrals and supports and create the POSC.

B. Infants are identified as substance exposed as evidenced by toxicology results of the newborn or mother as interpreted by a clinician, or when the mother discloses substance use during pregnancy. C. Hospitals, birth centers, and perinatal providers shall use an evidence-based tool to evaluate infants born affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or fetal alcohol spectrum disorder.

D. Meconium, cord, and other lab toxicology shall be ordered as determined by clinicians when the results will impact the clinical or medical management of the child. They shall not be done without indication and discussion with the child's parents or guardians with the exception of a medical emergency. There is strong evidence in the literature that does not support this testing. CYFD workers have used this testing to 'prove' someone may be actively using, when the fact is that the test may show prior use. Not appropriate for the POSC creation. It has been used inappropriately to remove children in NM and nationally.

[8.3.2.9 NMAC – N, xx/xx/xxxx] 8.3.2.10 RESPONSIBILITIES REGARDING PLAN OF SAFE CARE CREATION: A. When an infant in New Mexico has been identified as substance exposed, a plan of safe care POSC must be created by the hospital, birthing center, or perinatal provider who receives this information. All providers at hospitals, birthing centers, or providers who perform perinatal medical visits, must be routinely, verbally screening for substance use disorder (screening is for substance use, and should not be used for diagnosis of a disorder. The screening may indicate that the person should be referred further to a professional who can make the diagnosis). See below, in another section

where it is stated correctly. in pregnant, birthing, and postpartum people and developing POSC when identifying substance use in pregnancy. If the POSC has not been developed in the prenatal period, it must be created prior to discharge from the hospital. Providers should access the CARA supports system portal (CSSP) to identify if a POSC has already been created. If not, these providers are required to create the POSC upon identification of the substance use. To the extent permitted by applicable federal and state privacy and confidentiality laws, including HIPAA and 42 C.F.R. Part 2, notification of the active POSC shall be shared with the following parties either in a physical copy, telecommunication or an electronic version within a reasonable timeframe but within no less than 24 hours of discharge. (1) The child's primary care provider. (2) The child's parent, relative, guardian or caregiver. (3) The CARA navigator/care coordinator. (4) If the child's parent, relative, guardian, custodian, or caregiver is a tribal member or resides on tribal land, the respective nation, pueblo, or tribe's responsible entity as identified by tribal leadership. (5) If there is CYFD involvement due to submission of a statewide central intake (SCI) or a family assessment, the respective staff from CYFD will receive a copy from the CARA navigator if they are not able to access the POSC via the CSSP. B. Plans of safe care should be signed by the parent, relative, guardian, or caregiver and the provider. This can be discharging hospital staff, the birthing center staff, or the perinatal provider who created the POSC. When parents, relatives, guardians, or caregivers refuse to sign the POSC that is considered POSC non-compliance and the provider shall initiate a referral to CYFD SCI to request a family assessment. C. A CARA POSC seeks to engage the family in support and treatment and is not on its own a referral to CYFD. The CARA POSC does not replace a report to the SCI system of CYFD. If child abuse or neglect is suspected, a SCI report shall be made. D. Emergency department or urgent care deliveries: In situations where a delivery occurs before transfer can occur to a birthing facility, the staff in the emergency or urgent care department shall initiate a POSC if the family qualifies for one based on verbal screening. [8.3.2.10 NMAC – N, xx/xx/xxxx] 8.3.2.11 REQUIREMENTS OF THE PLAN OF SAFE CARE: A. The POSC shall include the following components: (1) Referral to substance use prevention and treatment programs for the pregnant or birthing parent or guardian. (2) Referral for a home visiting program or an early intervention family infant toddler program for the infant overseen by ECECD. (3) Indication that the CARA navigator is engaging in communication, collaboration, and consultation with a child's nation, pueblo, or tribal social services/Indian Child Welfare Act (ICWA) coordinator to ensure the POSC is developed in a culturally responsive manner for each Native American. (4) Information about the child and the child's family, including: (a) The child's name, if available at discharge (b) Emergency contact name and phone number of at least one of the child's parents, relatives, guardians, custodians, or caregivers. If the parent or caregiver state they do not have a phone, they are required to provide contact information for someone they

keep in regular contact with who would serve as a contact for the CARA Navigator. (c) The address of the child's parent(s), relatives, guardian, custodian or caregiver who will be taking the child home from the birthing facility. (d) The names of the parents, relatives, guardians, custodians, or caregivers who will be living with the child. (e) In-utero exposures: If an infant is exposed to any substances during pregnancy, all exposures shall be documented in the POSC. Documentation of exposures includes exposures occurring during the timeframe in which the mother may not have known she was pregnant, and all substance exposures, including, but not limited to tobacco, fentanyl, heroin, methamphetamine, cocaine, alcohol, marijuana (medical or recreational), and medication assisted therapy such as methadone and buprenorphine. (f) Substance use assessment: The parents, domestic partners and key household members shall be offered screening or referral for assessment for substance use disorders, as clinically appropriate and with consent. If it is determined they have a substance use disorder, it shall be documented in the POSC. A copy of the POSC will be provided to individuals for whom such referrals are made. (g) Services and referrals: The POSC shall also include the services for which the family agrees to be referred as well as services the family is already participating in. If the family declines services in their community, the healthcare professional clearly documents this within the POSC. Families shall be informed that they may request a referral for services at a later time, even if they have declined these services during the initial development of the POSC, by communicating with their CARA navigator(s). If families decline all services identified as necessary to address infant safety and well-being, the provider shall follow the non-compliance referral requirements in section 8.3.2.13 NMAC. (h) The POSC shall include contact information for the infant and family's CARA navigator assigned to coordinate the implementation of the family's POSC pursuant to New Mexico Statutes section 32A-3A-13(B)(8) (2024). (i) Health insurance and care coordinator information: The POSC shall identify the managed care organization (MCO) or private insurer that the mother and infant are enrolled with and include contact information for the insurer. (j) Unknown information: If the individual completing the POSC does not have specific information necessary to complete the POSC, they shall fill it out to the best of their ability and write unknown where the information is not known. The assigned CARA navigator is responsible for completing the missing information once they receive the POSC.

If a caregiver declines to participate in the creation of the POSC the staff member will indicate this on POSC and submit as notification to the CARA program and to CYFD.

Please explain why a referral to CYFD is necessary?? Someone may decline because they are already in treatment and receiving services, this should be noted and used as a positive to support the newborn and caregivers.

B. In all situations where a SCI report or a CYFD family assessment referral is placed, the individual submitting the SCI report or a CYFD family assessment will access the POSC for the child in the CSSP and update the POSC to show that a SCI report or a CYFD family assessment has been placed. C. If an infant enters CYFD custody after a POSC has been created, the POSC shall be modified by the CARA navigator to address the needs of the infant in the new setting. The updated POSC shall contain the resource family's information and shall be re-sent to all entities required to receive copies of the POSC. D. The POSC may include the following referrals: (1) Public health agencies; (2) Maternal and child health services; (3) Infant mental health providers; (4) Public and private children and youth agencies; (5) Early intervention and development services; (6) Courts; (7) Local education agencies; (8) Managed care organizations; and (9) Hospitals and medical providers. [8.3.2.11 NMAC – N, xx/xx/xxxx] 8.3.2.12

IMPLEMENTATION OF THE CARA NAVIGATION PROGRAM:

This is very confusing as DOH advertises CARA Navigators on their website, yet these rules indicate that it is all managed out of HCA?? For providers this section needs to be more clear. Perhaps state, HCA shall work with DOH CARA Program for Navigation services, etc.

A. All infants with a POSC shall receive care coordination services through a CARA navigator. HCA shall oversee and monitor implementation of this Part and shall assure compliance with applicable federal and state law, including CARA and Section 32A-3A-13 NMSA 1978, by designating CARA navigators, maintaining procedures for receipt and review of plans of safe care and notifications, and initiating corrective action when required. B. CARA navigators and CARA navigation programs shall use an evidence-based intensive care coordination model that is listed in the federal Title IV-E prevention services clearinghouse or another nationally recognized EB clearinghouse for child welfare. C. CARA navigators are direct agents of HCA or its subcontractors who are designated to manage the CARA program and the associated care coordination activities to: (1) Ensure the plans of safe care are implemented and CARA families are supported; (2) Assure compliance with the Comprehensive Addiction and Recovery Act and this Part; and (3) Collaborate with all state agencies and service providers to ensure continuity of care and implementation of the CARA program. D. CARA navigators shall: (1) Complete a POSC if it was not completed by the infant hospital discharge staff upon their initial contact. (2) Ensure that, if CYFD is involved, the POSC is provided to the assigned investigator or other CYFD service provider

working with the family in the case of a family assessment. (3) Send a copy of the POSC to the infant's PCP within five business days of receiving notification for a new POSC. (4) keep the parent or caregiver updated and informed when changes are made to the POSC in a timely manner. (5) Upon receiving a copy of or the notification of new POSCs for each infant with substance exposure review plans of care for completeness, ensure that a PCP is identified, assure that correct insurance information is on the plan, and verify that all referred services are complete or in process and moving towards completion. (6) Work directly with the infant and family to ensure that necessary referrals are in place, appointments are scheduled and attended and to work with family on progression where progression has stalled to support the family in sustaining engagement with services that promote infant safety and well-being. (7) Act as a liaison to MCOs or private insurances if there is any issue in accessing necessary resources available within their health plan such as substance use disorder treatment or home visiting services. (8) Act as the primary point of contact to support coordination of the infant's POSC related services while the family is engaged in the CARA navigation program. (9) If the CARA navigator is unable to establish contact with the family after documented outreach or identifies that the family has not engaged in POSC identified services such as home visiting or substance use disorder (SUD) treatment, the CARA navigator shall contact SCI within 24 hours to request a family assessment. Outreach shall include at least three attempts at different times of day and one in-person visit to the home. (10) The CARA navigator shall make a report to CYFD SCI if the CARA navigator has immediate concerns for abuse or neglect. (11) During any CYFD screening or investigation, continue plan of safe care coordination and outreach and document all contacts, services, and outcomes. (12) If CYFD declines to open a case or closes a case without custody, the navigator shall, within five business days: (a) attempt contact with the family at least three times using at least two modalities; (b) escalate to CARA Navigation Leadership to review barriers and amend the plan of safe care as needed; (c) schedule follow-up in the home to establish the necessary intensity of engagement given CYFD decision in not pursuing a custody situation within 14 days; and (d) if safety concerns persist or new information arises, make a new referral to CYFD SCI. (13) A navigation case may be closed only when navigation closure criteria in Subsection F of 8.3.2.12 NMAC are met.

E. Facility CARA navigator/care coordinator: Are direct agents of the HCA or its subcontractor, who add on-site presence of the CARA navigation program to hospitals. There shall be facility CARA navigator coverage at every birthing facility in the state. Facility CARA navigators shall: (1) Ensure that all substance-exposed infants who have a plan of safe care receive care coordination to implement the plan of safe care. (2) Communicate,

collaborate and consult with a child's nation, pueblo, or tribe to ensure that plans of safe care are developed in a culturally responsive manner for each child. (3) Identify appropriate agencies to be included in POSC based on an assessment of the needs of the child. (4) Hospitals are required to ensure facility CARA navigators have the necessary information about CARA infants.

F. Navigation closure criteria: A navigator may close a case when one of the following occurs: (1) the family graduates from the CARA program when the infant is 13 months old and the family and the CARA navigator mutually agree that services are no longer needed; (2) the infant relocates out of state, or other circumstances documented by the navigator make continued navigation impracticable. The CARA navigator shall attempt to connect the infant and family to medicaid or care coordination in their new location; or (3) For non-responsive, difficult to engage families the CARA Navigator shall check with Family Services at CYFD to see if they are engaged with the family. (a) If family services is engaged with the family and provides services, navigator shall interact with family services to provide updated documentation in CARA system of family services involvement. (b) If family is not engaged with family services, navigator should reach out again to determine if the family would like any support from the navigator. If family still refuses CARA navigation, the CARA navigator program shall have processes in place to monitor listed CARA participants for law enforcement activity and or emergent medical care activity that shall prompt a new SCI report until the child is 13 months old. (4) the infant's nation, pueblo, or tribe has assumed full responsibility for a navigation case and has not requested state agency support. The CARA navigator shall document the name of the person responsible at the nation, pueblo, or tribe who advised the state the nation, pueblo, or tribe is assuming full custody. [8.3.2.12 NMAC – N, xx/xx/xxxx]

8.3.2.13 REFERRAL TO CYFD FOR SAFETY FAMILY ASSESSMENT: A. When a family is not compliant with a POSC then the provider or CARA navigator shall contact CYFD SCI within 24 hours to request a safety family assessment. B. Based on the results of the safety family assessment, CYFD may offer or provide referrals for counseling, treatment, or other services aimed at addressing the underlying causative factors that may jeopardize thepon their initial contact. (2) Ensure that, if CYFD is involved, the POSC is provided to the assigned investigator or other CYFD service provider working with the family in the case of a family assessment. (3) Send a copy of the POSC to the infant's PCP within five business days of receiving notification for a new POSC. (4) keep the parent or caregiver updated and informed when changes are made to the POSC in a timely manner. (5) Upon receiving a copy of or the notification of new POSCs for each infant with substance exposure review plans of care for completeness, ensure that a PCP is identified, assure that correct insurance information is on the plan, and verify that all referred services are complete or in

process and moving towards completion. (6) Work directly with the infant and family to ensure that necessary referrals are in place, appointments are scheduled and attended and to work with family on progression where progression has stalled to support the family in sustaining engagement with services that promote infant safety and well-being. (7) Act as a liaison to MCOs or private insurances if there is any issue in accessing necessary resources available within their health plan such as substance use disorder treatment or home visiting services. (8) Act as the primary point of contact to support coordination of the infant's POSC related services while the family is engaged in the CARA navigation program. (9) If the CARA navigator is unable to establish contact with the family after documented outreach or identifies that the family has not engaged in POSC identified services such as home visiting or substance use disorder (SUD) treatment, the CARA navigator shall contact SCI within 24 hours to request a family assessment. Outreach shall include at least three attempts at different times of day and one in-person visit to the home. (10) The CARA navigator shall make a report to CYFD SCI if the CARA navigator has immediate concerns for abuse or neglect. (11) During any CYFD screening or investigation, continue plan of safe care coordination and outreach and document all contacts, services, and outcomes. (12) If CYFD declines to open a case or closes a case without custody, the navigator shall, within five business days: (a) attempt contact with the family at least three times using at least two modalities; (b) escalate to CARA Navigation Leadership to review barriers and amend the plan of safe care as needed; (c) schedule follow-up in the home to establish the necessary intensity of engagement given CYFD decision in not pursuing a custody situation within 14 days; and (d) if safety concerns persist or new information arises, make a new referral to CYFD SCI. (13) A navigation case may be closed only when navigation closure criteria in Subsection F of 8.3.2.12 NMAC are met. E. Facility CARA navigator/care coordinator: Are direct agents of the HCA or its subcontractor, who add on-site presence of the CARA navigation program to hospitals. There shall be facility CARA navigator coverage at every birthing facility in the state. Facility CARA navigators shall: (1) Ensure that all substance-exposed infants who have a plan of safe care receive care coordination to implement the plan of safe care. (2) Communicate, collaborate and consult with a child's nation, pueblo, or tribe to ensure that plans of safe care are developed in a culturally responsive manner for each child. (3) Identify appropriate agencies to be included in POSC based on an assessment of the needs of the child. (4) Hospitals are required to ensure facility CARA navigators have the necessary information about CARA infants. F. Navigation closure criteria: A navigator may close a case when one of the following occurs: (1) the family graduates from the CARA program when the infant is 13 months old and the family and the CARA navigator mutually agree that services are no longer needed; (2) the infant relocates out of state, or other circumstances documented by the navigator make continued navigation impracticable. The CARA navigator shall attempt

to connect the infant and family to medicaid or care coordination in their new location; or (3) For non-responsive, difficult to engage families the CARA Navigator shall check with Family Services at CYFD to see if they are engaged with the family. (a) If family services is engaged with the family and provides services, navigator shall interact with family services to provide updated documentation in CARA system of family services involvement. (b) If family is not engaged with family services, navigator should reach out again to determine if the family would like any support from the navigator. If family still refuses CARA navigation, the CARA navigator program shall have processes in place to monitor listed CARA participants for law enforcement activity and or emergent medical care activity that shall prompt a new SCI report until the child is 13 months old. (4) the infant's nation, pueblo, or tribe has assumed full responsibility for a navigation case and has not requested state agency support. The CARA navigator shall document the name of the person responsible at the nation, pueblo, or tribe who advised the state the nation, pueblo, or tribe is assuming full custody. [8.3.2.12 NMAC – N, xx/xx/xxxx] 8.3.2.13

REFERRAL TO CYFD FOR SAFETY FAMILY ASSESSMENT: A. When a family is not compliant with a POSC then the provider or CARA navigator shall contact CYFD SCI within 24 hours to request a safety family assessment. B. Based on the results of the safety family assessment, CYFD may offer or provide referrals for counseling, treatment, or other services aimed at addressing the underlying causative factors that may jeopardize the

safety or well-being of the child. The child's parents, relatives, guardians, custodians or caregivers may choose to accept or decline any service or program offered subsequent to the family assessment; provided that if the child's parents, relatives, guardians, custodians or caregivers decline those services or programs, and the CYFD determines that those services or programs are necessary to address concerns of imminent harm to the child, the CYFD shall proceed with an investigation. C. If CYFD does not assume custody following screening or investigation, the facility, MCO, and navigator responsibilities under 8.3.2.10 through 8.3.2.12 NMAC remain in effect until navigation is closed under Subsection F of 8.3.2.12 NMAC. [8.3.2.13 NMAC – N, xx/xx/xxxx] 8.3.2.14

TRAINING REQUIREMENTS A. HCA will provide training to hospitals on SBIRT and evidence-based assessment tools to evaluate infants born exposed to substances. B. Hospitals and clinics that perform perinatal visits are required to ensure staff that interface directly with birthing people and infants have the necessary training.

Who is then responsible to assure that the hospitals have had the appropriate training to implement and create POSC?? Once again this law falls short of working with hospitals to assure that they are prepared and equipped to follow these rules.

[8.3.2.14 NMAC – N, xx/xx/xxxx] 8.3.2.15 DATA AND REPORTING REQUIREMENTS: The HCA shall be responsible for collecting data entered by hospitals, birthing facilities, health care providers and CARA navigators in the CARA supports system portal to meet federal and state reporting requirements, including the following from prenatal care offices, hospitals, birthing centers, and the CARA navigation program. All data collection and reporting under this section shall comply with applicable federal and state privacy and confidentiality laws, including HIPAA and 42 C.F.R. Part 2, as applicable. A. B. C. D. E. The primary substance(s) the infant was exposed to. The services that infants and families were referred to The availability and uptake of the services Whether an infant or an infant's family was subsequently reported to CYFD Data will be shared with children's medical services, family health bureau, department of health,

and CYFD for epidemiological analysis. [8.3.2.15 NMAC – N, xx/xx/xxxx]

COMMENT 6

Mondragon, Tabitha, HCA

From: Aine C Brazil <ACBrazil@salud.unm.edu>
Sent: Wednesday, April 8, 2026 3:34 PM
To: HCA-madrules
Subject: [EXTERNAL] Public Comment: SB 42 Draft Rules

Some people who received this message don't often get email from acbrazil@salud.unm.edu. Learn why this is important

CAUTION: This email originated outside of our organization. Exercise caution prior to clicking on links or opening attachments.

Dear Members of the New Mexico Healthcare Authority,

I'm writing as a community member and advocate who works closely with pregnant people and families navigating substance use. I strongly oppose the proposed draft rules related to Plans of Safe Care. As written, they will harm patients, erode trust in the healthcare system, and move us further away from what SB 42 was intended to do.

These rules don't reflect the spirit of SB 42. Instead, they double down on an approach that leans on surveillance and family separation rather than support. That's not what families need, and it risks further damaging trust in both healthcare providers and state systems.

I'm especially concerned about the shift in how the CARA program is being framed. Moving from a model that supports families to one focused primarily on monitoring and intervention changes the tone and impact entirely. It pulls us away from trauma-informed, patient-centered care and toward a more punitive approach that we know can lead to worse outcomes.

Requiring Plans of Safe Care based only on an admission of substance use, without any diagnosis of a substance use disorder, raises real clinical and ethical concerns. It opens the door to unnecessary intervention in the lives of families who don't need that level of oversight.

What worries me most is the impact this will have on patient honesty and trust with their providers. Patients are less likely to be open with providers if they fear legal implecations, punishment or losing their child. When that trust breaks down, people avoid care or withhold important information, which puts both parent and baby at greater risk.

In the long run, these rules are likely to worsen outcomes, not improve them. They will increase healthcare avoidance and continue to disproportionately impact already marginalized communities.

I urge you to withdraw these draft rules and take a more thoughtful, collaborative approach to implementation that actually reflects SB 42 and centers support, dignity, and evidence-based care.

Sincerely,

Áine Brazil

Áine Brazil *(she/her)* click to hear my name

FAMILY & COMMUNITY MEDICINE
CELEBRATING
FIFTY YEARS
UNM
SCHOOL OF MEDICINE

COMMENT 7

Mondragon, Tabitha, HCA

From: Matthew McBatra <matthew.mcbatra@gmail.com>
Sent: Wednesday, April 8, 2026 5:04 PM
To: HCA-madrules
Subject: [EXTERNAL] CARA

Some people who received this message don't often get email from matthew.mcbatra@gmail.com. Learn why this is important

CAUTION: This email originated outside of our organization. Exercise caution prior to clicking on links or opening attachments.

Hello,

I am a community pediatrician. I strongly believe that families deserve to be supported and not separated. I have seen first hand how well children do with their own parents. I have also seen how well families do when kept with their kids. Families who have their kids taken away loose all motivation for staying on treatment, and kids lose their parents this way. Addiction is a medical condition that deserves treatment and support, not stigma and penaliztion.

Sincerely,

Dr. Mateo McBatra
Pediatrician.

COMMENT 8

Mondragon, Tabitha, HCA

From:	Esther <joie822@proton.me>
Sent:	Wednesday, April 8, 2026 8:59 PM
To:	HCA-madrules
Subject:	[EXTERNAL] Address SB 42

Some people who received this message don't often get email from joie822@proton.me. Learn why this is important

CAUTION: This email originated outside of our organization. Exercise caution prior to clicking on links or opening attachments.

Please withdraw your proposed rule and craft a rule that addresses SB 42, a bipartisan approach that updated child welfare policies relating to substance use and pregnancy

This mandate is dangerous and unlawful. These directives undermine state law designed to provide support and resources to families when they show up for health care. These directives also break both state and federal laws that are supposed to keep Native children with their communities.

When patients—especially pregnant or postpartum parents—fear that being honest with their provider could result in investigation and loss of their child, they are less likely to seek care. This can quickly spiral into poor behavioral health outcomes, as well as dangerous untreated physical health problems for babies and parents. Directives like this turn medical settings into environments where patients are punished rather than cared for, and ultimately keep people from accessing the care they and their newborns need.

Substance use during pregnancy is complex. It often intersects with trauma, poverty, mental health conditions, and barriers to care. Addressing perinatal substance use requires trust-based conversations and patient-centered treatment—not criminalization. When providers are required to separate parents from their newborns, the system is undermining medical best practices and a provider's ethical obligation to act in the best interest of their patients.

The consequences of broken patient-provider trust are not theoretical. New Mexico's maternal mortality rate is 1.5 times higher than the rest of the country. We cannot afford to make childbirth more dangerous.

Involvement with child welfare systems—even if temporary—can traumatize families and interrupt practices, like breastfeeding, that improve overall infant outcomes. Separations can cause newborns, children and their parents lifelong emotional and developmental harm. Unwarranted removals disproportionately impact Indigenous, Black, Latine, and low-income families, further exacerbating existing inequities in perinatal and infant health outcomes. Listening to patients in a trusting partnership, with patient centered evidence-based care is the way to improve outcomes, not "one size fits no one" family removals. As providers it is our obligation to always consider the safety of our patients, including newborns. These directives take away our capacity to treat the unique needs of each family in our care.

Earlier this year the New Mexico Legislature passed SB 42, a bipartisan approach that updated child welfare policies relating to substance use and pregnancy. It's time to put down the harmful separation directives and instead implement New Mexico's SB 42 with integrity; this is a critical step that demonstrates our commitments to care for families.

We can acknowledge the complexities of these situations and together build accountable state responses that center the lived expertise of families that best understand these circumstances. Together we must build out access to detox and recovery beds available as soon as someone is ready and asking for support. We must create programs where parents can access treatment, while bringing little ones along and having somewhere to call home. Addiction is a health care issue and it should be treated as such—with compassion, dignity, and evidence-based practices.

I am a practitioner of Harm Reduction and a Licensed Clinical Social Worker.

Joie Michaels, LCSW

Sent from [Proton Mail](https://proton.me/mail/home) for iOS

COMMENT 9

April 8, 2026

Sent via email

New Mexico Health Care Authority
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
PO Box 2348
Santa Fe, NM 87504-2348
HCA-madrules@hca.nm.gov

RE: Proposed Rule 8.3.2 NMAC – Plan of Safe Care for Substance-Exposed Infants

Dear Secretary Armijo and Rulemaking Committee Members,

This letter serves as formal comment on the proposed amendments to 8.3.2 NMAC. On behalf of Sruwa shk'itsi Tsa tsema – Indigenous Family Solutions, we have significant concerns with the proposed rule, as currently drafted. First and foremost, the proposed rule expands mandatory intervention, creates pathways to unnecessary child welfare involvement, and departs from both legislative intent and best practices.

The rule requires Plans of Safe Care (POSC) without requiring a substance use disorder screening or diagnosis, ~~and~~ regardless of clinical necessity. It also includes mandatory POSC for prescribed medication and legal substances such as alcohol, marijuana, and tobacco. As a result, families who do not have a substance use disorder will be subjected to investigation by CYFD, unnecessary intervention, and mandated treatment.

POSCs include required referrals to substance use treatment programs, regardless of clinical necessity, and families will be compelled into treatment pathways which are not appropriate, culturally responsive, and significantly lacking throughout the state. This mandatory treatment is an overreach which raises both ethical and legal concerns.

Secondly, any perceived "non-compliance" with a POSC triggers a referral to CYFD for a family assessment. This creates a direct pipeline from healthcare disclosure to child welfare involvement and bypasses the multi-level, graduated response system envisioned in SB 42. Additionally, families who are actively already engaged in Medication-Assisted Treatment (MAT) are treated the same as individuals using illicit substances. This approach undermines evidence-based care and will discourage individuals from seeking or continuing treatment. The rule also establishes compliance-driven practices which shift the focus from supportive care (as

Indigenous Family Solutions, LLC
PO Box #665
Pueblo of Acoma, NM 87034
donalyn@indigenousfamilysolutions.com

was intended with the federal Comprehensive Addiction and Recovery Act (CARA)), to on-going surveillance of families with no clear end.

Child welfare should function as a support system, not a policing system. Surveillance, punishment, and threats do not change behavior, and fear does not heal trauma. Behavior changes when there is care, dignity, love and respect – paired with tangible support. When families are treated as human beings worthy of belief and hope, they rise – we all do!

Lastly, the proposed rule is inconsistent with the federal Indian Child Welfare Act (ICWA) and New Mexico's Indian Family Protection Act (IFPA), both of which require active efforts to prevent the unnecessary removal of Native children and ensure family reunification (if removal is necessary to prevent *immediate and imminent* danger). Given existing disparities, these provisions will disproportionately impact Native families – increasing unnecessary investigations, system involvement, and family separation. This raises serious concerns regarding compliance with both federal ICWA and NM IFPA; as well as broader obligations to provide remedial and rehabilitative services designed to *prevent* unwarranted disruption of Native families.

ICWA has been coined the "gold standard" of child welfare and in New Mexico, we believe IFPA is the platinum standard. Both were designed as a remedy to lived harm the system has and continues to inflict on Native children, families, and communities. The proposed rule is not child safety – it is a public health failure for all families who will continue to be trapped in an already overburdened system which doesn't serve them.

The blatant lack of transparency from the State to the Nations, Pueblos, and Tribes undermines Tribal sovereignty, violates jurisdictional authority, and disregards the State-Tribal Collaboration Act (STCA) – which requires on-going communication, positive collaboration, and meaningful consultation. Authentic engagement means recognizing children, families, and communities as the experts. It is apparent the proposed rule was drafted without meaningful engagement from all partners - including parents, behavioral health and medical providers, and NM's Nations, Pueblos, and Tribes.

We respectfully submit the attached amendments which are intended to ensure alignment with federal laws, NM statutes, and best practices in trauma-informed, family-centered care, while upholding Tribal sovereignty. Our proposed amendments are designed to restore alignment with statutory requirements and protect families from unnecessary harm.

Please see attached amendments for detailed revision, which also incorporate the following key legal frameworks:

Indigenous Family Solutions, LLC
PO Box #665
Pueblo of Acoma, NM 87034
donalyn@indigenousfamilysolutions.com

- Comprehensive Addiction and Recovery Act (CARA), 42 U.S.C. § 5106a
- New Mexico Statutes Annotated § 32A-3A-13
- New Mexico Senate Bill 42 (2024)
- New Mexico Children's Code § 32A-4-2 and § 32A-4-3
- HIPAA (45 C.F.R. § 164.502)
- 42 C.F.R. Part 2
- Americans with Disabilities Act (42 U.S.C. § 12101 et seq.)
- State-Tribal Collaboration Act (NMSA § 11-18-1 et seq.)
- Indian Child Welfare Act (25 U.S.C. § 1901 et seq.)
- Indian Family Protection Act (NMSA § 32A-23-1 et seq.)

In addition, we respectfully request the State:

- Withdrawal the proposed rules and pause any implementation on them
- Engage in formal and meaningful consultation New Mexico's Nations, Pueblos, and Tribes during the drafting and implementation process
- Draft rules which actually align with New Mexico Senate Bill 42, statutory requirements and best practice; and incorporate the proposed amendments

Respectfully submitted,

Donalyn Lorenzo, LMSW

Donalyn Lorenzo, LMSW
Founder & Social Impact Architect

Indigenous Family Solutions, LLC
PO Box #665
Pueblo of Acoma, NM 87034
donalyn@indigenousfamilysolutions.com

ATTACHMENT: REDLINE PROPOSED AMENDMENTS (WITH LEGAL CITATIONS)

8.3.2 NMAC – PLAN OF SAFE CARE FOR SUBSTANCE-EXPOSED INFANTS

SECTION 8.3.2.8 – CARA PROGRAM PURPOSE

Current Language:
"The overall objective of the New Mexico's comprehensive addiction and recovery (CARA) program is to ensure the safety and well-being of infants."
Proposed Revision (Redline):
"The overall objective of ~~the~~ New Mexico's comprehensive addiction and recovery (CARA) program is to ~~ensure the safety and well-being of infants~~ **support families through voluntary, trauma-informed, and culturally responsive services that promote the safety, health, and well-being of infants and their caregivers while preserving family unity whenever possible, consistent with 42 U.S.C. § 5106a(b)(2)(B)(iii) and NMSA 1978, § 32A-3A-13**."

SECTION 8.3.2.9 – IDENTIFICATION OF SUBSTANCE-EXPOSED INFANTS

Proposed Addition:
"E. Identification of substance exposure alone shall not trigger mandatory intervention. A clinically validated screening and, where appropriate, assessment must inform any determination of need for services or development of a Plan of Safe Care, consistent with evidence-based practices and federal CAPTA requirements under 42 U.S.C. § 5106a(b)(2)(B)(iii)."

Indigenous Family Solutions, LLC
PO Box #665
Pueblo of Acoma, NM 87034
donalyn@indigenousfamilysolutions.com

SECTION 8.3.2.10 – POSC CREATION

Proposed Revision (Redline):
“Providers… must be routinely, verbally screening… and ~~developing POSC when identifying substance use in pregnancy~~ **developing a Plan of Safe Care only when clinically indicated based on validated screening and assessment of need, consistent with NMSA 1978, § 32A-3A-13 and SB 42 (2024)**.”

Proposed Revision (Redline):
“When parents… refuse to sign the POSC that is ~~considered POSC non-compliance and the provider shall initiate a referral to CYFD SCI~~ **not, in isolation, considered non-compliance warranting referral. Referrals to CYFD shall occur only where there is reasonable suspicion of abuse, neglect, or imminent risk of harm as defined under NMSA 1978, § 32A-4-2 and § 32A-4-3**.”

SECTION 8.3.2.11 – REQUIREMENTS OF POSC

Proposed Revision (Redline):
“Referral to substance use prevention and treatment programs ~~for the pregnant or birthing parent~~ **when clinically appropriate and with informed consent of the individual, consistent with 42 C.F.R. Part 2 and HIPAA (45 C.F.R. § 164.502)**.”

Proposed Addition:
“All services and referrals included in a Plan of Safe Care shall be voluntary, culturally responsive, and based on individual clinical need. Participation in services shall not be coerced or mandated absent a court order or legal requirement, consistent with constitutional due process protections and New Mexico Children’s Code (NMSA 1978, § 32A-1-3).”

Indigenous Family Solutions, LLC
PO Box #665
Pueblo of Acoma, NM 87034
donalyn@indigenousfamilysolutions.com

SECTION 8.3.2.12 – CARA NAVIGATOR RESPONSIBILITIES

Proposed Revision (Redline):
"If the CARA navigator is unable to establish contact… or identifies that the family has not engaged… the CARA navigator shall ~~contact SCI within 24 hours to request a family assessment~~ **continue good-faith engagement efforts using supportive, non-punitive approaches. Referral to CYFD shall occur only when there is reasonable suspicion of abuse, neglect, or imminent risk of harm consistent with NMSA 1978, § 32A-4-3 and SB 42 (2024)**."

SECTION 8.3.2.13 – REFERRAL TO CYFD

Proposed Revision (Redline):
"When a family is ~~not compliant with a POSC~~ **demonstrating conditions that create reasonable suspicion of abuse, neglect, or imminent risk of harm as defined in NMSA 1978, § 32A-4-2** then the provider or CARA navigator shall contact CYFD SCI…"

NEW SECTION – MEDICATION-ASSISTED TREATMENT (MAT)

Proposed Addition:
"Participation in Medication-Assisted Treatment (MAT), when prescribed and monitored by a licensed provider, shall not alone constitute substance misuse or trigger a Plan of Safe Care. This provision aligns with federal guidance from SAMHSA and protections under the Americans with Disabilities Act (42 U.S.C. § 12101 et seq.)."

NEW SECTION – TRIBAL CONSULTATION AND SOVEREIGNTY

Proposed Addition:
"The Department shall engage in formal government-to-government consultation with Tribal Nations prior to implementation of this rule and for any future amendments, consistent with the

Indigenous Family Solutions, LLC
PO Box #665
Pueblo of Acoma, NM 87034
donalyn@indigenousfamilysolutions.com

State-Tribal Collaboration Act (NMSA 1978, § 11-18-1 et seq.). Tribal Nations shall have the authority to develop and administer culturally appropriate Plans of Safe Care for their members. All implementation involving Native families shall comply with the Indian Child Welfare Act (25 U.S.C. § 1901 et seq.) and the Indian Family Protection Act (NMSA 1978, § 32A-23-1 et seq.)."

SECTION 8.3.2.15 – DATA AND REPORTING

Proposed Revision (Redline):
"All data collection and sharing shall comply with applicable laws and ~~shall be shared~~ **shall be limited to the minimum necessary and require informed consent, except where otherwise required by law, consistent with HIPAA (45 C.F.R. § 164.502) and 42 C.F.R. Part 2. Tribal data sovereignty principles shall be upheld in all instances involving Native families**."

GLOBAL AMENDMENT – SB 42 ALIGNMENT

Proposed Addition:
"All implementation of this rule shall align with the multi-level response framework established in SB 42 (2024), prioritizing prevention, voluntary services, and least restrictive interventions before any referral to child welfare, consistent with legislative intent and child welfare best practices."

Indigenous Family Solutions, LLC
PO Box #665
Pueblo of Acoma, NM 87034
donalyn@indigenousfamilysolutions.com

COMMENT 10

Mondragon, Tabitha, HCA

From: CYNTHIA CHAVERS <cynthia.chavers@hotmail.com>
Sent: Wednesday, April 8, 2026 11:16 PM
To: HCA-madrules
Subject: [EXTERNAL] Public comment on promulgation of proposed rule 8.3.2 NMAC-Plan of Safe Care for Substance-Exposed Infants

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April 8, 2026

NM Health Care Authority
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, NM 87504-2348

Re: Public comment on promulgation of proposed rule 8.3.2 NMAC-Plan of Safe Care for Substance-Exposed Infants

Dear Secretary Armijo:

The original intent of the federal CARA legislation enacted in 2016 was to improve child welfare responses to pre-natal substance use disorder. It required states to develop Plans of Safe Care for infants born with, and identified as affected by, substance abuse, withdrawal symptoms, or FAS disorders. Here in NM, we decided to go beyond the requirements of the federal legislation by creating a system that was supposed to wrap support around families who are struggling with substance misuse.Unfortunately, intent does not equal impact. The CARA program has been shifted from its original intent to instead now be another arm of government surveillance. Under Governor Lujan Grisham's Executive Directive, CARA has become a weapon used to gather information on families for the purposes of monitoring their activities under threat of their child being removed from their care. These rules emphasize mandates and compliance rather than supports and interventions.

The proposed rules overall do not align with SB42 and because they are imprecise, will lead to further confusion in a system already fraught with confusion and misinformation.

The difficulties NM has faced in implementing CARA is having a real impact on families. During the recent CARA listening session held by HCA, we heard numerous stories of families who have been treated unfairly due to extensive confusion under the current rules. This includes stories of people in our communities who have faced distress because they were placed unfairly on plans of safe care. Once on a plan of safe care, they explained, there was no "off ramp"- no way to be discharged from a plan, even if the plan had been erroneously created by a healthcare provider.

Birthing families in NM deserve all of the support and resources we have access to-without the threat of arrest or criminalization. This is why CARA plans must be used only as a tool to assist families, rather than as a weapon to police pregnancy and labor.

HCA had the opportunity to engage expert feedback on these rules through the CARA workgroups established in proposed language and discuss as colleagues, since the workgroups were all paused earlier this year. This would have brought forth expertise from those currently working in and around this program, from across the State.

In addition, these drafted rules were not created with tribal consultation as required in the State-Tribal Collaboration Act. Native communities input is essential to developing policy in our state; we should be relying on our Indigenous communities as leaders in child welfare issues rather than an afterthought. These rules are not culturally responsive and are not compliant with the Indian Child Welfare Act, the NM Indian Family Protection Act, or the State Tribal Collaboration Act.

I ask that the HCA:

- Withdraw
- their proposed rule and craft a rule that addresses SB42, a bipartisan approach that updated child welfare policies relating to substance misuse and pregnancy;
- Hold
- consultation with the tribes/pueblos/nations and ICWA experts to allow the opportunity for input; and
- Ensure
- the experts in the workgroups are re-convened to review and add input before the proposed rules are issued again.

I am in favor of creating systems that support rather than punish families who are already struggling.

PROPOSED AMENDMENTS AND EDITS TO THE PROPOSED RULE

8.3.2.7 Definitions: These rules create new definitions for active efforts; caregiver; and other terms that do not align with the NM Children's Code and that eliminate definitions compliant with IFPA/ICWA:

> **Active efforts** definition exceeds what is in the Children's Code as well as SB42.
>
> **Caregiver** is not defined in the Children's Code so this creates a new definition.
>
> **Guardian** should match what is defined in the Children's Code.

Key household member is a new definition not in the Children's Code.

IFPA and ICWA need to be defined under "I" as they are both referred to in the rules.

Member conflicts with the Children's Code definition of Member and should be clarified. As used in these rules member means a member of an MCO. The Children's Code defines member or membership as "means a determination made by an Indian tribe that a person is a member of or eligible for membership in that Indian tribe.

Plans of Safe Care : there needs to be a consistent standard for when a POSC is created; is it truly including one-time exposure? One time exposure should not trigger the CARA protocol; exposure should be further defined. The treatment needs relevant to the child should include more than the safety of the child; it should also mandate other supports and resources that would not be directly linked to safety but rather the health and well being of the child i.e. healthcare interventions.

POSC non-compliance: language should not be "failure" as that indicates moral judgement; should change to "have not participated in the POSC"

Safety family assessment is not a term used by CYFD and is inaccurate; safety assessment is not even defined in the NM Children's Code and this can/will interfere with CYFD requirements. It is defined as a "family assessment" in SB42.

Safety is not defined in the Children's Code and should not be here as HCA is not making safety determinations. Also these are out of order alphabetically.

Service providers should not be limited to only those agencies working on a plan of safe care; families may be engaged with service providers outside of the plan.

8.3.2.8 CARA Program: The objective language created here is a new one that does not match the objective of the program as previously stated in the draft rules at 8.3.2.6 or on the HCAs website or as previously listed on the CYFD program site. The objective as now stated exceeds the authority of HCA and is rather the authority of CYFD. If the goal is to ensure the safety and well-being of infants, that is CYFD's authority and expertise. The program should be moved back to CYFD in that case. In addition, the language does not align with SB42. I suggest amending to the wording as listed above or even the one posted to the register: "New Mexico's CARA Program supports families living with substance use to provide a safe environment for newborns and children that are free from risks of abuse, neglect or abandonment through programmatic processes that connect CARA Families to services that promotes a healthy family environment.

8.3.2.9 Identification of Substance-Exposed Infants: the rules are not clear on the requirements for pre-natal Plans of Safe Care. This is already causing confusion for providers and families. The rules should specify the POSC is for MISUSE of substances not one time or accidental use (accidental here meaning use by someone who didn't realize they were pregnant yet and abstained after finding out). Will POSC be used to surveil families during the rest of their pregnancy? Rules state HCA will train hospitals and birthing centers but not pre-natal providers (?) while requiring the same documentation from pre-natal providers.

8.3.2.10 Responsibilities Regarding Plan of Safe Care Creation:
(B) Refusal to sign should not be used to initiate a referral to SCI for family assessment. This should be used as one consideration of the family's overall openness to participating in a healthcare plan for the child. This is unnecessarily punitive. The language is also unclear and confusing, "the provider shall initiate a referral to CYFD SCI to request a family assessment." NM utilizes the term "referral" to describe calling in a report child abuse or neglect. The language should be clarified here.

8.3.2.11 Requirements of the Plan of Safe Care

A. (1) One time use does not necessarily clinically indicate a need for a referral to a substance use prevention and treatment program. This is why the rules should be clarified to exclude one-time accidental use or minimal use that the parent admits to and ended when the person found out they were pregnant.

(3) was developed without the input of tribes/nations/pueblos and should be revised after feedback from sovereign communities.

(4)(b) Language requiring families to provide contact information is compliance-based. Suggesting change from "they are required to provide contact information for someone they keep in regular contact with…" to "If the parent or caregiver state they do not have a phone, the provider must ask them to provide a form of communication that would allow the CARA navigator to be in contact with them." The language here should match requirements for CARA navigators, 8.3.2.12 D (9) and (10)

(4)(e) should be removed altogether. This goes beyond the reach of SB42. I am especially concerned with parents who may unknowingly use substances recreationally prior to being diagnosed with pregnancy; and those on MAT who are participating in treatment programs already. This rule will further erode community trust in healthcare systems, as pregnant people will be afraid to be truthful with their prenatal providers for fear of surveillance and immediate removal of their child.

(4)(g) If the family declines services…should allow for documentation by the CARA navigator of the reasons the family has for not wanting to engage with recommended services. The family may have valid reasons they do not want to engage with specific providers without fear of being referred to CYFD i.e. the family may have previously had a negative experience with the provider, the family may have a balance that they cannot pay a the provider, there may be an issue with the distance, etc.

C. This is too limited. Situation changes could also include a family relocating or the infant relocating to a relative. CYFD involvement could call for a safety plan that allows the infant to live with a family member or kin who have been identified as a temporary home while the safety plan is being worked by the family. These situations can extend for months and sometimes years.

D. (6) Why would a family be referred to the courts on POSC??????? This needs to be removed.

(no citation) This section does not include any requirement for the state to inform the family of the CARA program requirements. Advocates and CARA program coordinators have heard over and over again from community the stories of numerous families who had no awareness they were ever placed on a plan of safe care; or the consequences of their "failure to comply." I am recommending an added lettered section here describing how the State is going to educate families on the program objectives and requirements.

8.3.2.12 Implementation of the CARA Navigation Program

B. Has an evidence-based care coordination model been identified??

E. (2) Should be revised to incorporate feedback from nations/tribes/pueblos.

(no citation) a section should be added with requirements for facility CARA navigators to communicate information to the family about the POSC and the CARA program prior to discharge.

F. (1) the family should be allowed out of a POSC if the plan was created erroneously. In these cases, the family should not have to wait a full 13 months. If the family's providers also determine they have completed the plan before the 13 months, this should also be the basis to close a plan.

(3.)(b) I am strongly opposed to asking CARA navigators to monitor CARA participants for law enforcement activity and emergency medical care. This far exceeds the authority of CARA Navigators and should not be allowed. This is a direct contradiction to treatment SUD as a medical disorder rather than a moral failing of the parent, and seems only intended to advance the Governor's Executive Directive of immediate removal at the time of birth for any substance exposed infant. This makes the CARA program an extension of the police state rather than a supportive intervention.

(4) should be revised after nations/tribes/pueblos provide feedback. In addition, the term "full custody" is used erroneously here as that is a legal term for a child placed on a State hold, not transfer of a POSC.

8.3.2.14 Training Requirements
A. All birthing facilities should be trained by HCA.
B. If birthing facilities are required to train their staff, how will this be monitored? Will HCA be checking?

8.3.2.15 Data and Reporting Requirements:
A. Again, should be clarified to exclude one-time exposure or accidental exposure.

Thank you for your consideration in this important issue. I respectfully urge the HCA to stop the promulgation process and engage in community and professional dialogue to create a sustainable, equitable policy.

Cynthia Chavers, LMSW
Social Worker, Advocate, Organizer

COMMENT 11

From: Margaret Chell <margaretannchell@gmail.com>
Sent: Thursday, April 9, 2026 12:44 AM
To: HCA-madrules
Subject: [EXTERNAL] SB 42

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Hello,

I am extremely disheartened by the legislation being drafted to separate infants from their caregivers in the setting of substance use as a medical student that aspires to be a psychiatrist in New Mexico. This proposed legislation is not in line with evidence-based practices to support families and children in New Mexico and will further harm our communities. Parental bonding postpartum is critical for the development of the infant, and for the relationship established between parents and their caregivers. These drafted rules would discourage pregnant from seeking care, ultimately leading to worse health outcomes. While substance use treatment is an important component of improving healthcare in New Mexico, this is not the way forward. I urge you to withdraw the proposed rule and craft a rule that addresses SB 42, a bipartisan approach that can improve child welfare relating to substance use and pregnancy.

Thank you for your time,

Margaret Chell, MD Candidate & NM resident

COMMENT 12

Vital Strategies

100 Broadway, 4th Floor
New York, NY 10005, USA
Offices
New York | Paris | Singapore | Jinan | São Paulo

+1 212 500 5720
vitalstrategies.org

April 9, 2026

New Mexico Health Care Authority
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, NM 87504-2348

RE: Proposed NMAC rule 8.3.2, *Family Health and Well Being, Plan of Safe Care for Substance-Exposed Infants*

On behalf of the Vital Strategies Overdose Prevention Program, we write to express our grave concern about the New Mexico Health Care Authority's (HCA) proposed rule governing notification procedures for substance-exposed infants. 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 substance use disorders (SUD).

Despite recent declines in overdose deaths nationally, the country's overdose crisis continues, and New Mexico is among only a handful of states in which overdose deaths increased in the past year.[1] Provisional data from the Centers for Disease Control and Prevention (CDC) showed that nearly 70,000 people died from drug overdose during the 12-month period ending in October 2025.[2] Recent CDC data also showed continued racial and ethnic disparities, with non-Hispanic Black and non-Hispanic American Indian or Alaska Native persons more likely to experience a fatal overdose.[3]

Overdose has also become a leading cause of death during and shortly after pregnancy.[4,5] According to CDC's most recent synthesis of data from state Maternal Mortality Review Committees (MMRCs), SUD was a contributor to almost a quarter (23.6%) of maternal deaths in 2021.[6] The same analysis described marked disparities – SUD contributed to over half (51.4%) of maternal deaths among American Indian or Alaska Native women.[7] At the same time, research has increasingly demonstrated how punitive policies and practices in response to prenatal substance use are associated with poorer

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[1] Provisional Drug Overdose Death Counts. Centers for Disease Control and Prevention. Last reviewed March 11, 2026. Accessed March 26, 2026.
[2] Provisional Drug Overdose Death Counts. Centers for Disease Control and Prevention. Last reviewed March 11, 2026. Accessed March 26, 2026 (Provisionally, there were 68,408 drug overdose deaths during this period).
[3] Garnett MF, Miniño AM. Drug overdose deaths in the United States, 2003–2023. NCHS Data Brief, no 522. Hyattsville, MD: National Center for Health Statistics. 2024. DOI: https://dx.doi.org/10.15620/cdc/170565.
[4] Han B, Compton WM, Einstein BE, et al. Pregnancy and Postpartum Drug Overdose Deaths in the US Before and During the COVID-19 Pandemic. JAMA Psychiatry. 2024;81(3). doi:10.1001/jamapsychiatry.2023.4523.
[5] Bruzelius E, Martins SS.US Trends in Drug Overdose Mortality Among Pregnancy and Postpartum Persons, 2017-2020. JAMA. 2022;328(21). doi:10.1001/jama.2022.17045.
[6] Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees. Centers for Disease Control and Prevention Maternal Mortality Review Information Application (Aug. 2025). Accessed March 26, 2026 (analyzing data from 46 states).
[7] Pregnancy-Related Deaths Among American Indian or Alaska Native Women: Data from Maternal Mortality Review Committees. (Data analyzed included 46 states). Centers for Disease Control and Prevention Maternal Mortality Review Information Application (Aug. 2025). Accessed March 26, 2026 (analyzing data from 46 states).

Vital Strategies

outcomes, including higher rates of neonatal abstinence syndrome (NAS).[8] Moreover, fear of surveillance and punishment can drive pregnant people away from lifesaving prenatal care.[9]

HCA's proposed rule establishing standards and procedures for the identification of substance-exposed infants and the development and implementation Plans of Safe Care (POSC) would increase families' unnecessary investigation by the Children, Youth and Families Department (CYFD) and undermine families' trust in healthcare and other supportive services. Vital Strategies submits this comment to outline our concerns with the proposed regulation and to offer recommendations on how the rule can be better aligned with state and federal law, as well as the evidence base.

I. Harmonize the use of key words and ensure readability

Vital Strategies recommends that HCA ensure consistency in the use of key terms throughout the rule. For example, the proposal includes definitions for terms that do not appear in the substantive rule text, such as "active efforts,"[10] and "navigation services."[11] The proposed rule defines some terms, such as "guardian," that are already defined in statute,[12] with some definitions differing from the applicable statutory language.[13] There are also several important domains where a mix of inconsistent terms is used across the proposed rule's definitions section and substantive provisions, which undermines the rule's clarity and comprehensibility, such as:

1. "Birthing facility," which is defined as inclusive of hospitals that provide labor and delivery services, as well as licensed birth centers,[14] appears in only three provisions of the proposed rule,[15] In other subsections of the proposal, the text refers variously to

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[8] Faherty LJ, Kranz AM, Russel-Fritch J. Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy with Rates of Neonatal Abstinence Syndrome. JAMA Network Open. 2019;2(11): e1914078. doi:10.1001/jamanetworkopen.2019.14078.

[9] Herbolsheimer C, Burge S. Afraid to Seek care? A Fixed Effects Analysis of State Fetal Protection Legislation and Prenatal Healthcare Utilization from 2022 to 2025. SSM Population Health. 2022;20. doi:10.1016/j.ssmph.2022.101273. *See also* Overdose deaths increased in pregnant and postpartum women from early 2018 to late 2021. News Release. National Institutes of Health. Published Nov. 22, 2023. Accessed March 26, 2026 ("'The stigma and punitive policies that burden pregnant women with substance use disorder increase overdose risk by making it harder to access life-saving treatment and resources,' said Nora Volkow, M.D., NIDA Director and senior author on the study. 'Reducing barriers and the stigma that surrounds addiction can open the door for pregnant individuals to seek and receive evidence-based treatment and social support to sustain their health as well as their child's health'").

[10] Proposed NMAC 8.3.2.7(A).

[11] Proposed NMAC 8.3.2.7(N). While the term "navigation services" appears in the definition for other terms (e.g., the definition for "CARA navigation program" in proposed NMAC 8.3.2.7(C)(2), it is not used in the substantive rule.

[12] *See generally* N.M. Stat. Ann. § 14-4-5.7(B) ("A word or phrase that is defined in an applicable statute should not be defined in rule. A conflict between a definition that appears in a rule and in an applicable statute is resolved in favor of the statute").

[13] *See, e.g.,* proposed NMAC 8.3.2.7(A) (defining "Active efforts" differently than N.M. Stat. Ann. § 32A-1-4(A)). *See also* proposed NMAC 8.3.2.7(P)(2) (defining "Plan of safe care (POSC)" despite the definition in N.M. Stat. Ann. § 32A-1-4(Y)).

[14] Proposed NMAC 8.3.2.7(B).

[15] Proposed NMAC 8.3.2.10(D)(" Emergency department or urgent care deliveries: In situations where a delivery occurs before transfer can occur to a birthing facility, the staff in the emergency or urgent care department shall initiate a POSC if the family qualifies for one based on verbal screening"), 8.3.2.11(A)(4)(c)(" The address of the child's parent(s), relatives, guardian, custodian or caregiver who will be taking the child home from the birthing facility"), 8.3.2.12(E)(" **Facility CARA**

“hospital,”[16] ”birthing hospitals,”[17] and ”clinics that perform perinatal visits,”[18] amongst other terms.

2. The proposed rule does not define “provider” or “perinatal provider” but these terms appear throughout its substantive provisions, including in proposed NMAC 8.3.2.9(A), 8.3.2.9(C), 8.3.2.10(A)-(B), 8.3.2.11(A)(4)(g), and 8.3.2.13(A). Whereas “health care professional” is a defined term,[19] it does not appear at all in the subsequent text of the proposal other than in the definition of ”Plan of safe care (POSC).”[20] “Clinician” is defined,[21] but appears only in proposed NMAC 8.3.2.9.

3. “CARA families” and “CARA infants” are not defined terms.

We also encourage HCA to consider modest changes to promote readability, including consistency in language within individual subsections of the proposed rule.[22] HCA should also confirm the accuracy of cross-references in defined terms.[23]

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navigator/care coordinator: Are direct agents of the HCA or its subcontractor, who add on-site presence of the CARA navigation program to hospitals. There shall be facility CARA navigator coverage at every birthing facility in the state”) (emphasis in original).

[16] Numerous provisions of proposed NMAC 8.3.2.

[17] *See, e.g.,* proposed NMAC 8.3.2.7(C)(2), (F).

[18] Proposed NMAC 8.3.2.14(B).

[19] Proposed NMAC 8.3.2.7(H)(1).

[20] Proposed NMAC 8.3.2.7(P)(2). The term “healthcare professional” also appears once in proposed NMAC 8.3.2.11(A)(4)(g).

[21] Proposed NMAC 8.3.2.7(C)(6). We also note that this definition appears inconsistent with other areas of New Mexico law, which describe ”certified nurse midwife” and ”licensed midwife,” only the former of which has independent prescriptive authority as contemplated by this proposed rule’s definition of ”clinician.“ *See* NMAC 16.11.2.11 and 16.11.3.14.

[22] For example, proposed NMAC 8.3.2.12(F)(4) describes a nation, pueblo or tribe assuming both ”full responsibility” and ”full custody” of an infant. These terms of presumably intended to be synonymous but neither is defined and the variability in use of terms invites confusion.

[23] *See, e.g.,* proposed NMAC 8.3.2.7(C)(1) (defining “CARA navigator” as, in part, “[f]or purposes of Section 32A-3A-2(C) NMSA 1978, a CARA navigator serves as the care coordinator for substance-exposed newborns under this part and is distinct from care coordinators employed by medicaid managed care organizations who perform the care-coordination functions required under 8.308.10 NMAC”). Section 32A-3A-2(C) NMSA 1978 is the statutory definition of “guardian.”

II. Establish or refine the definitions for critical terminology

1. ***Substance-exposed infant*: The definition of "substance-exposed infant" is concerningly overbroad, as *virtually anything* "has the potential to impact the health or development of [an] infant,"[24] and the proposed rule fails to define "substance." Over-the-counter medications such as acetaminophen or antacids, along with multivitamins or other supplements, easily fall within this definition. However, as written it also clearly encompasses things like caffeine, aspartame and other artificial sweeteners, or undercooked meat, seafood, and eggs.

   Further underscoring this issue, the proposed definition specifically *declines* to differentiate between illicit substances, prescribed medications, and legal substances.[25] Vital Strategies strongly recommends revisiting this definition so that it is not so vastly overinclusive.

   We recommend that HCA adopt the following definition of "substance-exposed infant":

   > ***Substance-exposed infant*** *means an infant under one year of age who is born with confirmed exposure in utero to alcohol or a non-prescribed controlled substance and who displays signs of substance withdrawal, a Fetal Alcohol Spectrum Disorder diagnosis, or other signs of an objective physical, neurological, or behavioral effect from the confirmed exposure in utero to alcohol or a non-prescribed controlled substance.*

---

[24] Proposed NMAC 8.3.2.7(S)(5).
[25] Proposed NMAC 8.3.2.7(S)(5) (referring to "illicit substance such as fentanyl, methamphetamine or heroin, prescribed medication such as opioids, methadone, buprenorphine, or legal substances including alcohol, tobacco, and marijuana").

2. ***Referral* vs. *Report* and *Assessment* vs. *Investigation*:** Proposed NMAC 8.3.2.7 does not offer a definition of "referral," "report," or "investigation," though differentiating these terms is critical to understanding the procedural and substantive requirements of this rule, as well as the respective roles and responsibilities of clinicians, institutions, and New Mexico agencies.[26]

   We also specifically note the harms of implementing the requirements of the Child Abuse Prevention and Treatment Act (CAPTA) in ways that fail to distinguish between a notification and a report.[27] In other words, the families of substance-exposed infants are commonly reported to the child protective services system and subject to investigation and its attendant consequences,[28] even where there is no credible safety concern. Moreover, families of color are disproportionately impacted by reporting, investigations, and child removal, including in the context of prenatal substance use.[29,30] In turn, women whose children are removed have higher odds of overdose,[31] underscoring the urgency of avoiding this outcome whenever possible, including by ensuring that this rule clearly delineates key definitions to minimize unnecessary reporting and investigation by CYFD.

3. ***CARA navigator* vs. *Care coordinator* vs. *Facility CARA navigator:*** Vital Strategies respectfully encourages HCA to streamline and simplify the use of these terms to avoid confusion. New Mexico statute governing Plans of Safe Care (POSC) includes the requirement for each birthing hospital in the state have at least one care coordinator available.[32] By contrast, this proposed rule defines a "facility CARA navigator" as an employee or contracted representative with an on-site presence at birthing hospitals or birth centers and a "care coordinator" as synonymous with "CARA navigator" (as distinct from a "facility CARA navigator"). We query the necessity of adopting different nomenclature than that in state statute.[33]

III. Focus on infants *affected by* substance exposure, consistent with state and federal law

In line with a public health approach and consistent with federal law and key provisions of New Mexico state law, Vital Strategies urges HCA to revisit this proposed rule in its entirety to focus chiefly on infants that are demonstrably *affected by* substance exposure.

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[26] State statutes also differentiate between notifications and a report of child abuse or neglect. *See, e.g.,* N.M. Stat. Ann. § 32A-4-3(I) (defining "notification" and specifying a notification "shall not constitute a ***report*** of child abuse or neglect") (emphasis added).

[27] Lloyd MH, Luczak S, Lew S. Planning for safe care or widening the net? A review and analysis of 51 states' CAPTA policies addressing substance-exposed infants. Children and Youth Services Review. 2019;99. doi:10.1016/j.childyouth.2019.01.042. ("Many states now mandate reporting all positive infant drug screens to CPS regardless of safety concerns"); National Center on Substance Abuse and Child Welfare (NCSACW). How States Serve Infants and Their Families Affected by Prenatal Substance Exposure: Brief 1 – Identification and Notification. 2021. Accessed March 28, 2026 ("Most states do not have a notification process separate from their reporting process for child abuse and neglect"). Even where a jurisdiction does

Federal law requires states to establish policies and procedures to ensure that "infant[s] ***born and identified as being affected by substance abuse or withdrawal symptoms***, or a Fetal Alcohol Spectrum Disorder" receive a plan of safe care.[34] A plain reading of this language suggests that the target is 1) *infants who have been born*, and; 2) *are experiencing some demonstrable health impact from substance exposure.* Per se substance exposure on its own in the prenatal period does not satisfy either of these criteria.

Key provisions of New Mexico law reinforce this reading, including NMSA § 32A-3A-13, which requires HCA to promulgate rules regarding the care of "newborns ***who <u>exhibit physical, neurological, or behavioral symptoms</u>*** ***consistent with prenatal drug exposure, withdrawal symptoms from prenatal drug exposure***, or fetal alcohol spectrum disorder."[35] Similarly, NMSA 32A-3A-13(B)(2) specifically directs HCA to promulgate a rule with "definitions … to identify a child ***born affected by*** substance use or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder."[36] The language of these provisions is unambiguously limited to infants showing one or more symptoms of substance exposure.

By contrast, proposed NMAC 8.3.2 as currently drafted, including the definition of "substance-exposed infant" in proposed NMAC 8.3.2.7(S)(5), sweeps in unverified gestational exposure to virtually any

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delineate between a notification versus a report of a substance-affected infant, the mechanisms for submission of that information and practical consequences (e.g., subsequent investigation) may be largely indistinguishable from one another.

[28] Such as case planning, ongoing monitoring, home visits, court hearings, separation, and termination of parental rights.

[29] Cort NA, Cerulli C, He H. Investigating Health Disparities and Disproportionality in Child Maltreatment Reporting. Public Health Management and Practice. 2010;16(4). doi:10.1097/PHH.0b013e3181c4d933.

[30] Dorothy Roberts. The Challenge of Substance Abuse for Family Preservation Policy. Journal of Healthcare Law and Policy. 1999;3 ("Most reports to child protection services based on positive newborn drug tests come from inner-city hospitals that serve poor minority communities").

[31] Thumath M, Humphreys D, Barlow J et al. Overdose among mothers: The association between child removal and unintentional drug overdose in a longitudinal cohort of marginalised women in Canada. International Journal of Drug Policy. 2021;91. doi:10.1016/j.drugpo.2020.102977

[32] N.M. Stat. Ann. § 32A-3A-13(B)(4)(a).

[33] We also note that the proposed definition of "facility CARA navigator" is *not* specific to CARA navigators and thus would include literally *any* employee or contracted representative with an on-site presence at birth hospitals or birthing centers, regardless of whether the employee or contracted representative is engaged in any relevant activities. Proposed NMAC 8.3.2.7(F).

[34] 42 U.S.C § 5106a(b)(2)(B)(iii) (emphasis added). This requirement is imposed as a funding eligibility condition for states to receive federal child abuse or neglect prevention and treatment grants.

[35] N.M. Stat. Ann. § 32A-3A-13(A) (emphasis added). The clear delineation of infants experiencing demonstrable health impacts from substance exposure (as opposed to substance exposure per se) is reinforced throughout the statute, including N.M. Stat. Ann.§§ 32A-3A-13(B)(3)(b) ("information pertaining to a child ***born and diagnosed by a health care professional as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure*** or a fetal alcohol spectrum disorder") (emphasis added), (G)(2) (training requirements on "how to assess whether to make a notification to the department pursuant to Subsection B of Section 32A-4-3 NMSA 1978 for a ***child who has been diagnosed as affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure*** or a fetal alcohol spectrum disorder") (emphasis added).

[36] N.M. Stat. Ann. § 32A-3A-13(B)(2) (emphasis added).

substance as a basis for a family's compulsory participation in the CARA navigation program,[37] regardless of whether there a documented effect on the infant or even a legitimate health or safety concern for the infant.[38] Moreover, HCA's proposed rule as a whole outlines a process that favors escalating surveillance and pressure on families rather than an individualized assessment of risks and needs (*see* additional discussion in Section V). The result is that thousands of New Mexico families will be ensnared in unnecessary system involvement that can lead to avoidable and traumatic family separation.

The following hypothetical scenarios demonstrate how this rule could be implemented in overbroad, unreasonable, and harmful ways:

- Out of an abundance of caution, a pregnant person discloses to their obstetrician that they drank a small amount of champagne at a wedding before they became aware of their pregnancy. The person did not consume any other alcohol or drugs while pregnant, has no history of substance misuse, and is not at risk for substance use disorder. The infant is born healthy, and it is clear that the champagne did not affect the infant in any way. Yet based on this single, precautionary disclosure, the proposed rule would require the development of a Plan of Safe Care (POSC), mandate referrals for substance use prevention and treatment programs and a home visiting or early intervention family infant toddler program, and subject the birthing person and their family to 13 months of invasive surveillance.
- A pregnant person unexpectedly goes into labor and is transported to the nearest birthing hospital. The birthing hospital asks the pregnant person for a list of any medications or substances they are taking to ensure there are no contraindications with medications that may be administered during delivery. The pregnant person discloses that they take blood pressure medication for hypertension and prenatal vitamins – both under the supervision of and as directed by a licensed health care professional. Despite the absence of any identified health effects or concerns for the infant based on this information, the proposed rule would compel the pregnant person and their family to participate in the CARA navigation program.
- A birthing hospital administers medication to a pregnant person in labor. Under the proposed rule, the infant now meets the definition of "substance-exposed infant," thereby requiring the birthing person and their family to participate in the CARA navigation program. Stated bluntly, the proposed rule would force a birthing person to submit to more than a year of compelled

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[37] Although a family ostensibly must consent to program participation by signing a Plan of Safe Care (proposed NMAC 8.3.2.10(B)), this is a fundamentally coercive process because declining to sign constitutes "POSC non-compliance" which is referred to the Children, Youth, and Families Department (CYFD).

[38] The current regulation defines "substance-exposed newborn" as "any newborn exposed in utero to an illicit substance such as methamphetamine or heroin, prescribed medication such as opioids, methadone, buprenorphine, and methadone." NMAC 8.10.5.7(V). There is nothing that has changed in state statute which suggests that the broader definition of proposed NMAC 8.3.2.7(S)(5) is required or appropriate.

participation in the CARA navigation program or forego receiving medically indicated care during the birthing process.

Separation of children from their families can have long-term negative consequences for their wellbeing across a range of domains.[39] The fear of surveillance and threat of family separation can also cause people to avoid seeking essential prenatal care,[40,41] which is associated with poorer health outcomes for birthing people and their infants,[42] and undermines trust in the patient-provider relationship for those who do seek such care. Research suggests that punitive policies toward substance use in pregnancy do not reduce substance during pregnancy,[43] and in fact are associated with higher levels of neonatal abstinence syndrome (NAS).[44] To effectuate the CARA program's goal of "ensur[ing] the safety and well-being of infants,"[45] HCA should revise this rule to considerably narrow its focus to circumstances where 1) there is toxicologically confirmed substance exposure; and 2) there is some demonstrable and clinically significant impact on an infant from that substance exposure.

Vital Strategies acknowledges that NMSA § 32A-4-3(G)-(I) can be read at first blush as requiring the creation of a POSC based on prenatal substance use alone without the presence of clinically significant health effects on an infant.[46] However, NMSA § 32A-4-3(H)(1) clearly distinguishes the required development of a POSC for a substance-exposed newborn versus a pregnant person who must agree to its creation.[47] Further, read in conjunction with NMSA 32A-3A-13, "substance-exposed newborn" may be reasonably understood within this requirement as limited to newborns who exhibit objective

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[39] M. Crittenden P, Spieker S. The effects of separation from parents on children. Understanding Child Abuse and Neglect - Research and Implications. Published online November 7, 2023. doi:10.5772/intechopen.1002940.
[40] Stone R. Pregnant women and substance use: Fear, stigma, and barriers to care. Health & Justice. 2015;3(1). doi:10.1186/s40352-015-0015-5.
[41] Herbolsheimer C, Burge S. Afraid to seek care? A fixed effects analysis of state fetal protection legislation and prenatal healthcare utilization from 2002 to 2015. SSM - Population Health. 2022;20:101273. doi:10.1016/j.ssmph.2022.101273.
[42] Wymelenberg S; Institute of Medicine (US). Science and Babies: Private Decisions, Public Dilemmas. Washington (DC): National Academies Press (US); 1990. 5, Prenatal Care: Having Healthy Babies. Available from: https://www.ncbi.nlm.nih.gov/books/NBK235274/#:~:text=Newborns%20whose%20mothers%20had%20no,who%20had%20early%20prenatal%20care.
[43] Austin AE, Hergenrother LC, Shanahan ME. Illicit Drug Use During Pregnancy in States With and Without Punitive Prenatal Substance Use Policies. Am. J. Preventive Med. 2025;70(3). doi:10.1016/j.amepre.2025.108155.
[44] Faherty LJ, Kranz AM, Russell-Fritch J, Patrick SW, Cantor J, Stein BD. Association of punitive and Reporting State policies related to substance use in pregnancy with rates of neonatal abstinence syndrome. JAMA Network Open. 2019;2(11). doi:10.1001/jamanetworkopen.2019.14078.
[45] Proposed NMAC 8.3.2.8.
[46] A volunteer, contractor, or staff of a hospital or freestanding birth center shall "make a notification" to HCA upon "[a] finding that a pregnant woman is using or abusing drugs made pursuant to an interview, self-report, clinical observation, or routine toxicology screen," though this finding may *not* form the sole basis for a report of suspected abuse or neglect. N.M. Stat. Ann. § 32A-4-3(G)-(I).
[47] N.M. Stat. Ann. § 32A-4-3(H)(1) ("A contractor or staff of a hospital, freestanding birthing center or clinic that provides prenatal or perinatal care shall . . . complete a written plan of safe care for a substance-exposed newborn or a pregnant person who agrees to creating a plan of safe care"). N.M. Stat. Ann. § 32A-3A-13(B)(1) reinforces this distinction between a permissive POSC prior to birth and mandatory POSC following birth, specifying that "participation in the plan of safe care development process, which ***may*** occur at a prenatal or perinatal medical visit and ***shall*** occur prior to a substance-exposed child's discharge from a hospital" (emphasis added).

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signs of substance exposure. Indeed, it is difficult to imagine that the New Mexico state legislature intended to compel participation in the CARA navigation program, inclusive of mandatory referrals for substance use prevention and treatment, for any pregnant individual based on nothing more than taking a medication as prescribed by their health care professional, being administered medication during childbirth, or consuming even a miniscule amount of alcohol or other substances that have no ultimate effect on the health of an infant.

By our reading, HCA would satisfy federal and state law requirements if it revised the rule to establish the following:

- Prenatal substance use on its own (however that is ascertained) triggers the creation of a POSC and a notification to HCA *only when* the pregnant person consents to the process;
- Creation of a POSC and notification to HCA are required *only when* 1) there is toxicologically confirmed substance exposure; 2) the exposure is to a non-prescribed substance; and 3) there is some demonstrable and clinically significant effect on the physical, neurological, or behavioral health of an infant who has been born from that substance exposure.

Section II.1 of this comment contains a proposed definition for "substance-exposed infant" that reflects this approach, the adoption of which would better align this rule with state and federal law. The approach would also be consistent with models implemented in other jurisdictions.[48] We strongly recommend that HCA protect against coercion in the implementation of these requirements and establish a process that is fundamentally non-punitive and family-centered (see Sections V and VI for further discussion).

IV. Clarify roles and responsibilities of agencies, institutions, and individuals

As currently drafted, HCA's proposed rule contains numerous ambiguities as to the roles and responsibilities of different agencies, institutions, and individuals. For instance, proposed NMAC 8.3.2.10(A) directs that "*[a]ll providers at hospitals, birthing centers, or providers who perform perinatal medical visits*, *must be routinely, verbally screening* for substance use disorder in pregnant, birthing, and postpartum people *and developing POSC when identifying substance use in pregnancy*."[49] Leaving

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[48] *See, e.g,* Ohio Admin. Code 5101:2-1-01(314) (defining "substance affected infant" to exclude in utero exposure to any substance used as prescribed during pregnancy), OR. Admin. R. 413-080-0050(32) (defining "Substance affected infant" to require *both* that "prenatal substance exposure is indicated at birth" *and* that an "assessment by a health care provider identifies signs of substance withdrawal, a Fetal Alcohol Spectrum Disorder diagnosis, or detectable physical, developmental, cognitive, or emotional delay or harm that is associated with prenatal substance exposure"), and Pennsylvania Plan of Safe Care Guidance, Appendix C. March 2019. Accessed April 8, 2026 ("Affected by" means "infant with detectable physical, developmental, cognitive, or emotional delay or harm that is associated with maternal substance use or withdrawal, as assessed by a healthcare provider").

[49] Proposed NMAC 8.3.2.10(A) (emphasis added). We also note this provision should likely read "all providers at hospitals, ***all providers at*** birthing centers, or providers who perform perinatal medical visits."

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aside the fact that "provider" is not defined in the rule (*see* Section I.2), this encompasses a huge and varied range of clinicians, including those who may only incidentally provide care or services to pregnant, birthing, or postpartum people. The breadth of this provision would likely result in a confusing and redundant patchwork from an implementation perspective.

In other areas of the proposal, responsibilities are crafted in remarkably narrow ways. CARA navigators are directed to "[c]omplete a POSC if it was not completed by the infant hospital discharge staff upon their initial contact."[50] Although presumably not the intended result, this provision as written would require a CARA navigator to create a POSC in any circumstance where it had been prepared by someone *other than* hospital discharge staff.

Other core requirements for the creation of a POSC are situated only as to "health care professionals," although a CARA navigator is specifically empowered to fulfill this function,[51] and subsequent related provisions refer simply to "the individual completing the POSC" and "the staff member."[52] We respectfully suggest that HCA closely review the rule to ensure that roles and responsibilities are clear, not in conflict or redundant with one another, and consistent with other provisions of New Mexico state law.

The interaction between HCA and CYFD would benefit from additional refinement in the rule. For example, proposed NMAC 8.3.2.11(B) stipulates that in "*all* situations" where a report or family assessment is placed with CYFD, the individual submitting the report or referral "will assess the POSC for the child in the [CARA supports system portal] and update the POSC" accordingly.[53] However, this fails to address that many such reports or referrals may originate from a non-health care professional and whether access to the portal would even be possible, let alone legally permissible or appropriate, given the inclusion of highly sensitive health and other information in a POSC.

Finally, it is also unclear how the proposed rule would relate to CYFD's July 2025 directive on taking custody of substance-exposed infants prior to discharge from the hospital. That directive has been vociferously opposed by public health advocates in New Mexico and beyond,[54,55] and was decried as illegal by the state's own Office of Family Representation and Advocacy.[56] Rather than providing the

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[50] Proposed NMAC 8.3.2.12(D)(1). We also note the ambiguity of "their" and whether is refers to the hospital discharge staff, the CARA navigator, or the family.
[51] *See, e.g.,* proposed NMAC 8.3.2.11(A)(4)(g).
[52] Proposed NMAC 8.3.2.11(A)(4)(j)
[53] Proposed NMAC 8.3.2.11(B) (emphasis added).
[54] Sign-on Letter: Supports Not Separation. Physicians for Reproductive Health. December 11, 2025. Accessed April 7, 2026.
[55] Esteban Candelaria, *New Mexico says new effort to aid drug-exposed newborns is working*, SEARCHLIGHT NEW MEXICO, March 23, 2026, https://searchlightnm.org/new-mexico-says-new-effort-to-aid-drug-exposed-newborns-is-working/ ("Advocates have continued to express concerns about the program, arguing the state's implementation was inconsistent and it violates existing protections. The fundamental concern: Ripping young children away from their families inflicts serious developmental harm and disproportionately affects certain communities").
[56] Jason McNabb, *'It's violating the law': State agency pushes back on Gov. Grisham's CARA directive*, KOAT ACTION NEWS. July 31, 2025. https://www.koat.com/article/its-violating-the-law-state-agency-pushes-back-on-governor-grishams-cara-directive/65555643

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clarity that New Mexico stakeholders need,[57] HCA's proposed rule would likely increase confusion and further amplify the harms of that directive. Although it is not the subject of this comment, Vital Strategies echoes the concerns and objections to the directive voiced by New Mexico stakeholders, including that it is overbroad, punitive, and fundamentally inconsistent with public health objectives.[58,59]

V. Shift away from emphasis on coercion, surveillance and punishment, including by addressing harmful presumptions that favor family separation

The final rule should avoid reinforcing the coercion, surveillance, and punishment of families who may be substance-involved and instead adopt a health-centered orientation that prioritizes family autonomy and well-being.

The reference to "parental competence" in the definition of "home visiting" is an early signal in the proposed rule of an orientation that disfavors parents and facilitates negative presumptions that will have harmful consequences for families.[60] This orientation is reinforced throughout, including by the following proposed provisions:

1. *Proposed NMAC 8.3.2.10(B)*: A parent, relative, guardian, or caregiver's refusal to sign a Plan of Safe Care (POSC) is considered per se "POSC non-compliance," resulting in a referral to CYFD to request a family assessment. This is intrinsically coercive and directly erodes family autonomy.[61]

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[57] Esteban Candelaria, *New Mexico says new effort to aid drug-exposed newborns is working*, SEARCHLIGHT NEW MEXICO, March 23, 2026, https://searchlightnm.org/new-mexico-says-new-effort-to-aid-drug-exposed-newborns-is-working/ ("The confusion [about the directive] led to inconsistent implementation of the program for months, said Donalyn Lorenzo, who until earlier this year worked as the director of CYFD's Office of Tribal Affairs").

[58] This comment has already addressed how punitive policy responses to substance use in pregnancy are ineffective. *E.g.*, Faherty LJ, Kranz AM, Russel-Fritch J. Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy with Rates of Neonatal Abstinence Syndrome. JAMA Network Open. 2019;2(11): e1914078. doi:10.1001/jamanetworkopen.2019.14078; Austin AE, Hergenrother LC, Shanahan ME. Illicit Drug Use During Pregnancy in States With and Without Punitive Prenatal Substance Use Policies. Am. J. Preventive Med. 2025;70(3). doi:10.1016/j.amepre.2025.108155.

[59] Leading medical organizations oppose these kinds of responses to substance use in pregnancy. *E.g.,* Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People. American Society of Addiction Medicine (ASAM). Adopted October 2, 2022. Accessed April 7, 2026 ("Child protection system agencies should not use evidence of substance use to implement sanctions on parents, especially child removal. Such sanctions should only be made when other risk factors or harms have been assessed or identified, and there is objective evidence of abuse, neglect, or other danger to the child"). *See also* Medical and Public Health Group Statements Opposing Prosecution and Punishment of Pregnant People. Pregnancy Justice. Revised June 2023. Accessed April 7, 2026 (including statements from the American Medical Association, the American College of Obstetricians and Gynecologists, the National Perinatal Association, the American Academy of Family Physicians, the American Society fo Addiciton Medicine, etc.).

[60] Proposed NMAC 8.3.2.7(H)(2).

[61] The currently applicable rules indicate this approach is not statutorily required. Even prior to the adoption of 2025 NM SB42, New Mexico statute required that "the child's parent, relative, guardian or caretaker who is present at discharge" sign the plan of care and required notification to CYFD "[i]f the parents, relatives, guardians or caretakers of a child released from a hospital or freestanding birthing center pursuant to a plan of care fail to comply with that plan." N.M. Stat. Ann. §§ 32A-3A-13(B)(1)(c) (2024), 32A-3A-14(A) (2024). 2025 NM SB42 did not make any relevant substantive changes to these requirements. Yet the

2. *Proposed NMAC 8.3.2.11(A)(4)(g)*: A family's decision to "decline all services identified as necessary to address infant safety and wellbeing" is considered POSC non-compliance, and results in a referral to CYFD for a family assessment. However, there is no meaningful rubric contained in the rule to assess what constitutes a service that is "necessary to address infant safety and well-being."
3. *Proposed NMAC 8.3.2.11(A)(4)(j)*: A caregiver's declining to participate in the creation of a POSC is recorded in the POSC and a notification is sent to both the CARA program and CYFD. Again, the proposal lacks guidance on what constitutes "non-participation," and invites kneejerk referral of families to CYFD.
4. *Proposed NMAC 8.3.2.12(D)(12)*: Where CYFD declines to open a case or closes a case without taking custody of an infant after a CARA navigator has reported immediate concerns for abuse or neglect,[62] a CARA navigator is required to dial up surveillance of a family, including in-home follow-up to "establish the necessary intensity of engagement given CYFD decision in not pursuing custody situation within 14 days."[63] The "necessary intensity of engagement" is open-ended and CARA navigators are required to make another referral to CYFD if "new information arises."[64] Combined, these provisions call for a high level of continuing scrutiny and intrusion into a family's life even after CFYD has made a finding that a case is not warranted or has concluded a case without taking custody of an infant. Because the language of the proposed rule is so permissive, families potentially face a perpetual cycle of HCA surveillance and CYFD assessment or investigation with no off-ramp or real procedural safeguards (*see* Section VI for more discussion of recommended safeguards).
5. *Proposed NMAC 8.3.2.12(F):* The rule's navigation closure criteria offer no pathway by which a family may simply opt out of services prior to an infant reaching 13 months of age, even if there is no documented health or safety concern for that infant. We urge HCA to establish a mechanism by which a family may opt to discontinue participation if there is no documented health or safety concern by HCA or CYFD.

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current administrative rules governing plans of care expressly contemplate the ability for a caregiver to refuse a plan of care and specify that a plan of care is inactive until signed by the parent or designated caregiver, with provisions related to non-compliance applying only once a plan of care is in place. NMAC §§ 8.10.5.8(A)(2)(c) (providing for "submission of the notification of CARA newborn status form" when "the caregiver of the newborn with substance exposure has refused a CARA plan of care"), 8.10.5.9(B)(8) (providing that "[a] POC shall be considered inactive until it has been signed by the parent or designated caregiver"), 8.10.5.12 ("If ***after the POC is in place***, the family disengages in services, the CC contacts the CARA navigators and shall follow internal processes regarding a report to SCI") (emphasis added).

[62] Our reading is that proposed NMAC 8.3.2.12(D)(11)-(12) are intended to be conditioned upon and follow proposed NMAC 8.3.2.12(D)(10), though that is not clear from rule as drafted. We recommend making this clear. Otherwise, proposed NMAC 8.3.2.12(D)(11)-(12) would be triggered in any instance where someone has made a report to CYFD and the agency has declined to open a case or closed a case without taking custody, even if the underlying report lacked credibility or merit.

[63] Proposed NMAC 8.3.2.12(D)(12)(c).

[64] Proposed NMAC 8.3.2.12(D)(12)(d).

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The navigation closure criteria regarding “non-responsive, difficult to engage families” warrant specific discussion”[65] As with other highly consequential terminology in the proposal rule, these terms are unaccompanied by any rigorous criteria or standards, leaving the door open for HCA to surveil and take adverse action against families based on a CARA navigator’s subjective assessment of what constitutes sufficient responsiveness or ease of engagement. For families in this category who are not engaged with CYFD, the proposed rule requires the CARA program to “have processes in place to monitor listed CARA participants for law enforcement activity or emergent medical care activity that shall prompt a new SCI report until the child is 13 months old.”[66] This is exceptionally intrusive while at the same time lacking guidance on what kinds of law enforcement or health care activity would suffice to initiate a new report. Any number of activities with absolutely no relevance to infant safety would easily fall into this provision, subjecting families to ongoing surveillance and potential CYFD investigation. Moreover, this posture toward families is likely to actively *discourage* activity that the state has an interest in promoting and protecting, such as a victim of domestic violence seeking assistance from law enforcement or a parent taking their child to see a pediatrician because the child has a fever, for example.

At each juncture, from the inception of a POSC to the criteria for navigation services to terminate, the proposed rule establishes a presumption in favor of intensified surveillance, intrusion, and potential entanglement with a CYFD investigation and its attendant consequences. In its totality, the proposed rule is fundamentally punitive, imposing harsh consequences on families who are deemed “non-compliant,” and offering no pathway for a family opt out of navigation services, irrespective of whether there is a continuing need or desire for those services. HCA should revise the rule to prioritize family autonomy, health, and wellbeing.

VI. Require meaningful procedural and substantive safeguards for families

Termination of parental rights has been described as the “civil death penalty” because of its devastating gravity and harm.[67,68,69] While Plan of Safe Care (POSC) creation and navigation services are distinct from that legal process, HCA’s proposed rule is intimately connected with CYFD’s powers of assessment, investigation, and child removal. We recommend the incorporation of more robust procedural and substantive safeguards throughout the rule for families who are involved with the CARA navigation program.

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[65] Proposed NMAC 8.3.2.12(F)(3).
[66] Proposed NMAC 8.3.2.12(F)(3)(b).
[67] Chris Gottlieb, The Birth of the Civil Death Penalty and the Expansion of Forced Adoptions: Reassessing the Concept of Termination of Parental Rights in Light of Its History, Purposes, and Current Efficacy, 45 Cardozo L. Rev. 1319 (2024). Available at: https://larc.cardozo.yu.edu/clr/vol45/iss5/2.
[68] Boevers, Ryan E. (2024) "Fast Track to the Civil Death Penalty: Involuntary Termination of Parental Rights and an Analysis of the Minnesota Supreme Court's Decision in R.D.L.," Mitchell Hamline Law Review: Vol. 50: Iss. 1, Article 4. Available at: https://open.mitchellhamline.edu/mhlr/vol50/iss1/4.
[69] Elizabeth Brico. “The Civil Death Penalty”—My Motherhood Is Legally Terminated. Filter. July 13, 2020. Accessed April 6, 2026. https://filtermag.org/motherhood-legally-terminated/.

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1. **Eliminate excessively vague standards and terminology that have profound implications for the rights and wellbeing of families.** The preceding sections have highlighted vague terminology, the interpretation and application of which is instrumental to the rule. We encourage HCA to eliminate or clarify this language to ensure the fair, equitable, and transparent implementation of this rule.
2. **Establish more robust procedural protections for families.** The proposed rule clearly implicates the rights and fundamental autonomy of families, yet there is a remarkable dearth of procedural protections when it comes to the intensification of CARA navigation services or referrals and/or reports to CYFD. Proposed NMAC 8.3.2.12(D)(9) is a notable exception, outlining what constitutes sufficient "outreach" before a CARA navigator requests a family assessment if the navigator is unable to reach a family or if a family has allegedly not engaged in POSC services. However, it is unclear how this provision interacts with other sections of the rule (e.g., proposed NMAC 8.3.2.13 and POSC "non-compliance" more broadly).

   We recommend a standalone section in a revised rule that addresses the rights of families participating in the CARA program. HCA should consider factors such as language and accessibility, informed consent, adequate notice and explanation regarding potentially adverse actions, etc. For example, proposed NMAC 8.3.2.11(A)(4)(f) should require *informed* consent by parents, domestic partners, and key household members prior to screening and referral for substance use disorder (SUD) rather than merely "consent." Individuals cannot meaningfully provide consent unless they fully understand the potential consequences of their decision (e.g., that a finding of SUD will be documented in a POSC that is accessible to any number of parties and that if referred services are considered necessary, declining to participate in those services will be deemed "noncompliance" and could result in adverse action).

3. **Require meaningful findings regarding infant safety and wellbeing before authorizing adverse action.** As currently drafted, the implementation of the rule could result in families entering perpetual limbo between intensified surveillance by the CARA program alongside the continuing threat of a referral and/or report to CYFD (*see* Section V on this dynamic). This is true even where CYFD may have already made a determination that there is not an imminent safety concern. A revised rule should ensure at minimum that there are rigorous, substantive standards to guide:
    - the CARA program's identification of a legitimate safety concern that justifies intensified engagement and/or a referral or report to CYFD;
    - what constitutes POSC "non-compliance" requiring a referral and/or report to CYFD consistent with state law;[70]
    - criteria for requiring a family's continuing participation in CARA navigation services if they wish to opt out.

[70] N.M. Stat. Ann. § 32A-3A-14(A) requires a notification to CYFD when a family "fail[s] to comply" with a Plan of Safe Care so that it may conduct an assessment. However, HCA has discretion in how it defines what constitutes "non-compliance." The proposed rule defines this as the failure to "take a required POSC action" or the failure to "accept a POSC referral identified as necessary for infant safety and well-being." Proposed NMAC 8.3.2.7(P)(3). The latter at least implicates some assessment of infant safety based on a family's (in)action relative to the POSC. The former is incredibly broad and correspondingly unclear. For example, is *any* action or referral contained in a POSC "required"?

4. **The lack of sufficient procedural and substantive safeguards raises substantial legal concerns.** The proposed rule requires implementation and enforcement by individuals and entities that may be considered as acting under color of state law and thus subject to the additional legal constraints applicable to state actors.[71] Our comment outlines numerous provisions which may run afoul of these constraints. For example, mandatory (or, at minimum, highly coercive) home visits and ongoing, pervasive surveillance based on mere "noncompliance" rather than individualized suspicion raises 4th Amendment and due process concerns.[72] The vagueness and lack of meaningful guidance throughout the proposed rule — what kinds of law enforcement or health care activity would suffice to initiate a new report, what constitutes "non-participation," who qualifies as "non-responsive, difficult to engage families," to name a few — likewise raise due process concerns by inviting subjective, arbitrary, and discriminatory enforcement.[73] Additionally, the lack of clear requirements around confidentiality, informed consent, and authorized disclosure raise both constitutional and statutory concerns, including potential violations of 42 CFR Part 2. These concerns underscore the practical and legal necessity to integrate more meaningful procedural and substantive safeguards throughout a revised rule.

VII. Reinforce importance of voluntary, family-centered services and support family autonomy

In the context of substance use, evidence does not support compulsory treatment,[74] but HCA's proposal is structured to effectively punish a family's non-engagement with treatment for substance use disorder as part of a Plan of Safe Care (POSC).[75] The rule includes other problematic forms of coercion, such as treating a parent's declining to sign a POSC as a form of "non-compliance" resulting in referral to CYFD.[76] This approach undermines family autonomy and a nullifies HCA's stated commitment to a "co-created" POSC.[77] It is also in direct conflict with the position of organizations like the American College of Obstetricians and Gynecologists (ACOG), which asserts that it is unethical to

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[71] *See, e.g.,* proposed NMAC 8.3.2.12(C) (specifying that "CARA navigators are direct agents of HCA or its subcontractors who are designated to manage the CARA program and the associated care coordination activities").
[72] Proposed NMAC 8.3.2.12(F)(3)(b) is particularly concerning as it effectively establishes a standing monitoring order for all law enforcement and medical activity over up to 13 months.
[73] Arbitrary and discriminatory enforcement could also lead to as applied equal protection challenges.
[74] Werb D, Kamarulzaman A, Meacham MC et al. The Effectiveness of Compulsory Drug Treatment: A Systematic Review. International Journal of Drug Policy. 2016;28. doi:10.1016/j.drugpo.2015.12.005.
[75] Proposed NMAC 8.3.2.12(D)(9) ("If the CARA navigator is unable to establish contact with the family after documented outreach or identifies that the family has not engaged in POSC identified services ***such as home visiting or substance use disorder (SUD) treatment***, the CARA navigator shall contact SCI within 24 hours to request a family assessment") (emphasis added).
[76] Proposed NMAC 8.3.2.10(B).
[77] Proposed NMAC 8.3.2.7(P)(2) defines "plan of safe care" as, in part, "***a written plan co-created with the birthing parent*** and family by a health care professional or care coordinator") (emphasis added).

"use manipulation, *coercion* or threats of criminalization to compel patients toward a particular medical decision or treatment, including during pregnancy or the postpartum period."[78]

Mandatory participation in any kind of service is also costly, can pose numerous barriers for families, and is antithetical to a person-centered approach to family wellbeing. This is particularly problematic given how the proposed rule fails to account for individuals who do not qualify for Medicaid (and thus do not have an MCO) and cannot afford private insurance yet are still required to participate in specified services – a population likely to increase in the wake of new federal Medicaid eligibility restrictions. The proposed rule also already contemplates the possibility that service *availability* may be variable,[79] further underscoring how problematic it is to coerce and punish families in order to enforce participation in mandated services.

We urge HCA to comprehensively revisit the proposed rule to avoid coercion and punitive responses to a family's purported "non-compliance."

VIII. Protect confidentiality

Proposed NMAC 8.3.2.10(A) and NMAC 8.3.10.15 acknowledge 42 CFR Part 2 and HIPAA but do not otherwise offer any guardrails around the use and dissemination of families' sensitive health information to ensure consistency with these confidentiality protections. Importantly, current rules *do* address confidentiality considerations, requiring that "[a]ny person or agency receiving information from the [Plan of Care] shall be directed to treat it as a confidential document and only to be used for the purpose of collaboration on [the] POC."[80]

We suggest HCA more robustly assess the consistency of its proposal with 42 CFR Part 2 and HIPAA. Moreover, compliance with these laws should be integrated into the trainings required as part of proposed NMAC 8.3.2.14.

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[78] Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period. ACOG Statement of Policy. Amended and Reaffirmed July 2024. Accessed April 7, 2026 (emphasis added).
[79] Proposed NMAC 8.3.2.15(C) (required reporting to include information on "the ***availability*** and uptake of the services") (emphasis added).
[80] NMAC 8.10.5.9(B)(8) ("Release of information: The [Plan of Care] shall include a release of information that includes an 8.10.5 NMAC 4 explanation of the entities with whom the information in the plan may be shared. The parent or designated caregiver completing the initial POC shall sign the document to indicate informed consent for the release of information and referrals included in the plan. A POC shall be considered inactive until it has been signed by the parent or designated caregiver. The individual completing the POC shall document that they reviewed the release of information with the caregivers. Any person or agency receiving information from the POC shall be directed to treat it as a confidential document and only to be used for the purpose of collaboration on this POC. The release of information is valid for two years").

IX. Data collection and recordkeeping should enable robust evaluation, including monitoring and addressing any racial and ethnic disparities

The proposed rule provides for ongoing data collection and dissemination, chiefly to comply with state and federal reporting requirements.[81] Vital Strategies respectfully recommends that HCA add a provision to ensure that data collection activities enable robust monitoring and evaluation, including as to any racial and ethnic disparities in the implementation of the rule. This should enable a clear assessment of whether families of color are overrepresented or otherwise disparately impacted at each stage of the process: screening, Plan of Safe Care development, alleged "non-compliance," and referrals or reports submitted to CYFD.[82] As noted in Section II.2, families of color are disproportionately impacted by reporting, investigations, and child removal, including in the context of prenatal substance use.[83,84] HCA should guard against a final rule that functions to reproduce these inequities.

Vital Strategies is concerned that HCA's proposed rule will inadvertently widen the net of system involvement for New Mexico families. Combined with proposed provisions that adopt a coercive rather than family-centered approach, the rule may ultimately drive birthing people away from essential care and supports, worsening outcomes for infants and families. We encourage HCA to closely review our recommendations and thank the agency for its consideration of our input. Should you have any questions, please do not hesitate to contact jrwan@vitalstrategies.org.

Sincerely,

Julie Rwan, MPH
Senior Technical Advisor
Vital Strategies Overdose Prevention Program
jrwan@vitalstrategies.org

Kate Boulton, JD, MPH
Senior Legal Technical Advisor
Vital Strategies Overdose Prevention Program
kboulton@vitalstrategies.org

Donette Perkins, MPP, MDIP
Technical Advisor
Vital Strategies Overdose Prevention Program
dperkins@vitalstrategies.org

Derek Carr, JD
Legal Technical Advisor
Vital Strategies Overdose Prevention Program
dcarr@vitalstrategies.org

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[81] Proposed NMAC 8.3.2.15
[82] We note that proposed NMAC 8.3.2.15(D) only refers to families who are *reported* to CYFD, but HCA should also monitor families who are *referred* for a family safety assessment.
[83] Cort NA, Cerulli C, He H. Investigating Health Disparities and Disproportionality in Child Maltreatment Reporting. Public Health Management and Practice. 2010;16(4). doi:10.1097/PHH.0b013e3181c4d933.
[84] Dorothy Roberts. The Challenge of Substance Abuse for Family Preservation Policy. Journal of Healthcare Law and Policy. 1999;3 ("Most reports to child protection services based on positive newborn drug tests come from inner-city hospitals that serve poor minority communities").

COMMENT 13

From: Hannah McDermott <hwmcdermott@gmail.com>
Sent: Thursday, April 9, 2026 10:37 AM
To: HCA-madrules
Subject: [EXTERNAL] Withdraw proposed rules on SB42

Some people who received this message don't often get email from hwmcdermott@gmail.com. Learn why this is important

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To Whom It May Concern:

I am a clinical psychologist with a specialty background in working with PTSD, trauma-related disorders, and substance use disorders. I am writing to express my strong opposition to the proposed rules for SB42 as I believe they will seriously harm families, children, and the health of our patients. These rules are deeply misguided and undermine their own proposed goals.

The rules as they are proposed will undermine patient trust in healthcare providers, putting pregnant mothers, their in-utero children, and their families at higher risk for adverse outcomes in terms of both physical and mental health. Patients will be disincentivize to be forthcoming about their challenges for fear of losing their children - putting everyone at higher risk. Additionally- these rules will penalize individuals receiving medication assisted treatment, making it more likely that individuals would use riskier street drugs and disincentivizing appropriate adherence to MAT protocols. Furthermore, these rules mean that individuals who are struggling with sobriety may not seek prenatal care at all (or at least early in pregnancy)- resulting in additional harms to mother and child.

Finally- research has resoundingly shown that punitive, stigmatizing, and mandatory substance use treatment does not work. The proposed rules will not result in New Mexicans getting appropriate health treatment and will likely result in worse outcomes, worse adherence to treatment, and rupture the already fragile trust between healthcare providers and patients.

SB42 should be crafted to effectively support families struggling with substance abuse, taking a more holistic approach to helping individuals. Please revise these rules accordingly.

Thank you,
Hannah McDermott
Licensed Clinical Psychologist

--

Hannah McDermott, PhD
Pronouns: She/Her

COMMENT 14

From: Liz McGrath <evmcg98@gmail.com>
Sent: Thursday, April 9, 2026 11:14 AM
To: HCA-madrules
Subject: [EXTERNAL] SB42

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I am writing to express my strong condemnation of the Governor's new policy of removing newborn children on the basis of their exposure to drugs. I am one of the founders of Pegasus Legal Services for Children, and practiced child welfare law for 25 years.

1. Every case of abuse or neglect is different and making an across the board policy such as is enshrined in SB42 goes against all best practices in child welfare.

2. The harm of removing a child, no matter how old, from its parent(s) reverberates throughout their lives causing untold harm to their mental and physical wellbeing.

3. Rather than remove a child under these circumstances, CYFD should be enveloping the family in supportive services.

I beg you to reject this extremely harmful law.

Elizabeth McGrath
Attorney, retired.

COMMENT 15

From: info@hsd.state.nm.us <mailservices@sks.com>
Sent: Thursday, April 9, 2026 11:50 AM
To: HCA-SubmitAComment <HCA-SubmitAComment@hca.nm.gov>
Subject: [EXTERNAL] HSD Public Comment

CAUTION: This email originated outside of our organization. Exercise caution prior to clicking on links or opening attachments.
What is your comment regarding?: General HSD Comment
Paragraph Text: Proposed 8.3.2 Rule

1. While private adoption and surrogacy are rare, they are important and significant means for gay men, trans women, and gender non-binary people to be able to have children. This rule does not create an exception to the mandatory plans of care for private adoption or surrogacy. Imagine a gay male couple who used a surrogate to conceive a child. The surrogate had to have some kind of emergency surgery during her first trimester, which required a few days of prescription pain medication. Under this rule, the surrogate would be required to be referred to a substance use prevention and treatment program (8.3.2.11(A)), her partner and the gay couple would be required to be referred to a substance abuse screening or referral program and all would be required to participate in that program for 13 months. Refusing to agree to this plan would subject the surrogate and the parents to a SCI report at CYFD. These referrals are unnecessary when the pregnant person surrenders all parental rights.
a. Suggested change: Add "A plan of safe care is not required for a substance exposed infant who is placed for private adoption or born to a surrogate." Alternatively, allow a plan of safe care to list no required service items for the exceptional situations where no services are necessary to ensure the child's safety.

2. Hundreds of thousands of disabled adults are prescribed pain medication to manage breakthrough pain. The decision of when to use these medications during pregnancy is a difficult one that is made privately between a patient and their doctor. These rules will make it impossible for those disabled people to give birth in the state of New Mexico without subjecting their families to a 13-month long mandatory plan of care. This restricts the reproductive freedom of disabled people by subjecting them to mandatory services and, if they refuse, to a child abuse investigation. It likely also violates the Americans with Disabilities Act. Given the history in the United States of highly problematic restrictions on disabled people's reproductive freedom, we should be especially cautious.
a. Suggested change: prescription pain medication, when taken as prescribed during pregnancy, should be removed from the list of substance-exposures. If it is not removed, patients must be given the opportunity to give informed consent when they are prescribed these medications, so they can choose between taking the medication or subjecting their family to a mandatory 13-month plan of care that could lead to a child abuse investigation if not followed.

3. Pregnant individuals experience crime and domestic violence at higher rates than the general population. Requiring these individuals to recover from violent injuries (gunshots, beatings, rape) without prescription pain medication, or be subject to 13 months of mandatory state services, is cruel and inhumane.
a. Suggested change: as above.

4. The current language requires a plan of care to be adopted during pregnancy, if a woman

discloses substance use during pregnancy. (See e.g. 8.3.2.10 A, suggesting that IF a POSC is not completed during pregnancy, it should be done after, implying that a POSC can be done during pregnancy). A person who does not sign such a plan is subject to a SCI report. CYFD cannot take SCI reports on fetuses, nor can they open an investigation into child abuse of an unborn child. New Mexico allows an abortion without gestational limits. Miscarriage or stillbirth are also common. CYFD has no jurisdiction to investigate a pregnant person who does not give birth to a live child.
a. Suggested change: clarify that failure to sign a plan of care may lead to a SCI report only after a live birth.

5. The current rule requires a verbal substance abuse screen at "all" prenatal medical visits. It is not uncommon to see specialized medical provider multiple times a week, especially if there are medical complications. Requiring a verbal screening at each of those visits will take significant time away from the other required medical care necessary at those visits.
a. Suggested change: require a verbal screen for substance abuse each trimester or a verbal screen for substance abuse at all "routine" prenatal medical check-ups.

6. The current rule requires a medical provider to engage in a verbal substance abuse screen. This screening is intended to diagnose a medical condition, it is conducted by a medical provider, and it is presumably paid for by insurance. It is, therefore, clearly a medical screening. Patients must be given the opportunity to give informed consent to medical screenings so they can weigh the risks and benefits of receiving the screening. While the substance use screen has significant possible benefits of providing desirable services, it also has the risk of subjecting the family to a mandatory plan of care. Medical providers have an ethical obligation to make sure that patients give informed consent unless there is an emergency and it would violate their medical ethics if they gave the screen without informed consent.
a. Suggested change: add "medical providers shall obtain informed consent prior to giving the substance use screen."

7. There is no billing code that allows medical providers to bill insurance for the required substance abuse screening.

8. 8.3.2.11(C) addresses when a child with a plan of care enters the "custody" of CYFD. Legal custody may be vested with CYFD while the child remains in the physical custody of the parents.
a. Suggested change: modify from "If an infant enters CYFD custody after a POSC has been created" to "If an infant enters CYFD custody after a POSC has been created and is placed in a resource home."

9. 8.3.2.10 (A) (2) requires disclosure of the plan of care to the child's parents. This requirement puts domestic violence victims at risk because it discloses the birthing parent's address, phone number and private medical information to the other parent.
a. Suggested change: Add "on request from the birth parent, contact information and protected health information shall be redacted on the copy of the plan of care that is sent to other parents, caregivers, or guardians."

Name:: Monika Myers
City/Town:: Albuquerque
Zip Code: : 87114
State:: NM

COMMENT 16

Mondragon, Tabitha, HCA

From: Bette Fleishman <bettemf@comcast.net>
Sent: Thursday, April 9, 2026 11:33 AM
To: HCA-madrules
Subject: [EXTERNAL] Public Comment

Some people who received this message don't often get email from bettemf@comcast.net. Learn why this is important

CAUTION: This email originated outside of our organization. Exercise caution prior to clicking on links or opening attachments.

I am writing in opposition to SB42.rules

The current draft does not align with SB$@ but instead implements an unlawful family separation.

It changes from supporting families to the safety of infants, stepping away from trauma-informed care to a much harsher and more harmful punitive response.

HCA should withdraw the proposed rule and craft a rule that addresses SB42 in a bipartisan approach. Please rewrite the rules with additional input from child welfare and substance abuse experts.

Sincerely.

B.M. Fleishman

COMMENT 17

PUEBLO OF ACOMA

OFFICE OF THE GOVERNOR

Charles P. Riley, Governor
Davy D. Malie, 1st Lt. Governor
Augustine Seymour, Jr., 2nd Lt. Governor
Steven Concho, Tribal Secretary
Norman F. Torivio, Tribal Interpreter

25 PINSBAARI DRIVE ACOMA, NM 87034 PO BOX 309 ACOMA, NM 87034 PHONE: 505-552-6604 FAX: 505-552-7204

April 9, 2026

VIA EMAIL:
New Mexico Health Care Authority
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, New Mexico 87504-2348
E: HCA-madrules@hca.nm.gov

Re: Pueblo of Acoma Written Comments on Proposed NMAC 8.3.2, Family Health and Well-Being, Plan of Safe Care for Substance-Exposed Infants

Dear Persons:

The Pueblo of Acoma ("Pueblo" or "Acoma"), submits the following comments on proposed New Mexico Administrative Code ("NMAC") 8.3.2, Plan of Safe Care for Substance-Exposed Infants, published through Tribal Notification Letter 26-06. The Pueblo appreciates the opportunity to comment, and the Health Care Authority's ("HCA") stated commitment to the government-to-government relationship with New Mexico's Indian Nations, Tribes, and Pueblos.

While the Pueblo supports the general objectives of ensuring the safety and well-being of substance-exposed infants, the proposed rule as drafted raises significant concerns regarding tribal sovereignty, the federal Indian Child Welfare Act ("ICWA"), 25 U.S.C. §§ 1901–1963, and critically, the New Mexico Indian Family Protection Act ("IFPA"), NMSA 1978, §§ 32A-28-1 to -42. The IFPA, enacted in 2022, is the controlling state law governing child custody proceedings involving Indian children in New Mexico. It provides protections that in many respects exceed those of federal ICWA and, under its conflict-of-laws provision at § 32A-28-40(B), prevails over any conflicting provision of New Mexico state law. The proposed rule fails to reference or comply with the IFPA in any respect. The Pueblo respectfully urges HCA to make substantial revisions before finalizing this rule.

I. The Proposed Rule's CYFD Referral Pathway Triggers IFPA Obligations That the Rule Entirely Ignores

The most fundamental deficiency of proposed 8.3.2 NMAC is its complete failure to address the IFPA. The IFPA defines "child custody proceeding" broadly to include not only foster care placements and terminations of parental rights, but also "**investigations and other preliminary activities preceding the formal initiation of an action**." NMSA 1978, § 32A-28-2(C) (emphasis added). The proposed rule establishes a framework under which POSC non-compliance, refusal to sign a POSC, or a CARA navigator's inability to contact a family automatically triggers a referral to CYFD's Statewide Central Intake for a safety family assessment. *See* proposed §§ 8.3.2.10(B), 8.3.2.12(D)(9), and 8.3.2.13(A). These CYFD safety family assessments constitute "investigations and other preliminary activities preceding the formal initiation of an action" within the meaning of the IFPA § 32A-28-2(C). Accordingly, the full gamut of IFPA protections—including active-efforts requirements, tribal notification by certified mail, tribal jurisdiction, coordination of services, and placement preferences—attaches at the point of any CYFD referral involving an Indian child.

Yet the proposed rule contains no reference to the IFPA, no mechanism for ensuring compliance with its requirements, and no recognition that the IFPA governs these proceedings. Under the IFPA's conflict-of-laws provision, "[t]o the extent the provisions of [the Children's Code] or any provision of New Mexico state law conflicts with the provisions of the Indian Family Protection Act, the provisions of the Indian Family Protection Act shall apply." § 32A-28-40(B). This supremacy clause applies to the proposed NMAC 8.3.2 with full force. HCA must revise the proposed rule to expressly acknowledge the IFPA's applicability and to ensure that all provisions governing CYFD referrals, safety family assessments, and subsequent actions comply with the IFPA when an Indian child is involved.

II. The Rule Fails to Recognize Tribal Jurisdiction Under Both ICWA and the IFPA

Under both federal ICWA, 25 U.S.C. § 1911(a), and the IFPA, § 32A-28-7(A), tribes have exclusive jurisdiction over child custody proceedings involving an Indian child who resides or is domiciled within the tribe's reservation. The IFPA further provides that "[w]hen an Indian child is under the jurisdiction of the tribal court, the Indian tribe shall retain exclusive jurisdiction, notwithstanding the residence or domicile of the child." § 32A-28-7(A). New Mexico is not a Public Law 280 state; there is no independent basis for state jurisdiction over child custody matters on tribal lands absent a transfer under § 32A-28-7 or a tribal-state agreement under § 32A-28-8.

The proposed rule's framework, which channels POSC non-compliance directly to CYFD for safety family assessments and potential investigation, creates a regulatory pipeline from a state health screening program into the state child welfare system. For Indian children domiciled on tribal lands, this pipeline is jurisdictionally improper. The proposed rule should expressly state that its CYFD referral and investigation provisions do not apply to Indian children over whom a tribe exercises exclusive jurisdiction and should provide a mechanism for

tribal child welfare systems to serve as the receiving entity for any concerns arising under the CARA program.

III. Tribal Notification Provisions Are Insufficient and Do Not Comport with ICWA or IFPA Requirements

Section 8.3.2.10(A)(4) requires that the POSC be shared with "the respective nation, pueblo, or tribe's responsible entity as identified by tribal leadership" when a child's parent, relative, guardian, custodian, or caregiver is a tribal member or resides on tribal land. While this notification provision is a start, it falls short in several critical respects:

A. IFPA notice requirements.

The IFPA imposes specific notice obligations that go well beyond the proposed rule's informal sharing of the POSC. Under § 32A-28-12(A), within twenty-four hours of initiating an investigation involving an Indian child, CYFD must notify the Indian child's tribe of specified information including the department's obligations to collaborate with the tribe. Under § 32A-28-5, notice in child custody proceedings must be provided by certified mail with return receipt requested. The proposed rule's generic requirement to "share" the POSC "either in a physical copy, telecommunication or an electronic version" does not satisfy these statutory obligations.

B. Timing and consent.

The rule requires only that the POSC be shared after creation, not that the tribe be consulted in its development. The IFPA's active-efforts standard requires collaboration with the child's tribe. Under the IFPA's investigation provisions at § 32A-28-12(B), the department must "coordinate services with the Indian child's tribe to prevent taking the child into custody" and "provide culturally appropriate remedial services designed to prevent the breakup of the Indian family." Simply notifying a tribe after the POSC has been finalized does not constitute the collaboration required by the IFPA. The rule should require that, for any Indian child or child eligible for tribal membership, the tribe be contacted and given a meaningful opportunity to participate in developing the POSC before it is finalized.

C. Identification of Indian children.

The rule contains no mechanism for identifying whether an infant is an Indian child as defined by ICWA, 25 U.S.C. § 1903(4), or as that term is used in the IFPA. The IFPA requires affirmative efforts to determine tribal affiliation: when a child is taken into custody, the department must make "active efforts to determine whether the child is an Indian child." NMSA 1978, § 32A-4-6(D). The proposed rule's trigger for tribal notification: whether a parent or caregiver "is a tribal member or resides on tribal land", is significantly narrower than the ICWA/IFPA definitions, which include children who are eligible for membership and are the

biological child of a member. The rule should require birthing facilities and providers to inquire about tribal membership or eligibility as part of the screening and intake process.

IV. The "Active Efforts" Standard Is Defined in the Rule but Not Operationalized; the IFPA Mandates Its Application

Proposed Section 8.3.2.7(A) includes a detailed definition of "active efforts" that correctly describes the standard as higher than "reasonable efforts." However, this definition is never referenced or applied anywhere else in the proposed rule. None of the POSC creation, implementation, CARA navigator, or CYFD referral provisions mandate that active efforts be made before any referral to CYFD or any determination of "non-compliance."

The IFPA does not leave this to agency discretion. Under § 32A-28-4(A), in a "[a]ctive efforts to maintain or reunite an Indian child with the Indian child's family shall be made pursuant to the Indian Family Protection Act. The department shall neither seek findings of futility nor aggravated circumstances." This requirement applies in all child custody proceedings which, as discussed above, includes the investigations and preliminary activities triggered by the proposed rule's CYFD referral mechanisms. The IFPA further requires that active efforts be documented and reported to the court. § 32A-28-4(E). Under § 32A-28-12(B), during an investigation involving an Indian child, the department must coordinate services with the tribe, provide culturally appropriate remedial services, and make active efforts to identify extended family members.

The Pueblo recommends that the rule be revised to require documented active efforts, in consultation with the child's tribe, before any referral to CYFD for a safety family assessment involving an Indian child consistent with the IFPA's requirements.

V. The Non-Compliance Framework Creates an Unacceptable Risk of Unnecessary Family Separation for Native Families

The proposed rule establishes a rigid non-compliance framework that poses particular risks for Native American families. Under Section 8.3.2.10(B), a parent's refusal to sign a POSC is automatically treated as non-compliance and triggers a mandatory referral to CYFD. Under Section 8.3.2.12(D)(9), a CARA navigator's inability to contact a family after three attempts and one in-person visit likewise triggers a mandatory CYFD referral within 24 hours.

These provisions fail to account for the realities of many tribal communities, including geographic remoteness, limited telecommunications infrastructure, cultural practices such as periods of ceremonial obligation during which families may be unavailable, and deeply rooted and well-founded distrust of state child welfare agencies among Native families. The historical context in which ICWA and the IFPA were enacted, the removal of up to 35% of Native American children from their families and placement of 85% of those children outside their

communities, compels a more measured approach.[1] A parent's reluctance to sign a state-created document or difficulty in being reached by phone does not, standing alone, indicate that an infant is unsafe. Yet the proposed rule treats these circumstances as equivalent to a child safety concern warranting CYFD intervention.

The IFPA's framework contemplates precisely the opposite approach and, notably, so does the proposed rule's own definition of "active efforts." Proposed Section 8.3.2.7(A) defines active efforts as including "actively helping parents obtain services rather than just providing referrals…[.]" Yet the rule's non-compliance provisions do not require any of these efforts before escalating to CYFD. The proposed rule's automatic escalation upon non-compliance is antithetical to the very partnership model that the rule itself articulates.

The Pueblo recommends that the rule be amended to: (a) require that, for Indian children, the tribe be contacted and given a meaningful opportunity to intervene and provide culturally appropriate services before any referral to CYFD; (b) extend the timeframes and modify the contact requirements to account for conditions in tribal communities; and (c) clarify that a parent's declination of a service or refusal to sign a POSC does not, without more, constitute grounds for a child abuse or neglect investigation.

VI. The Surveillance Provision at Section 8.3.2.12(F)(3)(b) Is Deeply Concerning

Section 8.3.2.12(F)(3)(b) provides that when a family refuses CARA navigation, "the CARA navigator program shall have processes in place to monitor listed CARA participants for law enforcement activity and or emergent medical care activity that shall prompt a new SCI report until the child is 13 months old."

This provision establishes a surveillance regime for families who exercise their right to decline voluntary services. Monitoring families for law enforcement and medical encounters and using those encounters as automatic triggers for new child protective services reports, raises serious due process, privacy, and civil rights concerns. It conflates a family's exercise of autonomy with a presumption of risk to the child. For Native American families, this provision is particularly troubling given the historical pattern of disproportionate state intervention in tribal family life that gave rise to the passage of both ICWA and the IFPA. Notably, the IFPA's active-efforts requirement specifically prohibits the department from seeking "findings of futility or aggravated circumstances[.]" § 32A-28-4(A). Yet this surveillance provision effectively treats a family's exercise of autonomy as a basis for ongoing state monitoring, a posture inconsistent with the IFPA's mandate to work in partnership with families.

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[1] *See* National Indian Child Welfare Association, "Setting the Record Straight: The Indian Child Welfare Act Fact Sheet" (available at: https://www.nicwa.org/wp-content/uploads/2025/02/Setting-the-Record-Straight-2018.pdf).

The Pueblo strongly recommends that this provision be removed or, at minimum, substantially revised to require individualized assessment of safety concerns before any such monitoring is initiated, and to exempt families subject to tribal jurisdiction.

VII. The Rule Should Reference Existing Tribal-State Agreement Obligations Under the IFPA

The IFPA at § 32A-28-8(A) requires the department to "make a good faith effort to enter into a tribal-state agreement for the coordination of care and custody of Indian children with each Indian tribe within the borders of this state." The transfer of CARA program administration from CYFD to HCA raises the question of whether existing tribal-state agreements encompass the CARA program and, if not, whether new or amended agreements are necessary. The proposed rule should require HCA to coordinate with CYFD and with each affected tribe to ensure that tribal-state agreements are updated to address the CARA program and the responsibilities of CARA navigators when interacting with Indian children and families.

VIII. The Tribal Case-Closure Provision Mischaracterizes Tribal Authority

Section 8.3.2.12(F)(4) provides for case closure when "the infant's nation, pueblo, or tribe has assumed full responsibility for a navigation case and has not requested state agency support." The provision further requires the CARA navigator to "document the name of the person responsible at the nation, pueblo, or tribe who advised the state the nation, pueblo, or tribe is assuming full custody."

This framing is problematic. Tribes do not "assume" authority from the state; they exercise inherent sovereign authority over their members and their children. Under the IFPA, § 32A-28-7(A), tribes have exclusive jurisdiction over Indian children domiciled on the reservation, and this jurisdiction exists as a matter of right, not by delegation from the state. The language referencing "full custody" conflates a navigation case with a custody case, which is both inaccurate and confusing. The Pueblo recommends that this provision be revised to state that, upon notification by a tribe that it is exercising its authority over an Indian child's welfare, the state shall close the CARA navigation case and cooperate in the transfer of any relevant documentation to the tribe.

IX. Data Collection and Sharing Provisions Raise Tribal Data Sovereignty Concerns

Section 8.3.2.15 requires the collection of data including substance exposures, service referrals, service uptake, and CYFD involvement, and provides for sharing of this data with multiple state agencies "for epidemiological analysis." While the rule references compliance with HIPAA and 42 C.F.R. Part 2, it does not address tribal data sovereignty, does not require tribal consent for the collection or dissemination of data on tribal members, and does not provide tribes with access to aggregate data concerning their own citizens.

The Pueblo requests that the rule be revised to: (a) require tribal consent before data concerning tribal members is shared with state agencies beyond those directly involved in the child's care; (b) provide tribes with access to de-identified aggregate data concerning their enrolled members; and (c) ensure compliance with tribal data governance policies in addition to HIPAA and 42 C.F.R. Part 2.

X. The Programmatic Transfer from CYFD to HCA and This Rulemaking Warrant Formal Tribal Consultation

The Tribal Notification letter states that, pursuant to NMSA 1978, § 32A-3A-13, the administration of the CARA program will transfer from CYFD to HCA effective July 1, 2026. This is a significant structural change that will affect the intergovernmental relationship between tribes and the State on child welfare matters. The Pueblo notes that a 30-day comment period with a single public hearing is insufficient to constitute meaningful government-to-government consultation on a regulatory framework that directly affects tribal children and families. In addition, it is also unfortunate that today's hearing coincides with the Behavioral Health Region 13 meeting, which has the largest number of Pueblos and Tribes in New Mexico. That meeting is to address our behavioral health priorities under SB 3 - The Behavioral Health Reform and Investment Act. This conflict in scheduling is unfortunate but significant as it limits tribal voices unnecessarily.

Therefore, in light of the foregoing comments and issues with the proposed rule and the commenting period, the Pueblo requests that HCA engage in formal, government-to-government consultation with each affected tribe before finalizing these rules, as required by the State-Tribal Collaboration Act, NMSA 1978, §§ 11-18-1 to -5, and consistent with the IFPA's mandate for tribal-state coordination.

Conclusion

The Pueblo of Acoma shares the goal of ensuring that all children, including substance-exposed infants, are safe, healthy, and supported. The Pueblo is committed to working with HCA to achieve these goals in a manner that respects tribal sovereignty, complies with federal law including ICWA, and fulfills the State's obligations under the Indian Family Protection Act.

The IFPA represents New Mexico's own legislative commitment—signed by the Governor—to protect Indian children and families from unnecessary state intervention and to ensure meaningful tribal participation in all proceedings affecting Indian children. The proposed rule as currently drafted does not reference the IFPA, does not comply with its requirements, and in several respects directly conflicts with its provisions. Therefore, the Pueblo urges HCA to incorporate the revisions recommended above and to engage in formal government-to-government consultation with the Pueblo and other tribal nations before finalizing NMAC 8.3.2.

Thank you for the opportunity to submit these comments. Please do not hesitate to contact my office if you have any questions regarding these comments.

Respectfully submitted,

Charles P. Riley
Governor

CC by Email: Pharon Morgan, HCA Native American Liaison
Pharon.Morgan@hca.nm.gov

Secretary Kari Armijo, NM Health Care Authority
Kari.armijo@hca.nm.gov

Acting Medicaid Director Alanna Dancis, HCA Medical Assistance Division
Alanna.dancis@hca.nm.gov

COMMENT 18

New Mexico Hospital Association

SENT VIA EMAIL

April 9, 2026

New Mexico Health Care Authority
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, NM 87504

Sent to HCA-madrules@hca.nm.gov

Re: Proposed Rule 8.3.2 NMAC – Plan of Safe Care for Substance-Exposed Infants

Dear Secretary Armijo and colleagues,

On behalf of our 48 New Mexico hospital members, which include all birthing and acute-care hospitals in the state, we appreciate the opportunity to comment on proposed rule 8.3.2 NMAC implementing the plan of safe care framework for substance-exposed infants and families.

We appreciate the work your agency has undertaken in developing these proposed rules. Hospitals strongly support the underlying goals of the Comprehensive Addiction and Recovery Act (CARA) and share the state's commitment to improving the safety, health, and care coordination for substance-exposed newborns and their families.

At the same time, given hospitals' central role in screening for substance use and developing plans of safe care, we offer the following comments and recommendations to ensure clarity and successful implementation of the new law.

8.3.2.7 – Definitions

Within the definitions section, we recommend revising several definitions to improve clarity, adding key missing definitions, and removing duplicative terms. These changes will provide consistent interpretation and support providers in carrying out their responsibilities under the rule.

Definitions needing clarification

- "Clinician"
  The definition of "clinician" should include "certified nurse" before midwife. In New Mexico, certified nurse midwives have prescriptive authority, while licensed midwives may administer approved formulary medications but do not have prescriptive authority. This distinction is important to ensure alignment with applicable scopes of practice.

- "Facility CARA navigator"
  The definition should clarify the employment or contractual relationship of the navigator.

It is currently unclear whether this role is employed by a state agency, a Medicaid managed care organization (MCO), a birthing facility, or another entity.

Additionally, the definition is inconsistent with the description in 8.3.2.12(E), which states that facility CARA navigators "are direct agents of the HCA or its subcontractor" and are present in birthing hospitals. In contrast, the definition references "birthing facilities," which would include birth centers. These sections should be aligned to clearly define both the role and care setting(s) in which the navigator operates.

- "Plan of Safe Care (POSC)"
  The definition would be strengthened by reflecting the collaborative nature of POSC development. We recommend the following revision:

  > *"Plan of safe care (POSC)" means a written plan co-created with the birthing parent and family by a health care professional ~~or~~ and care coordinator…"*

  This change reflects the shared responsibilities for POSC development and implementation described throughout the rule.

- "Substance-exposed infant"
  The definition would benefit from greater clarity and consistency. As written, it lists specific substances but does not align with other sections of the rule. For example, cocaine is referenced in 8.3.2.11(A)(4)(e) but is not included in the definition.

  To improve clarity and facilitate consistent screening expectations and practices, we recommend defining categories of substances and including all relevant examples. Below is a suggested alternative definition for consideration:

  > *"Substance-exposed infant" means an infant under one year of age, for purposes of this rule, who was exposed in utero to one or more of the following: opioids (illicit or prescribed, including medication-assisted treatment (MAT)), methamphetamine, cocaine, benzodiazepines or other misused prescription medications, alcohol, nicotine or tobacco, and marijuana.*

<u>*Unnecessary or duplicative definitions*</u>

- "CARA navigator" & "care coordinator"
  As used in the rule, "care coordinator" has the same role as "CARA navigator." We recommend keeping "CARA navigator" and eliminating "care coordinator," as "care coordinator" is a commonly used title within Medicaid MCOs and could be interpreted as referring to roles unrelated to CARA.

- "Caregiver" & "key household member"
  These terms have similar definitions, and "key household member" is used only once in the rule. We recommend removing "key household member" to reduce unnecessary complexity.

<u>Missing definitions</u>

We strongly encourage the agency to add definitions for “perinatal,” “perinatal medical visit,” “noncompliance,” and “referral to treatment.” The absence of these definitions creates ambiguity for providers, particularly with respect to screening requirements.

For example, “perinatal medical visit” is not defined, yet providers are required to perform SBIRT at such visits. Without clarification, this could be interpreted to include any medical visit occurring during the perinatal period, regardless of purpose. This could lead to unintended and impractical expectations, such as requiring SBIRT during visits unrelated to pregnancy, childbirth, or postpartum care (e.g., dermatology appointments).

We recommend defining “perinatal medical visit” as a visit related to pregnancy, childbirth, newborn care, or postpartum needs. This approach would ensure that screening requirements are appropriately targeted and operationally feasible.

8.3.2.9 – Identification of Substance-Exposed Infants

As written, the rule does not clearly specify the circumstances under which pregnant patients, postpartum individuals, and/or newborns should undergo toxicology testing, which extends beyond the requirement in SB 42 to conduct verbal SBIRT screening. Clarifying when testing is expected is essential to establishing consistent expectations for providers and patients and to ensuring uniform implementation across care settings.

Without this clarity, providers may interpret requirements differently, which could lead to inconsistent practices, potential patient confusion, and increased compliance risk.
Below is a list of questions relevant to this section. Providing additional specificity in this section will help ensure that identification practices are clinically appropriate, consistent with SB 42, and applied the same across providers.

1. What steps are prenatal, hospital, and perinatal providers expected to take if a patient declines to complete SBIRT?

2. Section 8.3.2.9(C) references the use of “evidence-based tool(s)” to “evaluate infants born affected by substance use or withdrawal symptoms”; however, no specific tools or parameters are identified. The rule should clarify which tools are acceptable or provide guidance on selection to ensure consistency in clinical practice, consistent with SB 42.

3. Section 8.3.2.9(D) does not address how providers should proceed if a parent or guardian objects to toxicology testing of a newborn.

8.3.2.10 – Responsibilities Regarding Plan of Safe Care Creation

As written, this section does not clearly delineate the respective responsibilities of prenatal providers, birthing facilities, perinatal providers, and CARA navigators in the initiation and

development of POSC. Greater specificity is needed to ensure consistent implementation and accountability across provider types. We request the agency revise this section to clearly assign roles and responsibilities by provider type and care setting, including specialty hospitals (long-term acute care, inpatient physical rehabilitation, behavioral health/psychiatric).

- Subsection A states that a POSC must be created by the hospital, birthing center, or perinatal provider. However, this excludes prenatal providers and appears inconsistent with the definition of "plan of safe care," which indicates that a POSC may be developed by a CARA navigator. These should be aligned to clearly identify all responsible parties and their respective roles in POSC development.

- Subsection A requires that a POSC be created prior to discharge from a hospital. We recommend revising this language to specify requirements for POSC creation by location of delivery (urgent care, emergency department, birthing hospital, and birthing centers) to ensure consistency with this rule's proposed definitions and other relevant sections.

- The proposed rule does not address how a POSC should be initiated or developed during the prenatal period. Clarification is needed regarding expectations for prenatal providers, including if the POSC should address needs of the unborn substance-exposed infant.

- It is unclear whether a separate POSC is required for the substance-using parent and the substance-exposed newborn, or whether a single, unified plan is intended. If a single POSC is required, the rule should clarify how components addressing the newborn's needs are to be developed during the prenatal period.

- Additional guidance is needed regarding situations in which a family declines to sign the POSC. For example, after a referral is made to CYFD's SCI for CARA-related noncompliance, the rule should clarify how providers are expected to handle an unsigned POSC, including documentation and next steps.

- Subsection D would benefit from additional details regarding expectations for non-birthing hospitals and urgent care settings. For example:

    - How should providers proceed if there is insufficient time to conduct SBIRT prior to delivery or transfer?

    - What is the minimum required information that must be documented in the POSC in these situations?

8.3.2.11 – Requirements for the Plan of Safe Care

Consistent with our comments on 8.3.2.7 Definitions and 8.3.2.10 Responsibilities Regarding POSC Creation, this section would benefit from clearer alignment between defined roles and the specific requirements for POSC content. As written, it is not always clear which elements

must be completed by a health care professional at the point of care versus those that are the responsibility of the CARA navigator during ongoing care coordination.

We recommend revising this section to clearly distinguish the minimum required elements that must be included in a POSC at the time it is initiated by a health care professional, and additional or optional elements that may be completed or supplemented by the CARA navigator in collaboration with the family.

Additionally, subsection A should be reorganized to present requirements in a logical order, beginning with core, required clinical and demographic information, followed by elements that are conditional or the responsibility of other parties. As currently structured, items appear out of sequence and create confusion regarding provider responsibilities. For example, subsection A(3), which references communication by the CARA navigator with a child's nation, pueblo, or tribe, is listed before more fundamental information such as contact details for the child and caregiver(s) and reflects activities outside the scope of the health care professional initiating the POSC.

- 8.3.2.11(A)(4)(e) should be revised to remove "if," as in-utero substance exposure is the triggering condition for development of a POSC. Additionally, the inclusion of a specific list of substances should be removed or aligned with the definition of "substance-exposed infant" in Section 8.3.2.7 to ensure consistency across the rule.

- 8.3.2.11(A)(4)(f) is unclear within the context of POSC content requirements. The requirement to offer substance use assessments to family members or others in close contact with the newborn should be detailed in a separate section of the rule, rather than housing it as a documentation requirement of the POSC itself. The need for this element of support may not be clear or evident until the CARA navigator establishes communication with the parent(s)/caregivers and would not be possible for this service to be identified prior to a newborns discharge.

- As noted in our earlier comments, 8.3.2.11(A)(4)(j) should specify how health care professionals are to proceed when a family member declines to sign the POSC. This subsection states that staff members are to "submit a notification to the CARA program and to CYFD" but this does not specify what that means. What is the CARA program to provide notice to? Does notifying CYFD mean making a report to SCI as it is stated in 8.3.2.10(B)? This section should be expanded with additional information and aligned with other sections of the proposed rule.

- 8.3.2.11(B) should be amended to clarify that when Statewide Central Intake (SCI) referrals or requests for CYFD family assessments are made by or learned about by a health care professional or CARA navigator, the POSC must be updated accordingly. As it is drafted the rule does not recognize that other parties may initiate such referrals but may not have access to CSSP. Clarification is needed regarding how these externally initiated actions are incorporated into the POSC and who is responsible for updating the record.

8.3.2.12 – Implementation of the CARA Navigation Program

Subsection (E) states that facility CARA navigators are on-site at hospitals; however, the definition of “facility CARA navigator” indicates that these navigators are present at both birthing hospitals and birthing centers. These two sections should align.

8.3.2.14 – Training Requirements

We appreciate the inclusion of specific training requirements in the proposed rule. Inconsistent training has historically been a barrier to consistent implementation of CARA requirements. Establishing clear and standardized training expectations will be critical to ensuring that birthing facilities, clinicians, and health care professionals understand their responsibilities prior to, and following, the July 1, 2026 implementation date.

- Subsections A and B should include birthing centers.

- This section should include HCA training on use of the CSSP and role-specific responsibilities for different provider types, including prenatal providers, birthing facilities, perinatal providers, and specialty hospitals.

- This section should address provider responsibilities in situations where the state does not have an approved SBIRT training vendor available, as has occurred previously. Clear contingency guidance is necessary to ensure ongoing screening and prevent compliance issues.

- Clarification and training on the tribal notification protocol is important as well and should be included in this section.

- Training should also be required for CYFD staff to ensure alignment in understanding of CARA requirements, particularly during case intake and investigations involving hospitals and providers.

Additionally, we strongly encourage the HCA and Department of Health to provide comprehensive training on program requirements and system changes prior to the July 1, 2026 implementation date, with ongoing training opportunities to support continued education and compliance.

In addition to our detailed section-by-section feedback, we offer two general comments below.

Prior to the July 1, effective date, HCA must provide clear communication about how Governor Lujan Grisham’s substance-exposed newborn directive issued in 2025 will be handled and enforced beginning July 1. As you know, the Governor’s directive directly contradicts SB 42, and elements of this proposed rule. Hospitals need clear and definitive direction about what will be in effect July 1, 2026, and the steps they must follow when a substance-exposed newborn is identified.

Additionally, the rule should clearly define the role of specialty hospitals (long-term acute care, inpatient physical rehabilitation, behavioral health/psychiatric) and the responsibilities applicable to these facilities. Under the current program, specialty hospitals are treated the same as acute care hospitals, despite differences in services and patient populations. Clarifying expectations for specialty hospitals will help ensure that requirements are appropriate and clear for compliance purposes.

Thank you again for the opportunity to provide detailed feedback on this proposed rule. Effective and seamless implementation of the changes to CARA is critical to supporting the safety and well-being of newborns and families across New Mexico. Clear, consistent, and operationally feasible requirements will be essential to achieving these goals.

If we can provide additional information or clarification, please do not hesitate to contact me or members of my team.

Thank you,

Troy Clark
President and CEO

COMMENT 19

Mondragon, Tabitha, HCA

From: Jen Laws <lawsjennifer@protonmail.com>
Sent: Thursday, April 9, 2026 2:13 PM
To: HCA-madrules
Subject: [EXTERNAL] Written Comment on Proposed Rulemaking: NMAC 8.3.2

Some people who received this message don't often get email from lawsjennifer@protonmail.com. Learn why this is important

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I am writing to express concerns about the structure and application of proposed rule NMAC 8.3.2 (Family Health and Well Being, Plan of Safe Care for Substance-Exposed Infants) to pregnant persons in the State of New Mexico. In the text of the proposed rule, made available on the website of the New Mexico Healthcare Authority (Medical Assistance Division Registers – New Mexico Health Care Authority), a vague and open-ended list of substances that have "the potential to impact the health or development of the infant" (8.3.2.7 S. (5)) is utilized.

The term "substance" or "substances" is not defined in the rule, despite being used in isolation in the section pertaining to "In-utero exposures" (8..3.2.11 A. (4)(e)): "If an infant is exposed to any substances during pregnancy, all exposures shall be documented in the POSC. Documentation of exposures includes exposures occurring during the timeframe in which the mother may not have known she was pregnant, and all substance exposures, including, but not limited to tobacco, fentanyl, heroin, methamphetamine, cocaine, alcohol, marijuana (medical or recreational), and medication assisted therapy such as methadone and buprenorphine."

The use of "including, but not limited to" grants a nearly unlimited scope of authority to the State of New Mexico to monitor pregnant New Mexicans, dependent upon the independent judgement and practices of "providers at hospitals, birthing centers, or providers who perform perinatal medical visits." (8.3.2.10 A.) The proposed rule mandates the use of "an evidence-based verbal screening brief intervention with referral to treatment (SBIRT) model at all prenatal or perinatal medical visits and live births" (8.3.2.9) but the information available to average New Mexicans about the details of SBIRT is slim at best. We have little basis upon which to evaluate whether or not this mandate would protect pregnant New Mexicans from being reported to HCA for drinking coffee, consuming sips of wine at communion, taking herbal or homeopathic remedies, or using over the counter medications such as Tylenol. As has been documented in news reports, federal officials have expressed open hostility to medications (such as Tylenol) and even basic vaccinations for flu or COVID that have been determined to be safe for use by pregnant people. In an environment of such uncertainty regarding some of the basics of medical care, a rule that may result in state monitoring of pregnant people must be crafted with particular care and precision.

The inclusion of methadone and buprenorphine among a list of "substances" is especially problematic. The U.S. Centers for Disease Control and Prevention expressly endorse the use of methadone and buprenorphine by pregnant persons with opioid use disorder: Treatment of Opioid Use Disorder Before, During, and After Pregnancy | Opioid Use During Pregnancy | CDC.

There are medical conditions, including but not limited to OUD, that may require the use of medications during pregnancy (under the care of medical professionals) that involve a careful balancing of risk and benefit. Said medications may meet the vague and open-ended definition of substances that have "the potential to impact the health or development of the infant" utilized in this proposed rule. Despite this fact, no explicit provision is made in this rule to ensure that pregnant people under the care of medical professionals and taking medically necessary (and sometimes risky) prescribed medications will not be subjected to medically and legally inappropriate surveillance and monitoring of an agency of the State of New Mexico during pregnancy and for months afterward.

The goals of the CARA program are laudable and important. Please do not undermine these important efforts aimed at infant, child, and family well-being with the use of overbroad and imprecise language that has the potential to adversely impact legitimate and necessary medical care during pregnancy.

Jennifer Laws
Albuquerque, NM

COMMENT 20

PRH Physicians for Reproductive Health

Doing Right By Birth

April 9, 2026

New Mexico Healthcare Authority Office of the Secretary
ATTN: Medical Assistance Division Public Comments
PO Box 2348
Santa Fe, New Mexico 87504

Submitted via email: HCA-madrules@hca.nm.gov

Re: New Mexico Administrative Code rule 8.3.2, *Family Health and Well Being, Plans of Safe Care for Substance-Exposed Infants*

Physicians for Reproductive Health (PRH) and Doing Right By Birth (DRBB) submit this joint comment in opposition to proposed rule NMAC Rule 8.3.2. As drafted, this rule establishes a dangerous and harmful family separation policy that does not align with the legislative intent of SB 42, a bipartisan approach that updated child welfare policies relating to substance use and pregnancy. As proposed this rule would shift the Comprehensive Addiction and Recovery Act (CARA) program away from a trauma-informed care model focused on supporting families, to a more harmful punitive response.

DRBB is a physician-led advocacy and education organization dedicated to advancing compassionate, evidence-based care for pregnant and parenting people who use drugs and their families. Through cross-sector collaboration, training, and legal-medical partnerships, it promotes policies and practices that support family wellbeing, build trust in care, and keep families together.

PRH is a national physician-led advocacy organization working to ensure access to equitable, comprehensive reproductive health care for the communities we serve. Our network includes physicians of various specialties from across the country, including New Mexico, committed to meeting the needs of the patients they serve. As clinicians, we know that trust is the foundation of the patient-provider relationship and that it is our job to earn and maintain that trust. Conversely, breaches of this trust can have devastating impacts for the health and wellbeing of patients and their families. Policies that mandate the separation of newborns from their families undermine this foundation of effective health care.

Mandating All Pregnant People Who Use Substances Comply With Plans of Safe Care Inappropriately Addresses Substance Use Disorder, Risks Traumatic Family Separation

Health care providers have the responsibility to use their medical expertise and training to provide patients with the best possible care, and to do no harm. Harm can manifest in various ways including forcing patients into health care they do not need or want, and funneling patients and their families towards state involvement.

This rule harms patients by forcing any pregnant and perinatal person that discloses substance use to comply with a Plan of Safe Care(POSC). Enrollment in a POSC is required regardless of whether there is evidence of a substance use disorder, and in doing so this rule mandates treatment for patients who may not necessarily need treatment. Additionally, this rule inappropriately applies to patients receiving medication assessment treatment (MAT).

The proposed rule includes "prescribed medications such as opioids, methadone, [and] buprenorphine" in the definition for "substance-exposed infant" (8.3.2.7 (S)(5)). Methadone and buprenorphine are two medications used to treat opioid use disorder as part of Medication Assisted Treatment (MAT). MAT uses FDA-approved medications often alongside behavioral therapies as an effective evidence-based addiction treatment method. Patients receiving MAT have made the brave decision to seek treatment and are receiving care under the direction and guidance of a trained physician. By including these prescription medications and directly naming MAT (8.3.2.11 (A)(4)(e)) as qualifying as in-utero exposure, this rule punishes pregnant people already receiving treatment and thereby patients will be discouraged from seeking care and disclosing drug use out of fear of criminalization. Pregnant and birthing people receiving MAT should not be at risk of involvement with the child welfare system.

Section 8.3.2.9 (B) goes on to dictate that infants are to be identified as substance exposed "when the mother discloses substance use during pregnancy." As a result, any pregnant person with an admission of use of substance, including prescribed medication, legal substances, and medications for opioid use disorder (MOUD), will be required to comply with a POSC, including mandatory substance use disorder treatment. Not everyone with substance use will meet criteria for a substance use disorder and people receiving MOUD are already engaged in care. Mandating treatment for people without a substance use disorder is medically perverse, financially wasteful, and takes treatment slots away from people who actually need them.

Not only will families be forced to enter into a POSC, refusal to sign the POSC will be considered non-compliance and result in a referral to the Child, Youth and Families Department (CYFD) which is responsible for screening and investigating reports of alleged child abuse and neglect. A

referral to CYFD exposes families to the risk of criminalization and traumatic family separation which is harmful to families.

Separating newborns from their parents during a critical time of maternal-infant bonding is traumatic and has long-lasting consequences for children[1] and parents.[2] It also contravenes recommended health care for substance exposed infants: skin to skin contact and bonding time with the new parent, known as "eat, sleep and console."[3] Separating a child from their parents can cause a "monsoon of stress hormones" to "flood the brain and body," and prolonged exposure to high levels of these hormones can "increase the risk of lasting, destructive [health and mental health] complications.[4] This is especially true for newborns, for whom the first stages of life impact infant-parent attachment, development, and the child's sense of security.[5] There are also severe consequences for the birthing parent, with researching telling us that mothers whose children are forcibly separated from them have greater odds of having a postpartum depression or anxiety diagnosis,[6] and higher rates of maternal mortality.[7] To put it succinctly, family separation is toxic for children and families.[8]

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[1] Kimberly Howard et al., Early Mother-Child Separation, Parenting, and Child Well-Being in Early Head Start Families, Attach Hum Dev. (January 2011). https://pmc.ncbi.nlm.nih.gov/articles/PMC3115616/

[2] Rosa Furneaux, Forcibly Separating Children From Their Mothers Doesn't Just Hurt the Kids, Mother Jones. (June 2018), https://www.motherjones.com/politics/2018/06/trump-forced-family-separation-children-devastating-effects-mothers-1/.

[3] Abrahams, R. R., MacKay-Dunn, M. H., Nevmerjitskaia, V., MacRae, G. S., Payne, S. P., & Hodgson, Z. G. (2010). An evaluation of rooming-in among substance-exposed newborns in British Columbia. *Journal of obstetrics and gynaecology Canada : JOGC = Journal d'obstetrique et gynecologie du Canada : JOGC*, *32*(9), 866–871. https://doi.org/10.1016/S1701-2163(16)34659-X

[4] See Allison Eck, Psychological Damage Inflicted by parent-Child Separation is Deep, Long-Lasting, NOVA (June 20. 2018), https://www.pbs.org/wgbh/nova/article/psychological-damage-inflicted-by-parent-child-separation-is-deep-long-lasting/?utm_source=FBPAGE&utm_medium=social&utm_term=20180620&utm_content=1603761016&linkId=53285432&utm_source=FBPAGE&utm_medium=social&utm_term; see also Trauma Caused by Separation of Children From Parents, American Bar Association (Last updated Jan. 2020), available at https://www.americanbar.org/content/dam/aba/publications/litigation_committees/childrights/child-separation-memo/parent-child-separation-trauma-memo.pdf;

[5] See Emma Ketteringham et al., Healthy Mothers Healthy Babies: A Reproductive Justice Response to the "Womb-to-Foster Care Pipeline," 20 CYNY L.R. 77, 100-101 (2016)

[6] Wall-Wieler, E., Roos, L. L., Brownell, M., Nickel, N. C., Chateau, D., & Nixon, K. (2018). Postpartum Depression and Anxiety Among Mothers Whose Child was Placed in Care of Child Protection Services at Birth: A Retrospective Cohort Study Using Linkable Administrative Data. *Maternal and child health journal*, *22*(10), 1393–1399. https://doi.org/10.1007/s10995-018-2607-x

[7] Wall-Wieler, Elizabeth & Roos, Leslie & Nickel, Nathan & Château, Dan & Brownell, Marni. (2018). Mortality Among Mothers Whose Children Were Taken Into Care by Child Protection Services: A Discordant Sibling Analysis. American journal of epidemiology. 187. 10.1093/aje/kwy062.

[8] Nguemeni Tiako MJ, Sweeney L. The Government's Involvement in Prenatal Drug Testing May Be Toxic. Matern Child Health J. 2022 Apr;26(4):761-763. doi: 10.1007/s10995-020-03110-2;

Forced Compliance Undermines Patients' Dignity and Trust Which is Essential to the Patient-Provider Relationship

Forcing families into POSC on account of alleged substance use while pregnant violates the autonomy of the pregnant/birthing person for the sake of alleged protection of their fetus/newborn. It depicts the pregnant person as a threat to the pregnancy and fetus, as though the maternal/infant dyad have opposing interests. Pitting the pregnant and birthing person against their own bodies and families.

In addition, policing and punishment conflict with medical professional ethics and stand in contrast to the principles of care. The old adage, "Healthy mother = healthy baby" is true of both pregnancy and postpartum. Caring for pregnant and parenting people who use drugs requires attention to the parent-infant dyad, not just the individual patient or newborn in isolation. The health and wellbeing of each is deeply intertwined: supporting the parent's stability, dignity, treatment access, and autonomy strengthens bonding, attachment, infant regulation, and longer-term child development. Both the parent and the infant thrive in the dyad and suffer in separation. A dyadic approach is central to medical practice and shifts care away from punishment and separation and toward relationship-based, trauma-informed support that promotes the wellbeing of both parent and child.

Addressing perinatal substance use requires trust-based conversations and person-centered treatment—not criminalization. When providers are required to separate parents from their newborns, the system is undermining medical best practices and a provider's ethical obligation to act in the best interest of their patients. As clinicians we trust our patients to know what is best for their health, lives, families, and futures.

When patients – especially pregnant or postpartum parents – fear that being honest with their provider could result in investigation and loss of their child, they are less likely to seek care. This can result in poor behavioral health outcomes and dangerous untreated physical health problems for infants and parents. Policies such as what is being proposed turn medical settings into environments where patients are punished rather than cared for, and ultimately keep people from accessing the care they need.

Substance Use Is Not An Appropriate Gauge of Child and Family Safety and Wellbeing

Admission or evidence of drug use is not a parenting test or assessment of infant safety.[9] Detection of illicit substance use during pregnancy should not be considered child maltreatment.[10] Drug tests cannot detect whether a person is using occasionally, recreationally, therapeutically, or chaotically and problematically. A positive drug test says nothing about a parent's capacity to parent their child or a parent's love for their child.

Reviews of the scientific literature examining the relationship between drug use and parenting have found that no study has been able to isolate the effects of drug use on parenting,[11] and that the literature contains methodological flaws, such as not having consistent measures of parenting or child maltreatment.[12] Another consistent feature of the social science literature claiming associations between drug use and child maltreatment is that it suffers from circular logic: the literature determines child maltreatment has occurred if a family regulation agent says it has occurred, and a family regulation agent determines child maltreatment has occurred if they find evidence of substance use.[13] For these reasons and more that will be elucidated below, the U.S. Department of Health and Human Services and leading medical organizations all concur that positive tests do not imply and should not be used to assess whether a child is at risk of maltreatment let alone used to separate children from their families.[14,15]

This is not to say that chaotic and problematic drug use by a caretaker can never pose a risk of harm to a child. Rather, it is to say that there is no evidence base for health care providers and

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[9] We credit this quote to several activists who have been fighting test and report for years, including Lynn Paltrow and Ericka Brewington.

[10] Nora D. Volkow, Biden Director of The National Institute of Drug Abuse, Pregnant people with substance use disorders need treatment, not criminalization, Statnews, Feb.8 2023, https://www.statnews.com/2023/02/08/addiction-pregnancy-treatment-not-criminalization/

[11] Michele Staton-Tindall, Ginny Sprang, James Clark, Robert Walker, and Carlton D. Craig, "Caregiver Substance Use and Child Outcomes: A Systematic Review," Journal of Social Work Practice in the Addictions 13, no. 1 (January 2013): 6–31, https://doi.org/10.1080/153325 6X.2013.752272.

[12] Cathy Banwell & Gabriele Bammer, "Maternal habits: Narratives of mothering, social position and drug use," 17 International Journal of Drug Policy 504-513 (2006). ("Studies on parenting attitudes and behaviours use inconsistent measures and definitions of parenting making it difficult to identify any distinct patterns in terms of drug-use and mothering.")

[13] Lawrence M. Berger et al., "Caseworker-Perceived Caregiver Substance Abuse and Child Protective Services Outcomes," 15 Child Maltreatment 199-210 (2010).The authors state that "The reliance on child welfare data at this stage of the investigative process is equally disturbing. Entry of data by child welfare workers lacks validity or reliability as well as specificity. Thus even sophisticated analysis of secondary data is likely working from poor data sources that will not allow exploration of complex associations, let alone cause and effect inferences."

[14] HSS Announces a Standard Clinical Definition for Opioid Withdrawal in Infants," U.S. Department of Health and Human Services (January 31, 2022). https://www.hhs.gov/about/news/2022/01/31/hhs-announces-standard-clinical-definition-for-opioid-withdrawal-in-infants.html

[15] American College of Obstetricians and Gynecologists, Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period, Dec. 2020, https://www.acog.org/opposition-criminalization-ofindividuals-pregnancy-and-postpartum-period.

family regulation agents using the results of a positive drug test, or the mere admission of substance use, to make determinations about child safety and family unity.

Drug Testing of Pregnant Patients and Their Newborns Emerged From The War on Drugs, Not Evidence Based

While this proposed rule does not focus on the drug testing of pregnant and birthing people, it is critical to understand that the widespread and longstanding practice of reporting positive drug tests to the child welfare system is not an evidence-supported practice.[16] In fact, this proposal goes even farther by asking health care providers to accept any evidence of drug use including admission by a patient as reason to funnel the family towards state involvement.

The growing body of research examining effects of reporting positive drug tests of pregnant people finds no reductions in alcohol and drug use and no improvements in birth outcomes associated with these policies.[17] A comprehensive legal epidemiology study examining the causal link between 40 years of state pregnancy-specific alcohol policies and birth outcomes and prenatal care use found that multiple policies including reporting positive drug tests to child welfare systems led to thousands of infants born low birth weight or preterm each year.[18] Other research suggests that criminalization policies such as considering in utero substance exposure grounds for child maltreatment actually increases rates of newborns experiencing neonatal abstinence syndrome.[19]

Conclusion

This proposed rule will funnel families into state involvement with the child welfare system and risks of criminalization. It does so regardless of whether or not there is evidence the birthing parent has problematic substance use that actually endangers the welfare of the child. This broad overarching approach discourages patients from seeking care and harms patient-provider trust, forcing health care providers to work on behalf of the state instead of centering the health

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[16] Roberts, S. C. M., Thompson, T. A., & Taylor, K. J. (2021). Dismantling the legacy of failed policy approaches to pregnant people's use of alcohol and drugs. International Review of Psychiatry, 33(6), 502–513. https://doi.org/10.1080/09540261.2021.1905616.
[17] Id.
[18] Subbaraman, M. S., Thomas, S., Treffers, R., Delucchi, K., Kerr, W. C., Martinez, P., & Roberts, S. C. M. (2018). Associations between state-level policies regarding alcohol use among pregnant women, adverse birth outcomes, and prenatal care utilization: Results from 1972 to 2013 Vital Statistics. Alcoholism: Clinical and Experimental Research, 42(8), 1511–1517. https://doi.org/10.1111/acer.13804
[19] Faherty LJ, Kranz AM, Russell-Fritch J, Patrick SW, Cantor J, Stein BD. Association of Punitive and Reporting State Policies Related to Substance Use in Pregnancy With Rates of Neonatal Abstinence Syndrome. JAMA Netw Open. 2019;2(11):e1914078. doi:10.1001/jamanetworkopen.2019.14078

care needs of their patient. Patients must be able to trust their health care provider without fearing retaliation. At the core of these concerns, this proposed rule substitutes admission of substance use as a gauge for child and family safety and wellbeing. Drug use is not an indication of parenting.

New Mexico families deserve support, not separation. It's time to put down the harmful separation directives and instead implement New Mexico's SB 42 with integrity. We respectfully request you withdraw this proposed rule.

Sincerely,

Physicians for Reproductive Health

Doing Right By Birth

COMMENT 21

PREGNANCY JUSTICE

April 9, 2026

Dear New Mexico Health Care Authority,

On behalf of Pregnancy Justice, we respectfully submit this written testimony to raise our concerns regarding the New Mexico Health Care Authority's Plan of Safe Care for Substance-Exposed Infants.

Pregnancy Justice is a non-partisan legal, policy advocacy, and research organization that advances and defends the rights of pregnant people; our work is rooted in the belief that all people, regardless of pregnancy status or outcome, have the freedom to make decisions about their bodies and their lives, without fear of surveillance, punishment, or criminalization.

Substance Use and Maternal Mental Health

As part of their recommendations for improving maternal health in the state, the New Mexico Maternal Mortality Review Committee (MMRC) stated that "substance use disorder and mental healthcare programs should focus on harm reduction by providing safe, community-informed, stigma-free, non-punitive help."[1] Unfortunately, Governor Michelle Lujan Grisham's July 2025 directive, which is under review today, contradicts this guidance, contradicts the prevailing science and best practices for substance-exposed infants, and federal law on the Comprehensive Addiction and Recovery Act (CARA).

Substance use during pregnancy is complex, often intersecting with trauma, poverty, system inequalities, and mental health conditions. The co-occurrence of mental health conditions and substance use disorder (SUD) is common among pregnant and postpartum women, with both linked to high-risk pregnancies, poor infant health outcomes, and maternal mortality.[2] In New Mexico, between 2015 and 2020, mental health was the leading cause of death for pregnancy-related deaths, with SUD present in more than half (54.5%) of cases.[3] Indigenous women experienced an almost 1.5 higher rate of pregnancy-associated mortality than non-Hispanic white women, and twice the rate of Hispanic women.[4] One study found that the most common stressors

[1] New Mexico Maternal Mortality Review Committee, *Pregnancy-Associated Deaths Report 2015-2020* (2025), nmhealth.org/publication/view/report/9227/.
[2] Policy Center for Maternal Mental Health, Substance Use Disorders and Maternal Mental Health (2025), https://policycentermmh.org/substance-use-disorders-and-maternal-mental-health/.
[3] *Supra* note 1.
[4] *Id*.

PREGNANCY JUSTICE

among people with SUD-related deaths were CPS involvement (54%), unemployment (49%), domestic violence (41%), and a previous suicide attempt (32%).[5]

The Harms of Family Separation

Research has shown that punitive responses to substance use during pregnancy, such as removal of a child by state social services agencies, disincentivizes and deters care (especially prenatal care), disrupts the provider-patient relationship, and leads to worse health outcomes for both mother and baby. Medical associations, including the American College of Obstetricians and Gynecologists (ACOG), explicitly discourage the use of punitive responses to substance use during pregnancy;[6] and leading medical experts note that punishing perinatal substance use makes pregnant people and postpartum women too afraid to visit their healthcare providers, as their providers are often deputized to report them to the family regulation (child welfare) agencies.[7]

Instead of separation, as currently practiced in New Mexico, the evidence-based best practice for substance-exposed infants is for the infant to be cared for by their mother, in the same room, breastfed, receiving skin-to-skin contact. Meanwhile, the mother should continue to stay in the care of a qualified healthcare professional and be offered support in accessing substance use treatment. Even if temporary, family regulation can traumatize families and cause lifelong emotional and developmental harm for infants, as essential, early bonding and breastfeeding can be disrupted. Removals have also been shown to disproportionately impact Indigenous, Black, Latine, and low-income families, further exacerbating existing inequities in maternal and infant health outcomes.

Ultimately, mental health and substance use during pregnancy are public health issues and should be treated as such; and anything that discourages a woman from seeking prenatal and postpartum healthcare or separates families will only exacerbate the

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[5] Jessica R Fuchs, et al., *Substance Use Disorder-Related Deaths and Maternal Mortality in New Mexico, 2015–2019* (2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10691991.

[6] "ACOG recommends . . . [that a] positive test not be a deterrent to care, a disqualifier for coverage under publicly funded programs, or the sole factor in determining family separation." ACOG, Policy Priorities: Substance Use Disorder and Pregnancy, https://www.acog.org/advocacy/policy-priorities/substance-use-disorder-in-pregnancy.

[7] Sarah C.M. Roberts and Cheri Pies, Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Prenatal Care, 15 Maternal and Child Health Journal, 3, 333–341, https://doi.org/10.1007/s10995010-0594-7 (2011). Amnesty International, Criminalizing Pregnancy: Policing Pregnant Women Who Use Drugs in the USA, https://www.amnesty.org/ar/wp-content/uploads/2021/05/AMR5162032017ENGLISH.pdf (2017). Orisha A. Bowers, et. al., Tennessee's Fetal Assault Law: Understanding its Impact on Marginalized Women, Sister Reach, Ibis Reproductive Health, Pregnancy Justice, https://www.sisterreach.org/uploads/1/3/3/2/133261658/full_fetal_assault_rpt_1.pdf (2014).

existing health crisis's, in turn leading to adverse outcomes for mothers, babies, and their families in New Mexico.

Supporting Healthy Mothers and Families

Parental substance use alone should never be the primary determination behind a child removal decision, and neither should the presence of prenatal substance exposure in an infant. A growing number of jurisdictions are working toward improved public health outcomes by decoupling punitive responses (including child welfare investigations), from perinatal substance use. While federal law, Child Abuse Prevention and Treatment Act (CAPTA), does require Plans of Safe Care for perinatal substance use, in these such jurisdictions, plans for safe care look like healthcare providers referring patients to supportive services without the involvement of the child welfare system.

We invite the New Mexico Health Care Authority to support the health and wellness of mothers and their children, by ceasing the harmful practice of family separation, and working within the best public health guidelines and practices for families navigating substance use disorder.

Thank you for your consideration.

COMMENT 22

Mondragon, Tabitha, HCA

From: Zoe Unruh <zoeunruh@proton.me>
Sent: Thursday, April 9, 2026 3:19 PM
To: HCA-madrules
Subject: [EXTERNAL] Comments regarding draft rules for SB 42

Some people who received this message don't often get email from zoeunruh@proton.me. Learn why this is important

CAUTION: This email originated outside of our organization. Exercise caution prior to clicking on links or opening attachments.

Dear Members of the New Mexico Healthcare Authority,

I am a nurse in Albuquerque who is deeply concerned about the proposed draft rules for SB 42. I urge you to withdraw these draft rules and take a more collaborative approach that actually reflects SB 42 and centers support, dignity, and evidence-based care.

Substance use in pregnancy does not equate child abuse, and yet the rules set forth by the HCA require **any** pregnant person who has had **any** type of substance use during pregnancy to submit a plan of safe care or be threatened with CYFD involvement. The threat of CYFD will no doubt decrease reports of substance use during pregnancy, negatively impacting substance use disorder treatment and prenatal care. We have the data to support that punitive approaches to substance use in pregnancy decrease care for both the pregnant person and the baby. These draft rules do not take the data into account.

I am concerned about the broad definition of substance-exposed infants in the draft rule. Requiring a Plan of Safe Care for any admission of substance use without a substance use disorder diagnosis will burden the system by requiring unnecessary intervention and oversight. It will also reduce patient reporting, leading to poorer outcomes and more harm for the pregnant person and their baby.

Additionally, pregnant people in active recovery who are taking medications to support their recovery should not be penalized for protecting their baby's health. Including a Plan of Safe Care requirement for prenatal use of buprenorphine and methadone is punitive and not rooted in evidence-based care.

In the long run, these rules are likely to worsen outcomes. They will increase healthcare avoidance and continue to disproportionately impact already marginalized communities. Instead of monitoring and intervention, the HCA should be prioritizing family health, encouraging treatment in true substance use disorder, and promoting prenatal care that uses a harm reduction lens.

Sincerely,

Zoe Unruh, RN BSN

COMMENT 23

April 9, 2026

New Mexico Health Care Authority
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, NM 87504-2348

RE: Proposed NMAC rule 8.3.2, Family Health and Well Being, Plan of Safe Care for Substance-Exposed Infants

The American Civil Liberties Union of New Mexico (ACLU NM) writes concerning the New Mexico Health Care Authority's (HCA) proposed promulgation of rules governing the notification procedures for substance-exposed infants.

Signed into law in 2016 by President Obama, the Comprehensive Addiction and Recovery Act (CARA) uses evidence-based practices, including providing care and support to families, leading to better results for child and parent. CARA recognizes that substance use is a healthcare issue that deserves treatment, healthcare, and social support. The proposed rules to implement CARA in New Mexico by the HCA strike against its intent and favors system involvement over treatment and care for infants and families. The proposed rules do not embody the best practices to assist and care for infants and their birthing parents in need of care for substance use issues.

These rules do not address how drug screenings will be done in such a way to ensure that there is clear and informed consent for the test by the patient, who on the medical team has the authority to request such tests, how to ensure the accuracy of results, and under what conditions they are necessary. These considerations are especially important to ensure that administration of such screenings are not used in a discriminatory way that have an oversized impact on women of color and other marginalized communities.[1] The outcome of these tests can lead to involvement not just with the child welfare system, but with the criminal justice system, punitive treatment, and possible incarceration. The policy also utilizes an overly-broad definition of 'substance exposed.' This definition should be narrow. As written, the breadth of the definition of 'substance exposed' could ensnare birthing parents in the process who do not have clinical diagnosis, made a self-report of legal substance use, or those not in need of treatment. Without clarity for such crucial processes and terms, room for interpretation makes differential treatment not only possible, but likely. Therefore, it is imperative HCA engages in thoughtful, cautious consideration for language and process in these rules.

[1] *Clinical Drug Testing of Pregnant People and Newborns,* Pregnancy Justice, February 2024 (attached)

The HCA's rules should reflect New Mexico's values of dignity and respect when providing healthcare to the families in our communities. Plans of Safe Care should be voluntary and take into account all factors of the infant and parents' unique situations. Families should not be separated and pushed into the child welfare system when there are less intrusive, science-based treatments that can be provided compassionately and create better, healthier outcomes for infants and their families, and by extension, our communities as a whole.

Sincerely,

Jazmyn Taitingfong
ACLU of New Mexico
Senior Attorney

PREGNANCY JUSTICE

Clinical Drug Testing of Pregnant People and Newborns

Pregnant and postpartum people and their newborn babies are typically drug tested in medical settings without their knowledge or explicit, informed consent. This testing disproportionately targets Black women and mothers.[1] Positive toxicology results are too often reported to government officials and used to support criminal and civil child abuse or neglect prosecutions. And yet, as the U.S. Department of Justice has explained, "A positive test result, even when confirmed, only indicates that a particular substance is present in the test subject's tissue. It does not indicate abuse or addiction, recency, frequency, or amount of use; or impairment."[2]

Clinical drug testing, without specific informed consent, is used as an excuse to intrude into people's lives with grave consequences, including criminal proceedings and family separation.

While such medical test results should never be used to prosecute people or accuse them of child abuse or neglect, it is particularly concerning that the test results may not even be accurate or reliable in the first instance. Yet clinical drug testing, without specific informed consent, is used as an excuse to intrude into people's lives with grave consequences, including criminal proceedings and family separation.[3] It is important to know the facts about clinical drug testing.

Clinical Drug Test Results Are Not Reliable and Are Not Forensic Evidence

A clinical drug test is an initial screening test done in a healthcare setting, and is meant to

[1] Roni Caryn Rabin, *Black Pregnant Women Are Tested More Frequently for Drug Use, Study Suggests*, NY TIMES (Apr. 14, 2023) https://www.nytimes.com/2023/04/14/health/black-mothers-pregnancy-drug-testing.html.

[2] Drugs, Crime, and the Justice System: A National Report from the Bureau of Justice Statistics, U.S. DEPARTMENT OF JUSTICE, (Dec. 1992), NCJ-133652 at 119.

[3] Moeller et al., *Urine Drug Screening: Practical Guide for Clinicians*, 45 Mayo Clinic Proceedings 66, 66 (2008) ("misinterpretation of drug tests can have serious consequences, such as unjust termination from a job, risk of prison sentence, . . . and possibly inappropriate medical treatment in emergencies."); Nina Martin, *Take a Valium, Lose Your Kid, Go to Jail*, https://www.propublica.org/article/when-the-womb-is-a-crime-scene; Erin Cloud, Rebecca Oyama & Lauren Teichner, *Family Defense in the Age of Black Lives Matter*, 20 CUNY L. Rev. (2016), available at: https://academicworks.cuny.edu/clr/vol20/iss1/14.

evaluate a patient's health and to design an appropriate treatment plan.[4] The most common clinical test is a urine test.[5] A clinical drug test is qualitative, meaning it establishes that a chemical compound is present in the bodily fluid.[6] If a clinical drug test is positive, it creates a *presumption* that a drug is present.[7] It does not *prove* that the drug is present.

To determine whether the positive clinical result is accurate, a forensic test *must* be done to confirm the result.[8] A forensic drug test is a more rigorous drug test, which is why it meets evidentiary and testing requirements and protocols.[9] It is a quantitative test, meaning it indicates how much of the chemical compound is present.[10] Such tests, however, are also more expensive which is why healthcare providers often start with a clinical drug test.

Clinical Drug Test Results Often Show False Positives

A positive clinical test does not prove the patient was using a particular substance because many clinical test results are wrong and imprecise.[11] A false positive may occur in two situations: when the chemical compound is not present at all (in other words the result is just wrong),[12] or when the chemical compound is present but comes from a

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[4] *Clinical Drug Testing in Primary Care*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, HHS Publication (SMA) 12-4668 at 5 (2012), available at https://store.samhsa.gov/sites/default/files/sma12-4668.pdf.

[5] Moeller *supra* note 3 at 66 ("Immunoassays, which use antibodies to detect the presence of specific drugs or metabolites, are the most common method for the initial screening process.").

[6] *Clinical Drug Testing in Primary Care supra* note 4 at 9.

[7] *Id.* at 9, 29.

[8] Moeller *supra* note 3 ("A confirmatory test (e.g. GC MS) is required before decisions can be made on the basis of UDSs" and "[t]he main disadvantage of immunoassays is obtaining false-positive results when detection of a drug in the same class requires a second test for confirmation."). Even in the 1970's, the National Bureau of Standards said clinical drug tests "should not be used as the sole evidence for the identification of a narcotic or drug of abuse." Ryan Gabrielson & Topher Sanders, *Busted*, PROPUBLICA (July 7, 2016) https://www.propublica.org/article/common-roadside-drug-test-routinely-produces-false-positives).

[9] Susan E. Lang, *Report of the Motherisk Hair Analysis Independent Review* (Dec. 15, 2015) https://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/lang/.

[10] James T. O'Donnell & James J. O'Donnell III, *O'Donnell's Drug Injury* (4th ed. 2016) Retrieved from https://www.lawyersandjudges.com/.

[11] Arthur L. Kellermann et al., *Utilization and Yield of Drug Screening in the Emergency Department*, 6 AM. J. OF EMERGENCY MED. 14, 19 (1988) ("these investigators have reported false-negative rates for urine screening of 30% and higher."). *See also* Hugh J. Hansen et al., *Crisis in Drug Testing: Results of CDC Blind Study*, 253 J. OF THE AM. MED. ASS'N. 2382 (1985).

[12] Gabrielson & Sanders *supra* note 8 ("Data from the Florida Department of Law Enforcement lab system show that 21 percent of evidence that the police listed as methamphetamine after identifying it was not methamphetamine, and half of those false positives were not any kind of illegal drug at all."). Even a seemingly small false positive rate can affect many people. "By our estimate…every year at least 100,000 people nationwide [in Canada] plead guilty to drug-possession charges that rely on field-test results as evidence." *Id.* Even if the false or innocent positive rate is one percent, that is still 1000 people who are affected.

lawful source, like medication or food[13,14] but in any event the test result does not distinguish between a positive for criminalized opioids, such as heroin, and non-criminalized opioids such as prescribed pain killers and the treatment medications methadone and buprenorphine.[15] The test results are therefore not reliable and should not be treated as concrete proof, without at least confirmatory testing.

Drug Tests May Be Conducted Improperly or Produce Inaccurate Results [16]

Examples from across the United States and abroad demonstrate the risks of contamination in laboratories and the resulting errors in test results and reporting.[17,18] For example, between 2005 and 2015, the Motherisk Laboratory at the Hospital for Sick Children in Toronto tested more than 24,000 hair samples for drugs and alcohol, from over 16,000 different individuals, for child protection purposes. The results were introduced as evidence in court and resulted in both temporary and permanent loss of custody of children. An independent review in 2015 found this testing was "inadequate and unreliable" for use in child protection and criminal proceedings."[19] In Houston, Texas, a leaky roof damaged specimens held in a police lab, and a state audit revealed serious contamination and employees lacking key qualifications and training required to conduct and interpret drug and DNA test results. The lab was shut down and several people convicted of crimes were exonerated.[20]

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[13] Robert L. DuPont et al., *Drug Testing: A White Paper of the American Society of Addiction Medicine,* 1, 6 (Oct. 26, 2013).
[14] Brahm, et al., *Commonly Prescribed Medications and Potential False-Positive Urine Drug Screens*, 67 AM. J. HEALTH-SYS PHARM 1344, 1349 (Aug. 15, 2010) ("A number of routinely prescribed medications have been associated with triggering false-positive UDS results."). Another example is Venlafaxine, an anti-depressant, which can lead to a positive result for PCP. Moeller *supra* note 3 at 72-73.
[15] Treatment medications for OUD during pregnancy can increase the chances of a healthy pregnancy for someone with substance us disorder. *See* Treatment for Opioid Use Disorder Before, During, and After Pregnancy, THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) https://www.cdc.gov/pregnancy/opioids/treatment.html (last reviewed Nov. 15, 2022)
[16] For example, "[n]o central agency regulates the manufacture or sale of" the roadside tests that police use to make drug arrests. Roadside tests are designed to be easy to use and will change color to indicate the presence of a chemical compound, but it is hard to determine a color late at night with police lights flashing. Gabrielson & Sanders *supra* note 8.
[17] *Mass. Lab Mishandling May Mean 1,140 Inmates Convicted Using Tainted Evidence, Report Says*, CBS BOSTON, (Sept. 25, 2012) https://www.cbsnews.com/news/mass-lab-mishandling-may-mean-1140-inmates-convicted-using-tainted-evidence-report-says/.
[18] Justin Zaremba, *Lab Tech Allegedly Faked Result in Drug Case; 7,827 Criminal Cases Now in Question,* NEWJERSEY.COM (Mar. 2 ,2016) https://www.nj.com/passaic-county/2016/03/state_police_lab_tech_allegedly_faked_results_in_p.html.
[19] Susan E. Lang, *Report of the Motherisk Hair Analysis Independent Review* (Dec. 15, 2015), available at https://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/lang/; The Honourable Judith C. Beaman, Commissioner, *Harmful Impacts: The Reliance on Hair Testing in Child Protection Report of the Motherisk Commission* (Feb 2018).
[20] Paul C. Giannelli, *Houston! We Have a Problem!*, 21 CRIM. J., 40 (2006) (on file with NAPW).

“Secret” Drug Testing Undermines the Doctor-Patient Relationship

The use of drug testing without informed consent (especially without the patient’s knowledge), and the practice of reporting the results to government officials, violates physicians’ ethical responsibility[21] and can deter people from obtaining prenatal and other healthcare during pregnancy. For people who are pregnant and actually have a substance use disorder, it can deter them from seeking treatment. Recent studies demonstrate how drug testing can lead to worse maternal and fetal health outcomes.[22]

Major medical and public health associations, including the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Society of Addiction Medicine oppose the prosecution of pregnant people based on drug use.[23]

The U.S. Supreme Court has ruled that it is unconstitutional to use the results of drug testing obtained in the guise of medical care for law enforcement purposes without informed specific consent to a search for evidence of a crime.[24]

Drug Testing Practices Further Discrimination and Racial Profiling

Current drug testing policies and practices disproportionately burden women of color. Despite the fact that drug use by Black and white women occurs at approximately the same rate in the United States,[25] numerous studies and investigative news reports find that infants born to Black mothers are more likely than those born to white mothers to have been screened or tested for criminalized drugs.[26] As leading researchers in one

[21] American College of Obstetricians and Gynecologists, Committee Opinion 633, *Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice* (June 2015).
[22] Noelle G. Martinez et al., *Reconsidering the Use of Urine Drug Testing in Reproductive Settings*, 5 American Journal of Obstetrics & Gynecology MFM (Nov. 2023) https://doi.org/10.1016/j.ajogmf.2023.101206.
[23] *Medical and Public Health Group Statements Opposing Prosecution and Punishment of Pregnant Women,* Pregnancy Justice (Revised June 2023), available at https://www.pregnancyjusticeus.org/wp-content/uploads/2023/09/Medical-Public-Health-Statements-2023.pdf.
[24] *Ferguson v. City of Charleston,* 532 U.S. 67 (2001); *Id. on remand,* 308 F.3d 380 (4th Cir. 2002).
[25] *Results from the 2013 National Survey on Drug Use and Health Summary of National Findings*, U.S. Dept. of Health & Human Services (2014), https://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf.; *Highlights by Race/Ethnicity for the 2021 National Survey on Drug Use and Health*, SAMHSA (2021), https://www.samhsa.gov/data/sites/default/files/2022-12/2021NSDUHFFRHighlightsRE123022.pdf
[26] Marian Jarlenski et al., *Association of Race With Urine Toxicology Testing Among Pregnant Patients During Labor and Delivery*, 4 JAMA Health Forum (Apr. 14, 2023) doi:10.1001/jamahealthforum.2023.0441; Chasnoff, Ira J., Harvey J. Landress, & Mark E. Barrett, *The Prevalence of Illicit-Drug Or Alcohol use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 New England J. of Medicine 1202 (1990); Ellsworth, Marc A., Timothy P. Stevens, & Carl T. D'Angio, *Infant Race Affects Application of Clinical Guidelines when Screening for Drugs of Abuse in Newborns*, 125 Pediatrics e1379 (2010); Roberts, Sarah C., and Amani Nuru Jeter, *Women's Perspectives on Screening for Alcohol and Drug use in Prenatal Care*, 20 Women's Health Issues 193 (2010)

study concluded, "providers seemed to have used race as a factor in deciding whether to screen an infant for maternal illicit drug use."[27]

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2869475/pdf/nihms180105.pdf; Brenda W. Rotzoll, *Black Newborns Likelier to be Drug Tested: Study*, CHICAGO SUN-TIMES (Mar. 16, 2001) available at http://www.mapinc.org/drugnews/v01.n467.a04.html; Troy Anderson, *Hospital Staff More Likely to Screen Minority Mothers*, L.A. DAILY NEWS (June 30, 2008) https://www.dailynews.com/2008/06/30/hospital-staff-more-likely-to-screen-minority-mothers/.

[27] Emma Ketteringham et al., *Healthy Mothers, Healthy Babies,* 20 CUNY L. REV. 77, fn. 53 (2016), citing Marc A. Ellsworth et al., *Infant Race Affects Application of Clinical Guidelines When Screening for Drugs of Abuse in Newborns*, 125 PEDIATRICS 1379 (2010). *See also* Sarah CM Roberts, E Zahnd, C Sufrin, and MA Armstrong, *Does adopting a prenatal substance use protocol reduce racial disparities in CPS reporting related to maternal drug use?* 35 JOURNAL OF PERINATOLOGY 146 (2015).

COMMENT 24

Mondragon, Tabitha, HCA

From: Lilo, Emily <elilo@phs.org>
Sent: Thursday, April 9, 2026 3:37 PM
To: Mondragon, Tabitha, HCA; HCA-madrules
Subject: [EXTERNAL] NMAC comments
Attachments: Outlook-yzzazdrg

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Hi,

A few collective pieces of feedback from Presbyterian.
Thank you for the opportunity to comment!
Emily

- Delineation of roles in the act itself- what is the clinic vs hospital role, CHW MCO role, DOH navigator role, health insurance navigator role, makes it confusing for moms, they don't understand why so many people are trying to meet with them, so really needs to be clear definition of expectations and what are we responsible for and what the handoffs look like
  - Not clear what we are responsible and being held accountable for
  - Without clear delineation, it cascades into everyone who needs to have access to manage the roles and into the portal, and who can access and see it
- Is the state taking a stance on universal drug testing for either pregnant people or infants? The guidance on how and when to make determinations of when to test vs screen is not fully clear, and there have been a lot of questions around this point.
- **8.3.2.11 REQUIREMENTS OF THE PLAN OF SAFE CARE:(e) In-utero exposures: If an infant is exposed to any substances during pregnancy, all exposures shall be documented in the POSC. Documentation of exposures includes exposures occurring during the timeframe in which the mother may not have known she was pregnant, and all substance exposures, including, but not limited to tobacco, fentanyl, heroin, methamphetamine, cocaine, alcohol, marijuana (medical or recreational), and medication assisted therapy such as methadone and buprenorphine**
  - This may be interpreted that a POSC is required even if exposure was early in pregnancy and has not continued by the time they are screened. Is the intent that if any exposure has occurred at any point, even if they no longer report use at time of screening that they still need a plan?
- **8.3.2.14 TRAINING REQUIREMENTS A. HCA will provide training to hospitals on SBIRT and evidence-based assessment tools to evaluate infants born exposed to substances. B. Hospitals and clinics that perform perinatal visits are required to ensure staff that interface directly with birthing people and infants have the necessary training.**
  - Perinatal is often interpreted as prenatal and postpartum only and focused on the parent, and does not always include family practice, PCPs, or pediatricians, but they also need

this training. We have heard repeatedly that many, many more staff and providers across facilities and disciplines need to be included.

Emily Lilo, PhD, MPH
Pronouns: *She/Ella (*[Why pronouns matter)](#)
Perinatal Health Quality & Equity Initiative, Enterprise Lead
Community Health, Presbyterian Healthcare Services
elilo@phs.org
505-291-2027
"There is nothing permanent or unalterable about health inequities"- John Green

[Free Healthy Eating, Active Living Classes](#)
[Health Equity Training Opportunities](#)

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COMMENT 25

The Navajo Nation
Yideeskáádi Nitsáhákees
DR. BUU NYGREN PRESIDENT
RICHELLE MONTOYA VICE PRESIDENT

April 9, 2026

The Honorable Michelle Lujan Grisham
490 Old Santa Fe Trail, Room 400
Santa Fe, NM 87501

RE: Opposition to Proposed Title 8 Social Services, Chapter 3, Part 2 – Plan of Safe Care for Substance-Exposed Infants (8.3.2 NMAC)

Dear Governor Lujan Grisham,

On behalf of the Navajo Nation, I respectfully submit the enclosed position paper expressing our formal opposition to the proposed rule, Title 8 Social Services, Chapter 3, Part 2 – Plan of Safe Care for Substance-Exposed Infants (8.3.2 NMAC).

While the Navajo Nation supports the intent of the Comprehensive Addiction and Recovery Act (CARA) to provide supportive, family-centered services, we have significant concerns that the proposed rule does not align with federal and state protections, including the Indian Child Welfare Act (ICWA) and the New Mexico Indian Family Protection Act (IFPA). Additionally, the rule raises serious issues related to tribal sovereignty, jurisdiction, and the potential for unnecessary child welfare system involvement.

The Navajo Nation respectfully requests that the State of New Mexico pause implementation of this rule and engage in formal government-to-government consultation with tribal nations prior to any adoption. It is critical that any CARA-related implementation honors tribal sovereignty, fully complies with ICWA and IFPA, and reflects culturally responsive, community-based approaches to care. Furthermore, we strongly oppose provisions that mandate intervention without a clear clinical basis or create automatic pathways into the child welfare system based solely on non-compliance.

We remain committed to working collaboratively with the State to ensure that policies support the health and well-being of infants and families while respecting tribal authority and upholding the law.

Post Office Box 7440 • Window Rock, Arizona 86515 • Phone: (928) 871-7000 • Fax: (928) 871-4025

Thank you for your attention to this important matter. If you have any questions, please feel free to contact Mr. Thomas Cody, Executive Director of the Navajo Division for Children and Family Services, at (928) 871-6849 or via email at Thomas.cody@ndcfs.org. We look forward to meaningful consultation and continued partnership.

Sincerely,

Dr. Buu Nygren, *President*
THE NAVAJO NATION

Enclosure: Position Paper

Opposition to Proposed Title 8 Social Services, Chapter 3, Part 2 – Plan of Safe Care for Substance-Exposed Infants (8.3.2 NMAC)

Introduction

The Navajo Nation formally expresses its opposition to the proposed rule, Title 8 Social Services, Chapter 3, Part 2 – Plan of Safe Care for Substance-Exposed Infants (8.3.2 NMAC). While the Nation supports efforts to improve outcomes for infants and families affected by substance use, this rule raises significant concerns regarding tribal sovereignty, jurisdictional overreach, and conflicts with established federal and state protections for Native children and families.

Background

The Comprehensive Addiction and Recovery Act (CARA) promotes prevention, treatment, and family-centered services through culturally appropriate, community-based approaches that prioritize family unity.

Since July 2025, the Navajo Nation Indian Child Welfare Act Program has experienced an increase in referrals of approximately 15 to 20 cases from the New Mexico Children, Youth, and Families Department involving substance-exposed infants. Many cases do not meet the standards outlined under the Indian Child Welfare Act (ICWA) and the New Mexico Indian Family Protection Act (IFPA), and lack evidence of active, family-preserving efforts prior to state involvement.

Position and Analysis

The proposed rule is inconsistent with ICWA and IFPA, which require active efforts to prevent unnecessary removal of Native children, ensure family reunification, and uphold tribal authority. Provisions within the rule may initiate child welfare involvement based on non-compliance rather than clinical evidence of abuse or neglect, expand monitoring without judicial oversight, and position state systems as primary coordinators over tribal authorities.

Additionally, the rule establishes compliance-driven mechanisms that shift the focus from supportive care to surveillance. Requirements such as mandatory Plans of Safe Care prior to discharge, rapid interagency data sharing, ongoing monitoring by state-designated navigators, and automatic referrals for perceived non-compliance may discourage families from seeking care and erode trust in service systems.

The Navajo Nation further asserts that the rule infringes upon tribal sovereignty by allowing state oversight of Navajo families without tribal consent, mandating the sharing of sensitive information through state-controlled systems, and assigning coordination responsibilities to state-appointed personnel rather than tribal social services. This approach does not reflect true government-to-government engagement and undermines tribal self-determination.

Finally, the rule departs from the intent of CARA by emphasizing enforcement over engagement. Rather than strengthening families through culturally responsive and community-based care, it increases the likelihood of unnecessary child welfare involvement and expands surveillance practices.

Recommendations

The Navajo Nation respectfully requests that the State of New Mexico:

- Pause implementation of the proposed rule
- Engage in formal government-to-government consultation with tribal nations prior to any adoption or implementation
- Ensure that any CARA-related implementation:
  - Honors tribal sovereignty and jurisdiction
  - Fully complies with ICWA and IFPA protections
  - Centers on culturally responsive, community-based approaches to care
- Remove or revise provisions that:
  - Mandate intervention without a clear clinical basis or evidence of abuse or neglect
  - Create automatic pathways into the child welfare system based solely on non-compliance or lack of engagement
- Revise the rule to:
  - Recognize and uphold tribal authority in all applicable cases
  - Protect tribal data sovereignty
  - Prioritize voluntary, supportive services over punitive or surveillance-based approaches

Conclusion

The Navajo Nation remains committed to collaborative efforts that support the health and well-being of infants and families affected by substance use. However, such efforts must respect tribal sovereignty, comply with federal and state law, and reflect culturally grounded, family-centered principles. The Nation looks forward to engaging in meaningful consultation and partnership with the State to develop a framework that achieves these shared goals.

COMMENT 26

Mondragon, Tabitha, HCA

From: jfgoodfriend <jfgoodfriend@proton.me>
Sent: Thursday, April 9, 2026 3:42 PM
To: HCA-madrules
Subject: [EXTERNAL] Submission of public comment on Draft Rule TITLE 8 SOCIAL SERVICES CHAPTER 3 FAMILY HEALTH AND WELL-BEING PART 2 PLAN OF SAFE CARE FOR SUBSTANCE-EXPOSED INFANTS

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To the rule committee
RE: Draft Rule TITLE 8 SOCIAL SERVICES CHAPTER 3 FAMILY HEALTH AND WELL-BEING PART 2 PLAN OF SAFE CARE FOR SUBSTANCE-EXPOSED INFANTS

I am writing to expressed my discomfort with the draft rule and my opinion that the rule be rescinded and drafted with intent that better speaks to the implementation of SB42.

As a midwife, I have served Espanola and the surrounding communities in Northern NM for over 18 years providing care to pregnant people, families and infants. I am deeply invested in the wellbeing of our communities and the safety of our children. I have been proud to be a part of several initiatives that seek to better care for families in cycles of substance abuse, including people who are pregnant and have young children. I am very concerned at the language in this drafted bill and its lack founding in the care systems that keep children and families safe. As currently drafted, I believe these rules will result in a huge catchment of individuals who do NOT have substance use disorder, while not increasing safety for vulnerable infants and children. I am concerned in particular about the equating of "admission of use' with Substance use disorder--- a claim that has no evidence to support it and will significantly confuse who needs additional support and who does not.

I believe this draft rule attempts to change the meaning and purpose of CARA-- something I have been involved in the implementation of for many years. The shift from supporting families with substance exposed infants to 'ensuring safety for infants' is a dangerous narrowing of focus that has the potential to criminalize our communities and make care access points less safe for families who are struggling and ready to seek help.
I am deeply concerned by this draft and believe it does not reflect a strategy for the long arc wellbeing of our communities or a data driven approach to helping families struggling with substance use disorder. I strongly encourage this rule to be re-drafted with the intent of SB42 at the center.

Respectfully, Jess Gutfreund LM, CPM, IBCLC, MSM

Sent with Proton Mail secure email.

COMMENT 27

April 9, 2026

New Mexico Health Care Authority Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

To Whom it May Concern,

If/When/How: Lawyering for Reproductive Justice submits this comment in response to the New Mexico Health Care Authority's (HCA) proposed New Mexico Administrative Code (NMAC) rule 8.3.2, "Family Health and Well Being, Plan of Safe Care for Substance-Exposed Infants" (Proposed Rule). If/When/How strongly opposes the Proposed Rule, and asks that the HCA withdraw it and craft a new rule that follows the contours of the originating statute, Senate Bill 42 (SB 42), and does not impose burdens on families that are not required by federal or state law.

If/When/How's experience at the intersection of reproductive health care and people's fear of punishment or surveillance by the state informs our interest in the Proposed Rule. Our Repro Legal Helpline[1] receives thousands of calls every year from individuals about the legal risks they may face by seeking reproductive health care in the formal health care system. If/When/How also educates and trains medical providers on mandatory reporting laws, including mandatory notifications related to substance use during pregnancy[2] and the harmful consequences of subsequent family separation.

We welcome the HCA's proposal of a substance-exposed infant notification pathway that is distinct from child abuse reporting pathways. However, we are deeply concerned about the Proposed Rule's mandate of a Plan of Safe Care (POSC) for every instance of substance use during pregnancy, regardless of actual substance dependency, untreated substance use disorder, or harm to an infant. This overbreadth will arbitrarily impact families who do not need a POSC. It will also be exacerbated by elements of the Proposed Rule that require a referral to the Children, Youth, and Families Department (CYFD) for any family deemed "non-compliant" with a POSC. Under the Proposed Rule, increasing the number of families with an unwarranted POSC will increase the number of families reported to an already-overburdened CYFD, and that will inevitably cause family separation.

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[1] ReproLegalHelpline.org provides legal information, advice, representation, and attorney referrals to people seeking pregnancy- and abortion-related care, including fear of or actual child welfare involvement during pregnancy.
[2] If/When/How maintains a detailed 50-state Resource on prenatal and infant drug testing and reporting requirements. *See* If/When/How: Lawyering for Reproductive Justice, *Prenatal Drug Exposure: CAPTA Reporting Requirements for Medical Professionals* (Jan. 2026), https://ifwhenhow.org/resources/prenatal-drug-exposure-capta/.

The Proposed Rule's harm will not be limited to the subset of families that are forced to comply with an unneeded POSC or are actually separated. Imposing unnecessary POSCs will increase patients' *fear* of pregnancy-related family separation and criminalization. As has been true with other overregulated health care, such as abortion care, enhanced state scrutiny frightens patients into withholding significant medical information from their providers. The threat of government involvement in their lives also causes some individuals to delay or avoid care entirely. Fear of accessing care will ultimately worsen maternal-child health care outcomes across New Mexico.

HCA should withdraw the Proposed Rule, and instead work with local advocates, tribal governments, and systems-impacted parents to create a rule that adheres to SB 42's family-supporting mandate. We urge the HCA to follow the leadership of both its own working group of experts and of tribal governments as the Proposed Rule is re-drafted.

I. The Proposed Rule imposes burdens on families that are not required by federal law and risks harming families.

Federal law[3] requires that states have procedures for addressing the needs of each newborn identified as "affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder;" notifying child welfare when a newborn has been so identified; and ensuring the newborn's safety and well-being following their release from health care providers by developing a POSC.[4] The POSC is intended to do two things: address the health and treatment needs of the infant and their affected family or caregiver, if any, and monitor whether local entities are delivering appropriate services to the infant and family.[5] A POSC is different from a child protective services report.

Though CAPTA-CARA requirements are a legal floor, many states are beginning to understand the potential for harm posed by state involvement in cases of substance use during pregnancy and are actively taking steps to minimize that involvement and reduce related family separation.[6]

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[3] There are two relevant federal statutes: the Child Abuse Prevention and Treatment Act (CAPTA), and an amendment to that act, the Comprehensive Addiction and Recovery Act (CARA). CAPTA provides funds for state agencies to address child abuse and neglect. CAPTA requires states to create laws mandating that certain professionals report child abuse or neglect (suspected and actual) to a child protective services agency to obtain CAPTA funds. CARA requires medical professionals to notify child protective agencies when an infant is born and identified as affected by substance use disorder (SUD) or withdrawal symptoms. This comment will refer to these laws and legal requirements jointly as "CAPTA-CARA." States implement their own reporting requirements to comply with CAPTA-CARA. *See* Pregnancy Just., *Understanding CAPTA and State Obligations* (2020), https://www.pregnancyjusticeus.org/wp-content/uploads/2023/09/Understanding-CAPTA-and-State-Obligations-3.pdf.

[4] Child Abuse Prevention and Treatment Act, 42 U.S.C. § 5106a(b)(2)(ii-iii) (2019).

[5] 42 U.S.C. § 5106a(b)(2)(B)(iii)(I)-(II); Child Welfare Information Gateway, Admin. for Children & Families, *State Statutes Series: Plans of Safe Care for Infants with Prenatal Substance Exposure and Their Families* (2025), https://perma.cc/UE9J-UFEP.

[6] *See, e.g.,* Taleed El-Sabawi & Sarah Katz, *Deinstitutionalizing Family Separation in Cases of Parental Drug Use*, 134 Yale L.J. Forum 1022 (Mar. 28, 2025) (discussing harmful effects of family separation, particularly among

SB 42 was intended to help bring New Mexico in line with these efforts. But the Proposed Rule deviates from that intent, imposing burdens that stand to harm New Mexico's families.

A. The Proposed Rule risks overinvolving the family regulation system in New Mexican families by expanding who requires a POSC.

CARA requires a POSC for newborns "born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder." This definition, crafted in consultation with medical experts, is purposefully narrow. First, it applies only to an infant that is already born, meaning that it does not apply to a pregnant person. Second, the infant must be "identified as being affected by substance abuse or withdrawal symptoms," requiring clinical determination of actual symptoms related to the birthing parent's substance use. Third, the statute intentionally uses "substance abuse" to distinguish untreated or uncontrolled substance use disorder from casual use or the use of prescribed controlled substances under a provider's direction.

By contrast, under the Proposed Rule, any parent who uses substances during their pregnancy, *whether or not their infant is born and identified as affected* by that substance use, is required to have a POSC. This sweeps in a range of families who may not need or benefit from a POSC. And the POSC itself as described by the Proposed Rule is overinclusive of required services. For instance, a parent who is in long- or short-term Medication Assisted Treatment (MAT) for substance use disorder is required to attend a prevention program, irrespective of whether the parent has *already* attended substance use prevention programs. Parents who admit to using a substance at all, even before they know they are pregnant — including many substances that are legal under New Mexico law — would be required to have Early Childhood Care and Education Department (ECECD) visits,[7] wasting state funds and burdening families. The Proposed Rule also states that, contrary to the carefully crafted interventions required by SB 42, failure to comply with a POSC will lead to penalties. The mere threat of punishment or surveillance is enough to keep some families away from the health system entirely.

SB 42 requires that a POSC identify appropriate agencies for support and services based on a family's specific needs. It does not require families to actually access these supports and services, and it certainly does not mandate punishment if families refuse to access services unless the infant is actually at serious risk without them. The Proposed Rule undermines this, requiring a one-size-fits-all mandate to attend treatment and have a government agency visit a family's home without their consent.

Black, Indigenous, and other marginalized families, and legislation such as the Families First Prevention Services Act). *See also* Wash. State Dep't of Children, Youth & Families, *HB1227 and SB6109*, https://perma.cc/Y4HQ-67YH (discussing the 2023 "Keeping Families Together Act," which has yielded a 14% decrease in number of children placed in out-of-home care).

[7] The Proposed Rule includes the New Mexico ECECD Home Visiting Program in its POSC requirements, regardless of if a family needs this or would find it helpful.

Though the POSC is not a child abuse report, and the CARA navigators required by the Proposed Rule are not CYFD, the Proposed Rule risks treating families with a POSC as though they are under current CYFD investigation – negating the entire purpose of SB 42.

B. *The Proposed Rule expands the requirements for families with a POSC in a one-size-fits-all manner, increasing state intervention and its potential for harm.*

The POSC is a tool to ensure family care in support of the infant, and to hold local entities accountable for service provision.[8] A POSC's development should be co-led by the birthing parent and their chosen support network, which may or may not include a medical provider. Instead, the Proposed Rule seems to use a POSC as a way to 1) force families into drug treatment or intervention, *even when a medical professional identifies it as unneeded or a family has already had it*, 2) send yet another government agency, ECECD, into a family's home, and 3) invite HCA and its CARA navigators to surveil families similar to the way CYFD has. SB 42 was crafted in recognition of the potential harm of CYFD involvement; the Proposed Rule simply replaces it with involvement from other agencies. When offered to families as options, and disconnected from punitive mechanisms, these services may be welcome and wanted. When mandated, they may be disruptive and harm the well-being of both parents and children.

The Proposed Rule imposes requirements that are not federally-required, not tailored to the individual needs of New Mexico families, and risks treating families with a POSC as though they are under CYFD investigation, undermining the legislative purpose of SB 42.

II. The Proposed Rule's expansion of who requires a POSC will increase patient fear of family separation, worsening health outcomes.

Family separation – and the threat of it – worsens health outcomes for mothers and infants. Increasing government agency scrutiny of families, even agencies that are intended to be one step removed from CYFD, will necessarily mean that more New Mexican families are exposed to potential harm from the family regulation system. SB 42 was purposefully designed to create additional layers of separation between CYFD and families in order to improve health outcomes for families and infants. The Proposed Rule's expansion of family surveillance in New Mexico will erode patient-provider trust, dissuade families from accessing essential health care, and punish parents who are already vulnerable or struggling.

A. *Patients who fear family separation and criminalization may withhold information, or delay or avoid care entirely.*

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[8] *See* 42 U.S.C. § 5106a(b)(2)(B)(iii). Some states even allow a de-identified POSC to satisfy CAPTA's data reporting requirements while avoiding unnecessary state intervention.

Patient-provider relationships rooted in trust are essential for strong health outcomes, particularly for stigmatized health care. Trust is a threshold requirement for patients to disclose sensitive personal information about their health and behavior with providers, and patients who do trust their providers ultimately report better compliance with care plans, fewer symptoms, and greater quality of life.[9] When patients feel they can safely have unfettered discussions about their health with providers, their candor contributes to higher-quality care and patient satisfaction.[10]

In contrast, patients often do not feel safe sharing sensitive health and behavior information with their providers when they believe that honesty could trigger significant personal or legal consequences. When patients do not trust providers, they may withhold relevant health information, delay care, or avoid care entirely, all of which can lead to adverse health outcomes. Patient concerns about safety include the risk of involvement in the family regulation system: the threat of mandatory and permissive reporting to state agencies or law enforcement has been shown to deter help-seeking behaviors.[11]

Patient trust in providers is difficult to establish, easily lost, and already quite tenuous for many patient populations. This is especially true for groups that experience discrimination, lack financial resources, or have historically had their trust in the medical system abused.[12] People seeking and receiving reproductive health care also have difficulty trusting health care providers

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[9] *See, e.g.*, Johanna Birkhäuer et al., *Trust in the Health Care Professional and Health Outcome: A Meta-Analysis*, PLoS One, Feb. 2017, at 6–8, https://perma.cc/UGE6-ALAM ("Across diverse clinical settings, patients reported to be more satisfied with treatment, to show more beneficial health behaviours, less symptoms and higher quality of life when they had higher trust in their health care professional."); Stefanie Mollborn et al., *Delayed Care and Unmet Needs Among Health Care System Users: When Does Fiduciary Trust in a Physician Matter?*, 40 Health Servs. Res. 1898, 1898–99, 1910–11 (2005), https://perma.cc/5VFX-L5LJ ("Most patients who have a trusting relationship with their physicians are less likely than those with less trust to report having *unmet health care needs*.").

[10] *See* Am. Coll. of Obstetricians & Gynecologists, *Effective Patient-Physician Communication* 1 (2025), https://perma.cc/4PAQ-P3MF; Jennifer Fong Ha et al., *Doctor-Patient Communication: A Review*, 10 Ochsner J. 38, 38–39 (2010), https://perma.cc/4XUM-FVUL.

[11] Carrie Lippy et al., *The Impact of Mandatory Reporting Laws on Survivors of Intimate Partner Violence: Intersectionality, Help-Seeking and the Need for Change*, 35 J. Fam. Violence 255, 260–62 (2020), https://perma.cc/422L-NCHS; Jill R. McTavish et al., *Children's and Caregivers' Perspectives About Mandatory Reporting of Child Maltreatment: A Meta-Synthesis of Qualitative Studies*, BMJ Open, Apr. 2019, at 6, 9, https://perma.cc/6564-GP7E; *see also* Mike Hixenbaugh et al., *Mandatory Reporting Was Supposed to Stop Child Abuse. It Punishes Poor Families Instead.*, ProPublica (Oct. 12, 2022), https://perma.cc/SHV9-HF4U ("[Philadelphia City Councilmember] Oh said not enough has been done to mitigate the fear created by mandatory reporting, especially in poorer Black communities. 'In those neighborhoods, everyone knows about mandatory reporters. . . . [s]o when your child falls off a bike, you've got to think, "Do we take him to the hospital or not?"'").

[12] *See, e.g.*, Martha Hostetter & Sarah Klein, *Understanding and Ameliorating Medical Mistrust Among Black Americans*, Commonwealth Fund (Jan. 14, 2021), https://perma.cc/F5G2-ZW2C (describing medical mistrust in the Black community due to historical and present-day medical abuse and discrimination); Whitney R. Garney et al., *Adolescent Healthcare Access: A Qualitative Study of Provider Perspectives*, 15 J. Primary Care & Community Health 1, 2, 7 (2024), https://perma.cc/3Q2T-6JN4 ("[A]dolescents often avoid initiating conversations about sensitive topics with their healthcare providers because of fear, stigma, embarrassment, and/or a lack of trust," and providers "stated that trust is a precondition to discussing sensitive topics with adolescents, yet it is difficult to establish."); S.E. James et al., Nat'l Ctr. for Transgender Equality, *The Report of the 2015 U.S. Transgender Survey* 5 (2016), https://ustranssurvey.org/download-reports/ (finding that transgender people avoid accessing health care).

as states have increasingly restricted or criminalized that care. And increasingly, pregnant and postpartum people are facing child welfare involvement, family separation, and criminalization in relation to substance use – including in many cases where a drug test was flawed, or where the substance at issue was given to a patient by a provider during labor or birth.[13] For groups already wary of consequences due to error or stigma within the formal health care system, any added risk will reduce their trust in that system and worsen their health outcomes.

B. Mandating a POSC for every substance-exposed infant will increase patient fear and erode already-tenuous trust between patients and providers.

As discussed above, the Proposed Rule drastically expands who is required to have a POSC, noncompliance with which can lead to punitive consequences. This forces people to choose between being forthcoming about substance use with their provider and being subject to surveillance, or withholding information and forgoing needed care. The risk is exacerbated by the requirement for medical providers to screen for substance use at every prenatal visit, essentially treating all pregnant and postpartum patients as suspect at all times. Constant scrutiny, coupled with threat of a POSC and further state intervention, is likely to severely damage patients' trust in their providers and reduce their comfort engaging with pregnancy-related care at all.

The Proposed Rule is likely to frighten and penalize precisely the people that HCA aims to assist, particularly parents with SUD who want support from health care providers and opt-in state programs. The Proposed Rule could shatter the already-tenuous trust that marginalized parents have in their providers and the formal health care system, and it should be withdrawn.

III. Requested Remedy

The Proposed Rule injects fear of state intervention, family separation, and criminalization into a system meant to provide care. That fear has meaningful consequences: it will push pregnant and postpartum people away from health care, whether or not they use substances, at the moment they may most need support. Accordingly, we urge HCA to withdraw the Proposed Rule and, alongside local advocates and tribal governments, craft a new rule implementing SB 42 in the spirit of its intent of protecting the integrity of New Mexican families.

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[13] Shoshana Walter, *Hospitals Gave Patients Meds During Childbirth, Then Reported Them for Positive Drug Tests,* Marshall Project (Dec. 11, 2024), https://perma.cc/Z67V-5UYJ; Shoshana Walter & Jill Castellano, *Tens of Thousands of Mothers Were Flagged to Police Over Flawed Tests at Childbirth,* Marshall Project (Feb. 10, 2026), https://perma.cc/L9LM-ALYL.

COMMENT 28

April 9, 2026

To: New Mexico Health Care Authority (HCA), Medical Assistance Division (MAD)

From: Melissa Moore, Director – Civil Systems Reform, Drug Policy Alliance

Testimony for New Mexico Administrative Code (NMAC) rule 8.3.2, Family Health and Well Being, Plan of Safe Care for Substance-Exposed Infants (NMSA 32A-3A-13)

The Drug Policy Alliance (DPA) respectfully submits this written testimony regarding proposed rulemaking (NMSA 32A-3A-13) for SB 42. **We oppose the proposed rule**, which is not in keeping with the legislative intent of SB 42, and request that the department withdraw it and instead draft a rule that follows SB 42 and appropriately implements its aims relating to substance use and pregnancy.

Drug Policy Alliance is a non-partisan 501(c)(3) nonprofit organization with tens of thousands of members nationwide, including in New Mexico. The Drug Policy Alliance (DPA) addresses the harms of drug use and drug criminalization through policy solutions, organizing, and public education. We advocate for a holistic approach to drugs that prioritizes health, social supports, and community wellbeing. We believe that seeking medical care, including care for substance use disorder, should be met with accessible, evidence-based options and not expose people to harm, such as surveillance, criminalization, or civil punishment, including penalties impacting child custody.

The aim of SB 42 was to facilitate safety and stability for newborns and families; peer-reviewed research shows moving away from punitive approaches is necessary to meet that goal. This proposed rule instead further expands and entrenches such approaches and does not follow with the Legislature's directive in SB 42.

We call on the Department to withdraw this proposed rule and redraft such that the rule follows the intent of SB 42 and focuses on building collaborative and trusting relationships between pregnant patients and healthcare providers. The Department should prioritize efforts that address and remove barriers to accessing voluntary, evidence-based care for SUD among pregnant and postpartum populations and ensure responses to drug use among reproductive-age people shift practice away from punishment and toward appropriate care. We offer further context below.

Proposed Rule is Counter to Public Health Research

Public health research underscores that the proposed rule would in fact be opposed to the policies and practices that are needed to improve birth outcomes, keep families intact, and ensure that voluntary treatment is accessible. The rule should be redrafted to be in alignment with both SB 42 and public health research findings, as outlined below.

When birthing people feel connected to care instead of punitive responses, research shows better outcomes for newborns *and* birthing people. Conversely, research shows *increased* rates of neonatal abstinence syndrome in states with punitive policies.[1] Additional new research indicates that punitive policies toward people who use drugs during pregnancy – such as mandatory reporting and termination of parental rights – fail to reduce substance use, which is often the purported goal of such policies.[2] These worse outcomes are driven by pregnant and postpartum women facing substantial barriers to effective, evidence-based care for substance use disorder. Instead of care, pregnant people are being met with punishment that does not support healthy outcomes. Policies and practices like those in the proposed rule present barriers to accessing substance use treatment for those who need it: they drive pregnant people away from the health care system and alienate them from the supports they need to have healthy pregnancies and births and deter healthcare for families.

The American College of Obstetrics and Gynecology (ACOG) brief *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician–Gynecologist*[3] clarifies:

> "Studies indicate that prenatal care greatly reduces the negative effects of substance abuse during pregnancy, including decreased risks of low birth weight and prematurity.[4] Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and fetus."

Pregnancy and postpartum are key periods for people to make changes in their overall health choices and specifically their drug use. The study *Substance Use in Pregnancy*[5] details:

> "Most women who use substances decrease their use during pregnancy. In general, women do not choose to begin using any potentially toxic substances once they know they are pregnant. Those who can quit on their own usually do so, which is the distinguishing factor between substance use and substance use disorder (SUD). […] Pregnancy is a strong motivator for abstinence, and most women refrain from or decrease their use of tobacco, alcohol, marijuana, and cocaine by the second trimester. Those with [opioid use disorder] OUD receiving medication-assisted treatment, enrolled in a comprehensive program with behavioral counseling and psychosocial support, usually maintain sobriety until delivery."

Instead of leveraging this momentum for positive change as SB 42 envisioned, the proposed rule establishes additional barriers and punitive responses that will have a chilling effect over pregnant people engaging with their healthcare provider for fear of punishment or family separation, even in situations where they are reducing or stopping their use.

Punitive policies such as those in the proposed rule deter people from accessing prenatal care for fear of being reported, and lack of medical care can often lead to poor health and pregnancy outcomes,[6] in violation of the Convention on the Elimination of All Forms of Discrimination against Women.[7] Black, Latine, and Indigenous families disproportionately experience the punitive effects of these systems,[8] despite similar rates of drug use to other populations;[9] this stems from decades of racist drug war spurred stereotypes regarding low-income women of color as justification for punitive state intervention.[10]

Further research shows fears of child welfare involvement within communities that are targeted and overrepresented within the child welfare system can lead to women of color delaying prenatal care,[11] which can result in adverse pregnancy outcomes, negative outcomes for women, and lifelong impacts for children.[12, 13] The study *Child Removal Fears and Black Mothers' Medical Decision-Making* describes how "Black mothers are highly aware of the collaboration between the health care system and punitive institutions like CPS [child protective services]" and how "[f]ear of

child removal not only shapes *how* Black mothers receive maternity and pediatric care for themselves and their children but also *where* they receive care."[14] This is also true for Indigenous and low-income pregnant people, who have disproportionately higher rates of being reported to child welfare agencies, being investigated, and being separated from their children – despite similar rates of use.

New Mexico should address the specific well-founded concerns that parents of color face in accessing healthcare for themselves, specifically care for SUD, because of the ever-present threat of child welfare system intervention and its harms. While this is the case for perinatal people overall, it is especially magnified for perinatal people of color who are also navigating substance use and face barriers to accessing appropriate medical care and treatment.

Separation of a mother and newborn – an increased likelihood under the framework of the proposed rule – also contravenes medical literature for best practices when a newborn is experiencing neonatal abstinence syndrome (NAS), neonatal opioid withdrawal syndrome (NOWS), or other symptoms of withdrawal. Research in this area over the past ten years emphasizes the importance of maternal-infant bonding during the critical postpartum period and the "Eat, Sleep, Console" model of care as the most effective form of treatment for infants experiencing NOWS or NAS.[15] The U.S. Centers for Disease Control and Prevention emphasizes the Eat, Sleep, Console model of care for infants with substance exposure "has resulted in decreased average hospital stay, fewer infants treated with morphine, lower hospital costs, and increased bonding between mother and child."[16] However, policies like those in the proposed rule that would separate a new mother from their newborn deny them the opportunity for these better outcomes—resulting in harmful impacts for the newborn and also for the birthing woman[17] in violation of multiple international human rights conventions.[18]

SB 42 aligns New Mexico's policies and practices with evidence-based care for children and families and accounts for the generational harms of the child welfare system. As such, rulemaking for SB 42 should be similarly rooted in research about best practices for reproductive justice and trauma-informed care and material support for treatment and family support work that is voluntary, evidence-based, and disconnected from punitive responses.

Proposed Rule is Counter to Institutional Guidance

Guidance about CAPTA/CARA highlights that Plans of Safe Care (POSC) are meant to support the health and safety of newborns affected by substance use and their families or caregivers. The intention is to ensure that families are receiving comprehensive support, care, and treatment that meets their needs – not to serve as a punitive tool. Under CAPTA/CARA, hospitals and birth centers must collect and provide to the state aggregate de-identified data reflecting the number of newborns who are substance *affected* (as opposed to *exposed*). This does not constitute a need to report to the child welfare system. The requirements of this proposed rule go beyond CAPTA/CARA in ways that are unnecessary under federal law and do not support positive outcomes for New Mexico newborns and families.

The proposed rule is also counter to the guidance from leading medical associations on this issue. American College of Obstetrics and Gynecology (ACOG) Committee Opinion *Alcohol Abuse and Other Substance Use Disorders*[19] highlights research on treatment for mothers and the concerns about child welfare system involvement that should inform the redrafting:

> "[R]emoving children from the home not only violates child welfare goals of family integrity, but actually may subject children to greater risks in the foster care or child

> welfare systems.[20] Treatment of substance use disorder is more effective and less expensive than restrictive policies[21] and results in a net medical savings per mother–infant pair.[22] Women who have custody of their children during treatment of substance use disorder also complete treatment at a higher rate than women whose children are taken from them."[23, 24]

ACOG's *Opioid Use and Opioid Use Disorder in Pregnancy*[25] further underscores why SB 42 was necessary and how this rulemaking should be re-aligned to follow suit:

> "[O]bstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed.[26] In states that mandate reporting, policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions.[27]" [emphasis added]

Additionally, guidance issued this year by the U.S. Administration for Children and Families along with Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration[28] clarifies that evidence-based medications for opioid use disorder (including methadone, buprenorphine, and naltrexone) are considered "well-supported interventions to increase access to evidence-based substance use disorder treatment for families at risk" and are approved by the agencies as services to prevent family separation. The federal agencies also issued a dear colleague letter[29] that details:

> "When individuals with OUD lack access to appropriate treatment, including MOUD, the consequences extend beyond individual health outcomes to affect family stability, and long-term well-being. Conversely, when parents receive timely, evidence-based treatment for OUD, families can be strengthened and preserved, reducing the need for out-of-home placement or supporting successful reunification when placement has occurred."

Solution: Address Care Accessibility – Without Punitive Measures

Quality care must be decoupled from punitive interventions that push people to the shadows and are a barrier to healthy outcomes for newborns and pregnant and postpartum people. According to the U.N. General Assembly Special Session on drugs,[30] drug use should be treated as a public health issue and access to treatment should be provided for those requesting it. This includes culturally appropriate, affordable, appealing, and accessible and evidence-based care for substance use disorder to anyone who needs it – regardless of their pregnancy, delivery, or family status. This involves providing care to both the birthing parent and, postpartum, to the newborn in a thoughtful and effective manner that follows evidence-based best practices and focuses on keeping families together.

If a pregnant or postpartum person is struggling with substance use, New Mexico has an interest in creating safe, accessible avenues for them to get the care they need and be able to speak openly with their healthcare provider without fear that doing so will lead to punitive measures.[31] Achieving the positive health outcomes prioritized by SB 42 requires ensuring that no person will be punished or lose their parental rights solely because of substance use. This is a crucial safeguard so that people will not only seek care but also maintain care for both themselves and their newborn.

This aligns with the ACOG Committee Opinion *Alcohol Abuse and Other Substance Use Disorders*[32] ethical frameworks, which states:

> "The core ethical purpose of routine screening for substance use disorder is the beneficent provision of timely and effective care, rather than stigmatization or punishment. […]
> A significant ethical dilemma is created by state laws that require physicians to report the nonmedical use of controlled substances (drugs or other chemicals that are potentially addictive or habit forming) by a pregnant woman and laws that require toxicology tests of the woman, her newborn, or both after delivery when there is clinical suspicion for fetal exposure to potentially harmful controlled substances. Such laws may unwittingly result in pregnant women concealing substance use from their obstetricians or even forgoing prenatal care entirely. State lawmakers are encouraged to look to sciencebased guidelines, medical evidence, and ethical principles to guide appropriate public health interventions." [emphasis added]

The focus of rulemaking for SB 42 should be to strengthen access points to evidence-based treatment and to avoid family separation – not establish a rubric that will increase surveillance and separation as currently drafted.

Opportunities for Rewritten Rule for SB 42

In addition to the points included above for redrafting the rule for SB 42, the revised version should recognize and replicate successes from peer navigators in other supportive spaces, such as harm reduction for people who use drugs. Peer-driven support options present an opportunity to foster a safe dynamic where people who are pregnant and postpartum can feel more comfortable speaking about their challenges with SUD and seek constructive support. There are many examples of peer-based support models within the broader harm reduction movement that offer an example to be built upon for this population.

Additionally, New Mexico should work toward implementing a trauma-informed and harm reduction−oriented Family Wellness Plan (in place of Plan of Safe Care), which are supported by the National Center on Substance Abuse and Child Welfare (NCSACW) and their Center for Children and Family Futures offers technical assistance to states seeking to implement Family Wellness Plans. Such plans better account for the nature of SUD and include planning for how to navigate instances of recurrence of use (relapse) to ensure children are safe and avoiding child welfare system involvement.

Conclusion

New Mexico must follow the will of SB 42 and prioritize efforts that will provide families access to the necessary supports and healthcare they need – while avoiding family separation and without involving the child welfare system.

This is the time for New Mexico to expand supportive resources that build positive relationships with medical providers and encourage − rather than discourage and punish − people accessing medical care. This needs to be predicated on pregnant people knowing they can speak openly with providers and seek care without fear of punitive responses and family separation, as would be the case under the proposed rule.

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[19] American College of Obstetrics and Gynecology. Committee Opinion No. 633: "Alcohol Abuse and Other Substance Use Disorders." *Obstetrics & Gynecology* 125(6):p 1529-1537, June 2015. | DOI: 10.1097/01.AOG.0000466371.86393.9b
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[30] United Nations Office on Drugs and Crimes: https://www.unodc.org/documents/postungass2016/follow-up/18-01924_UNGASS_eBook_002.pdf
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COMMENT 29

135 CAPITOL SQUARE DRIVE
ZIA PUEBLO, NM 87053-6013

PHONE (505) 867-3304
FAX (505) 867-3308

4/9/2026

RE: Pueblo of Zia – Statement on Proposed HCA CARA Rule Changes

The Pueblo of Zia respectfully expresses our strong concern regarding the proposed rule changes being advanced by the New Mexico Health Care Authority (HCA) related to the implementation of the Comprehensive Addiction and Recovery Act (CARA). At this time, the Pueblo of Zia does not support the adoption of these rules in their current form.

While we acknowledge and support efforts to strengthen services for families affected by substance use, we remain deeply concerned that these policy changes continue to move forward without meaningful and consistent tribal representation in the decision-making process. Too often, policies that directly affect Native families and children are developed and implemented without adequate consultation with Tribal Nations, Pueblos, and tribal leadership.

Decisions that impact Native children must recognize and uphold the protections already established under the **Indian Child Welfare Act (ICWA)** and the **Indian Family Protection Act (IFPA).** These laws exist to safeguard the rights of Native children, families, and sovereign tribal governments. Any policy framework that affects child welfare or family intervention must ensure alignment with these protections and must include tribes as equal partners in the process.

The Pueblo of Zia is therefore formally requesting an **extension of the current rulemaking process** to allow sufficient time for meaningful tribal engagement and representation. This extension would provide an opportunity for Tribal Nations, Pueblos, and tribal organizations to participate in collaborative discussions regarding how CARA services can be implemented in a manner that respects tribal sovereignty, cultural considerations, and the unique needs of Native families.

We strongly believe that CARA programming can be more effective when developed **in partnership with tribes**, rather than imposed without consultation. True collaboration will ensure that services are culturally appropriate, legally compliant, and supportive of tribal communities.

The Pueblo of Zia respectfully requests HCA to pause the current rulemaking timeline and work alongside Tribal Nations, Pueblos, and tribal representatives to develop an approach that reflects shared responsibility and respect for tribal sovereignty. Should you need any additional information please contact Yvette Herrera, Social Services Director at Yvette.Herrera@ziapueblo.org

Respectfully,

Boyd Toribio
Governor – Pueblo of Zia

COMMENT 30

MESCALERO Apache TRIBE

P.O. Box 227
108 Central Avenue Mescalero, New Mexico 88340

Office: (575) 464-4494
Fax: (575) 464-9220

April 9, 2026

VIA EMAIL ONLY TO HCA-madrules@hca.nm.gov

Re: Formal Comment Opposing Draft Rules for 8.3.2 NMAC (Plan of Safe Care for Substance-Exposed Infants

Greetings:

On behalf of the Mescalero Apache Tribe (the "Mescalero"), I submit this formal comment opposing the draft rules for 8.3.2 NMAC (Plan of Safe Care for Substance-Exposed Infants) (the "draft rules"). The draft rules ignore the government-to-government relationship that exists between tribes and the State of New Mexico and disregard the responsibilities of the State of New Mexico and the rights of tribes established by state and federal law. In addition, the draft rules do not reflect the intent of the Comprehensive Addiction and Recovery Act ("CARA") or Senate Bill 42. For these reasons, Mescalero respectfully requests that the draft rules be rescinded pending meaningful tribal consultation or at the very least, requests that the comment period be extended.

The State-Tribal Collaboration Act (the "STCA"), NMSA 1978 § 11-18-1 *et seq.*, affirms the State of New Mexico's responsibility to meaningfully consult with tribes on a government-to-government basis by requiring that state agencies make reasonable efforts to collaborate with tribes in the implementation of policies, agreements, and programs. In the case of the draft rules, given the complexity and importance of the issues, which the draft rules seek to address, the Health Care Authority ("HCA") should have included tribes in the development of the draft rules in the first place – not after the fact. Clearly, again given the complexity of the issues and the problems listed below, a thirty-day comment period and a single public hearing is not enough to constitute reasonable efforts to collaborate with tribes.

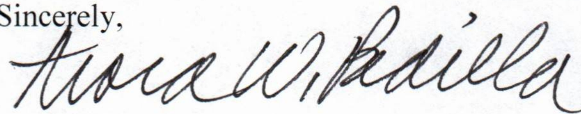
Further, under the Indian Child Welfare Act ("ICWA"), 25 U.S.C. § 1912 (d) and the Indian Family Protection Act ("IFPA"), NMSA § 32A-28-4(A), the State has an obligation to make "active efforts" to prevent the removal of children or promote reunification. The draft rules at 8.3.2.7 (A) define "active efforts." However, the term "active efforts" is only listed in the definitions section of the draft rules. That is, the draft rules do not state when or if "active efforts" must be made. This ignores the fact that the State – and any and all of its agencies and

employees – must comply with ICWA and IFPA. CARA employees are not exempt and this must be clear in the draft rules. Given this oversight alone, it is clear that the HCA did not carefully consider the interplay of the draft rules and federal and state laws governing the treatment of Native American children and families.

Additionally, Mescalero believes that the intent of CARA and Senate Bill 42 was to increase support to those families struggling with substance abuse issues. Instead, the draft rules will expand mandatory interventions and increase Children Youth and Families Department ("CYFD") involvement in situations where such involvement is unwarranted. The draft rules could create distrust of health care providers and discourage pregnant tribal members from disclosing important information or seeking pre- and post-natal care for fear of being reported to CYFD. This does not create a system conducive to providing support for families in need.

For all these reasons, respectfully, Mescalero requests that the draft rules be rescinded until meaningful consultation with tribes can take place or at the very least, that the comment period be extended.

Sincerely,



Thora Walsh Padilla
President

COMMENT 31

Mondragon, Tabitha, HCA

From: John B Bettler <jbettle2@salud.unm.edu>
Sent: Thursday, April 9, 2026 4:25 PM
To: HCA-madrules
Subject: [EXTERNAL] SB42 Feedback

Some people who received this message don't often get email from jbettle2@salud.unm.edu. Learn why this is important

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As an attending on the UNM Maternal Child Health Service as well as in the Milagro clinic (specialty clinic for individuals struggling with addiction who are pregnant), I would like to give feedback on SB42. The current use of CaRA plans is not meeting the needs of our patients and, sadly, seems to be more of a tool to get patients into the CYFD system. Patients seem afraid to engage as it is interpreted by them as part of CYFD... rather than ask for the support/help they may actually want.

CaRA plans should serve their original intent to support families affected by substance use; CaRA plans should not be used as a punishment.

Substance use does not equal child abuse.

Thanks for your attention to this important matter

John B Bettler, MD, FAAFP (he/him/his)
Vice Chair for Clinical and Associate Professor, UNM Department of Family & Community Medicine

Has someone in Family and Community Medicine gone above and beyond, or are they doing great work? Recognize them here.

COMMENT 32

Mondragon, Tabitha, HCA

From: Micha Bitsinnie <micha@boldfuturesnm.org>
Sent: Thursday, April 9, 2026 4:46 PM
To: HCA-madrules
Subject: [EXTERNAL] Bold Futures: Public Comment 8.3.2, Family Health and Well Being, Plan of Safe Care for Substance-Exposed Infants
Attachments: HCA CARA rules feedback 2026.pdf

Some people who received this message don't often get email from micha@boldfuturesnm.org. Learn why this is important

CAUTION: This email originated outside of our organization. Exercise caution prior to clicking on links or opening attachments.

My name is Micha Bitsinnie with Bold Futures NM. We would like to formally submit a PDF with suggestions as well as a request for additional time.

Regarding 8.3.2 Plans of Safe Care, given the breadth and depth of feedback being received from providers, community organizations, directly impacted families, and Tribal partners, additional time is necessary to ensure that the final rule is thoughtfully developed and responsive to the realities of implementation across New Mexico.

This rulemaking process presents a critical opportunity to align CARA implementation with the original intent of Senate Bill 42—to create a healthcare-centered, supportive framework for families. The current landscape, including the Governor's recent directive, has introduced significant confusion and, in some cases, practices that risk obscuring CARA's purpose and intent.

Extending the timeline will allow for more meaningful engagement, clearer alignment with SB42, and the development of rules that prioritize health, dignity, family integrity, and Tribal sovereignty. We believe that taking this additional time will ultimately result in stronger, more effective, and more equitable implementation across the state.

Please see PDF attached for initial suggestions.

Micha Dayzie Bitsinnie (she/her/hers)

Policy Manager
Bold Futures (Formerly Young Women United)
505.831.8930 (O)
Facebook | Twitter
BoldFuturesNM.org

My name is Micha Bitsinnie with Bold Futures NM. We would like to formally submit suggestions as well as a request for additional time.

Regarding 8.3.2 Plans of Safe Care, given the breadth and depth of feedback being received from providers, community organizations, directly impacted families, and Tribal partners, additional time is necessary to ensure that the final rule is thoughtfully developed and responsive to the realities of implementation across New Mexico.

This rulemaking process presents a critical opportunity to align CARA implementation with the original intent of Senate Bill 42—to create a healthcare-centered, supportive framework for families. The current landscape, including the Governor's recent directive, has introduced significant confusion and, in some cases, practices that risk obscuring CARA's purpose and intent.

Extending the timeline will allow for more meaningful engagement, clearer alignment with SB42, and the development of rules that prioritize health, dignity, family integrity, and Tribal sovereignty. We believe that taking this additional time will ultimately result in stronger, more effective, and more equitable implementation across the state.

General Feedback:

- Add definitions for "Informed Consent"
- Clarify Indian Child Welfare Act & Indian Family Protection Act Process
- Clarify data use between agencies

Specific language change suggestions:

8.3.2.7 Definitions

P. (3) "POSC non-compliance" means [an intentional] failure by the infant's family or caregivers to take a required POSC action or to accept a POSC referral identified as necessary for infant safety and well-being.

[(a) POSC non-compliance shall not be determined when barriers to completion are due to lack of access to services, transportation, housing instability, or other socioeconomic factors.]

S. (1) "Safety family assessment" means a comprehensive assessment prepared by the children youth and families department to determine the needs of a child and the child's parents, relatives, guardians, custodians or caregivers, including an assessment of the ~~likelihood~~ [imminent danger] of:

(a) ~~Imminent danger to~~ a child's well-being;

(b) The child becoming an abused child or neglected child;

(c) The ~~strengths and needs~~ [the inability] of the child's family members, including parents, relatives, guardians, custodians or caregivers, with respect to providing for the health and safety of the child.

(5) "Substance-exposed infant" means an infant under ~~one year~~ [90 days] of age for the purposes of this rule who was exposed in utero to a ~~substance~~ that has the potential to impact the health or development of the infant, including an illicit substance such as fentanyl, methamphetamine or heroin, prescribed medication such as opioids, methadone, buprenorphine, or legal substances including alcohol, tobacco, and marijuana. A substance-exposed infant is a substance-exposed newborn as otherwise defined in state law.

8.3.2.9

B. Infants are identified as substance exposed as evidenced by toxicology results [verified by 8.3.2.9 D.] or ~~mother~~ [pregnant person] as interpreted by a clinician, or when the ~~mother~~ [pregnant person] discloses [long term] substance use [or substance use disorder] during pregnancy. [Disclosure of substance use by a pregnant person shall not trigger mandatory reporting, testing, or POSC without clinical indication]

D. Meconium, cord, and other lab toxicology shall be ordered ~~as determined~~ by clinicians ~~when the results will impact the clinical or medical management of the child~~ [to verify toxicology reports and pregnant parent disclosure]. They shall not be done without indication and discussion with the child's parents or guardians with the exception of a medical emergency. [8.3.2.9 NMAC – N, xx/xx/xxxx]

8.3.2.10

When an infant in New Mexico has been identified as substance exposed, a plan of safe care POSC must be created by the hospital, birthing center, or perinatal provider who receives this information. All providers at hospitals, birthing centers, or providers who perform perinatal medical visits, ~~must~~ [shall] be routinely, verbally screening for substance use disorder in pregnant, birthing, and postpartum people and developing POSC when identifying substance use in pregnancy. [Screening shall be voluntary, conducted with informed consent, and may be declined without penalty, reporting, or impact on care] If the POSC has not been developed in the prenatal period, it must be created ~~prior to~~ [within seven days of] discharge from the hospital. Providers should access the CARA supports system portal (CSSP) to identify if a POSC has already been

created. If not, these providers are required to create the POSC upon identification of the substance use. To the extent permitted by applicable federal and state privacy and confidentiality laws, including HIPAA and 42 C.F.R. Part 2, notification of the active POSC shall be shared with the following parties either in a physical copy, telecommunication or an electronic version within a reasonable timeframe but within no less than ~~24 hours~~ [within seven days of] of discharge.

(1) The child's primary care provider.

(2) The child's parent, relative, guardian or caregiver.

(3) The CARA navigator/care coordinator.

(4) If the child's parent, relative, guardian, custodian, or caregiver is a tribal member or resides on tribal land, the respective nation, pueblo, or tribe's responsible entity as identified by tribal leadership.

(5) If there is CYFD involvement due to submission of a statewide central intake (SCI) or a family assessment, the respective staff from CYFD will receive a copy from the CARA navigator if they are not able to access the POSC via the CSSP.

[B Information collected through CARA and POSC processes shall remain confidential within the healthcare system and not be shared with law enforcement, shall not be entered into the child youth and families department database without informed consent.]

[C]~~B~~. Plans of safe care [must be reviewed with the birthing parent in the appropriate language for understanding and] should be signed [without coercion, threat, or implied penalty] by the parent, relative, guardian, or caregiver and the provider. This can be discharging hospital staff, the birthing center staff, or the perinatal provider who created the POSC. ~~When parents, relatives, guardians, or caregivers refuse to sign the POSC that is considered POSC non-compliance and the provider shall initiate a referral to CYFD SCI to request a family assessment.~~

D. Emergency department or urgent care deliveries: In situations where a delivery occurs before transfer can occur to a birthing facility, the staff in the emergency or urgent care department shall initiate a POSC if the family qualifies for one based on verbal screening [and upon verification of toxicology with meconium results. Emergency circumstances shall not waive requirements for informed consent except in cases of immediate, life-threatening medical necessity].

8.3.2.11

A. (4) (e) ~~In-utero exposures: If an infant is exposed to any substances during pregnancy, all exposures shall be documented in the POSC. Documentation of exposures includes exposures occurring during the timeframe in which the mother may not have known she was pregnant, and all substance exposures, including, but not limited to tobacco, fentanyl, heroin, methamphetamine, cocaine, alcohol, marijuana (medical or recreational), and medication assisted therapy such as methadone and buprenorphine.~~

COMMENT 33

Planned Parenthood®
Rocky Mountains
Affiliate Headquarters
7155 East 38th Ave
Denver, CO 80207

April 9, 2026

New Mexico Health Care Authority
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, New Mexico 87504

Re: Proposed Rule 8.3.2 NMAC

Dear Secretary Armijo,

Thank you for the opportunity to provide testimony on proposed rule 8.3.2 NMAC. We respectfully request that that the authority engage in additional stakeholder work before continuing forward with this proposal. As drafted, and held in conjunction with the Governor's 2025 directive creating an automatic custody rule, which the legislature did not enact, the proposed rule has major policy issues and could result in serious harms to patients if it is adopted without substantial revision.

1. The proposed rule operationalizes Senate Bill 42 by making Plans of Safe Care effectively mandatory, beyond the scope of the legislation;
2. The rule fails to account for medical realities including hospital-administered and prescribed medications;
3. As is the case with many policies that increase surveillance and investigation of patients in medical settings, the rule risks racially inequitable enforcement and long-term trauma to children and families.

SB 42 authorized plans of safe care for newborns prenatally exposed to substances, but did not require that agencies treat all positive toxicology tests identically for child welfare purposes. Per the draft rule, "[i]nfants are identified as substance exposed as evidenced by toxicology results of the newborn or mother as interpreted by a clinician" (8.3.2.9 B.), and "[w]hen an infant in New Mexico has been identified as substance exposed, a plan of safe care POSC must be created by the hospital, birthing center, or perinatal provider who receives this information" (8.3.2.10 A.). The rule does not adequately differentiate between cases of illicit substance use and exposure to clinician prescribed medications or even hospital-administered drugs including epidurals administered during labor.

Affiliate Headquarters
7155 East 38th Ave
Denver, CO 80207

The rule doesn't account for medical realities. Positive toxicology in isolation is not an indicator of abuse. The rule should therefore 1) require documentation when toxicology reflects hospital-administered or prescribed medications, including epidural fentanyl and other hospital pain control used during labor, prescribed MAT, or other documented or reported treatment; 2) prohibit mandating Plans of Safe Care (POSCs) in such cases absent additional, individualized risk factors; and 3) preserve clinical judgement consistent with the standard of care. As drafted, a medically normal epidural could qualify an infant as "substance-exposed," require a POSC, and trigger a referral pathway. Even without automatic custody as directed by the Governor, that is a hugely consequential expansion of state involvement beyond what SB 42 explicitly contemplated.

The Authority should also clarify that POSCs are not themselves abuse/neglect findings, require consideration of and plans to mitigate racial or socioeconomic bias in screening, and make very clear that the practice of automatically taking any newborn identified as substance-exposed into custody is outside the scope of SB 42. We know that Indigenous, Black, and Latina patients are more likely than white patients to be drug-tested without their consent, including during labor. Screening thresholds are applied inconsistently across racial and socioeconomic lines. A rule that mandates POSCs or referrals based on toxicology alone, lacks safeguards for documented medical explanations for positive results, and fails to require standardization of screening criteria will predictably produce racially inequitable outcomes – particularly in New Mexico, where Indigenous families are already disproportionately impacted by child welfare systems.

Furthermore, requiring referral to CYFD when families do not comply with POSC requirements disregards the realities that families may be experiencing, and should instead provide mechanisms to distinguish between inability to comply versus refusal to comply, and trivial versus serious noncompliance.

SB 42 did not create a new category of abuse or neglect based on toxicology alone, mandate removal into state custody of all substance-exposed newborns, or eliminate clinical judgement – it authorized a public health program to support and protect families. Given the rapid and escalating criminalization of pregnant and parenting people across the country, we must ensure that implementation does not strip discretion and create harmful – and foreseeable – outcomes.

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7155 East 38th Ave
Denver, CO 80207

Any revisions to the proposed rule must:

1. Explicitly state that automatic custody is not authorized or appropriate under SB 42;
2. Clarify that POSCs are not mandatory for every positive toxicology result;
3. Require documentation when toxicology reflects hospital-administered or prescribed medications;
4. Preserve clinical discretion in determining whether a POSC is appropriate; and
5. Include equity protections to prevent discriminatory screening and application.

We urge the Health Care Authority to table this rule to allow time for revisions to bring it into alignment with medical reality and legislative intent.

Thank you.

Jack Teter
Vice President of Government Affairs
Planned Parenthood of the Rocky Mountains

COMMENT 34

Mondragon, Tabitha, HCA

From: Jane Epstein <janeele@me.com>
Sent: Thursday, April 9, 2026 4:53 PM
To: HCA-madrules
Subject: [EXTERNAL] Comments on SB42

[Some people who received this message don't often get email from janeele@me.com. Learn why this is important at https://aka.ms/LearnAboutSenderIdentification]

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The policy of removing infants solely on the basis of an infant's exposure to drugs is horrible and very regressive. The birth of a child is a great time to intervene to provide support for parent and child - removing the child has so many bad effects for the infant - effects that ripple throughout their lives. We are better than this.

Jane Epstein
Albuquerque NM 87107
NM Senate District 10

COMMENT 35

MEMO

TO: HCA

FROM: Gov. Harry Antontio, Laguna Pueblo

RE: Public Commentary on HCA 8.3.2 – NMCA 1- CARA

In August of 2025 Health Care Authority, Department of Health, and CYFD, through their secretaries, came to All Pueblo Counsel of Governors and gave a presentation to the Governors. At that meeting HCA, DOH, and CYFD heard the concerns of the collective Governors over the July 7, 2025 directive from Gov. MLG. They heard the concern regarding data sovereignty, about accessing tribal lands, active efforts, about the lack of the tribal liaison and meaningful consultation. HCA then went forward and drafted these rules, in support of the directive, in violation of CARA and ICWA and despite knowing that tribal partners had very real concerns and want to be heard on these issues.

The Indian Child Welfare Act applies to any organization attempting to remove Indian children from their Indian caretaker. It is not limited to CYFD, or even to State agencies. HCA is attempting to subvert the due process afforded to these families by taking over the investigative branch of CYFD. That is fine, but it does not alleviate them from the active effort duties under ICWA. The intent of HCA is evident by excluding tribal partners from consultation, discussion, and even the definitions of these rules. They did include an active efforts definition but nowhere is the rules is active efforts mentioned a applying. These rules as drafted bring many different organizations and health insurance companies into the lives of Native Families and none of those people are being trained in upholding ICWA or their role in child removal. While is it is true that CYFD will be the ones to file the court cases, they rely on the efforts of the CARA team to draft their affidavits for removal. The CARA team become the ones responsible for making active efforts to prevent removal.

The rules cite an “evidence based verbal screening” as the primary tool used to determine drug exposure. There is no evidence based verbal screenings and the Doctors of the UNM CART (Child Abuse Response Team) have stated that there is no reliable drug screening for newborns that could accurately account for drug exposure. If the HCA is going to create an evidenced base verbal screening will there be cultural and Tribal considerations or meaningful consultation? Furthermore, the rules state that drug testing shall be ordered but does the HCA have the authority to order a medical provider to do anything? There is also a concern of separation of powers. The HCA is an executive branch department attempting to subvert legislation by passing these rules that mimic the July Directive which is in direct opposition to the Children’s Code, The IFPA, and CARA. These rules also go against the evidence-based treatment we know that works, Medically Assisted Treatment (MATS) This will discourage individuals from seeking or continuing treatment. This approach contradicts practices that professionals in our communities have put in place to support these families.

Health Care Authority is a state agency, and as a state agency they are authorized to create regulations to implement or interpret laws, but they cannot legally go beyond the scope of that authority, nor contradict the statute itself. They must stay within the constraints of the law. At this time ICWA is the prevailing law that determines the standard of efforts that need to be implemented before removal of Indian children. The Children’s Code of the state of New Mexico is the prevailing law that states that prenatal drug exposure is not sufficient to remove a child from their legal custodian. CARA is the prevailing law that determines what are the safety measures to be taken if a baby is drug exposed. These rules proposed by HCA are contradictory to at least these three points of law. The rules require a Plan of Safe Care (POSC) based either on an admission of substance use without requiring a substance use disorder (SUD) screening or diagnosis OR a substance use screening tool. The draft rule includes mandatory POSC for prescribed medications and legal substances such as tobacco, marijuana, and alcohol, as a result, families who do not have a substance use disorder will be subjected to

investigation by the state child welfare agency and unnecessary intervention and mandated treatment. This increased policing of families and statistically we know this will disproportionately affect native families. Any perceived “non-compliance” with a POSC triggers a referral to CYFD for a family assessment. This creates a direct pipeline from healthcare disclosure to child welfare involvement. It bypasses the multi-level, graduated response system envisioned in SB 42 and instead defaults to a surveillance and enforcement model. We request that HCA retract these rules, have meaningful consultation with tribes, and ensure any future proposed rules follow the laws that are enacted.

COMMENT 36

Mondragon, Tabitha, HCA

From: Monica J Armas Aragon <MAAragon@salud.unm.edu>
Sent: Thursday, April 9, 2026 4:55 PM
To: HCA-madrules
Subject: [EXTERNAL] Comments about proposed rule 8.3.2-NMAC-1

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Good afternoon,

Thank you for allowing me the opportunity to comment on the following regarding the proposed rule 8.3.2-NMAC-1

Definitions: P.2. This indicated that the "written plan is co-created with the birthing parent and family" which suggests that it must include both. How will "family" be identified and how will this be handled if the birthing parent does not wish to disclose substance use to family?

8.3.2.11 A1 "Referral to substance use prevention and treatment programs" this suggests that two separate referrals must be made. Please provide clarification around what exactly is expected

8.3.2.11 A4b "they are required to provide contact information for someone they keep in regular contact with who will serve as a contact for the CARA Navigator" Will there be assurances by DOH that when the CARA Navigator contacts this person, personal information will not be divulged to the contact that would compromise privacy?

Thank you.

Monica J. Armas Aragon, LCSW, IMH-E III
Program Operations Director
UNM Developmental Care Program
505-272-3946

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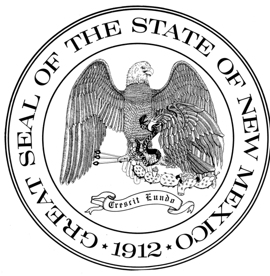
COMMENT 37



State of New Mexico

House of Representatives

Santa Fe

MICAELA LARA CADENA

D – Doña Ana

District 33

P. O. Box 1510

Mesilla, NM 88046

Email: micaela.cadena@nmlegis.gov

COMMITTEES:

VICE CHAIR: Taxation & Revenue

Agriculture, Acequias and Water Resources

INTERIM COMMITTEES:

Revenue Stabilization & Tax Policy

Water and Natural Resources

April 9, 2026

NM Health Care Authority
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, NM 87504-2348

Delivered via email to: HCA-madrules@hca.nm.gov

Re: Public comment on promulgation of proposed rule 8.3.2 NMAC-Plan of Safe Care for Substance-Exposed Infants

I write today as a New Mexico legislator who worked directly on the updates to New Mexico's CARA program that were amended into SB 42 (2025). Simply put, these draft rules do not reflect the legislative intent nor legal framework advanced by SB 42 (2025).

Instead, these draft rules seem to entrench implementation of an unlawful family separation directive issued by New Mexico Governor Lujan Grisham in July of 2025

Please withdraw these draft rules.

Follow through with requests for Tribal consultation on the CARA program made by several sovereign nations and the All Pueblo Council of Governors.

Finally, center the expertise of impacted families, child-welfare leaders, medical providers and hospitals as you transition the CARA program from the Children, Youth and Families Department (CYFD) to the Health Care Authority (HCA) with integrity.

Best,
Representative Micaela Lara Cadena

COMMENT 38

April 9, 2026

New Mexico Health Care Authority
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
PO Box 2348
Santa Fe, NM 87504-2348

Re: Public comment on promulgation of proposed rule 8.3.2 NMAC-Plan of Safe Care for Substance-Exposed Infants

Secretary Armijo,

For decades, I have worked with families who are/were navigating substance use. Substance use isn't far from many of our New Mexican families. Generations of colonization, cycles of violence, the impacts on people have been deep.

New Mexico has long been a leader in treating substance use as a healthcare issue. I am disheartened to see this turn that will keep families from the care that they need.

In the winter of 2025 leaders on the ground here in New Mexico, Physicians for Reproductive Health and providers all over the country wrote an open letter to say families deserve support not separation.

I ask that the state withdraw the proposed rule and instead craft rules designed around SB42. Healthcare providers and impacted families are ready to provide their expertise.

Thank you,
Denicia Cadena

COMMENT 39

Mondragon, Tabitha, HCA

From: Low Low <SaLow@salud.unm.edu>
Sent: Thursday, April 9, 2026 5:00 PM
To: HCA-madrules
Subject: [EXTERNAL] NM HCA Rules

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New Mexico Healthcare Authority,

The thoughts and opinions expressed below are entirely my own and do not represent the organization I work for. I am sharing my thoughts as a concerned individual.

I am a social worker/counselor who works directly with pregnant people and parents impacted by substance use disorders. I'm writing to express my deep concern regarding the draft rules for Title 8, Chapter 3, Part 2, Plan of Safe Care for Substance-Exposed Infants. The draft rules seem to disregard the bipartisan effort of SB 42, and instead mirror the dangerous efforts of Governor Lujan Grisham to further criminalizing families.

I appreciate the efforts of the HCA in attempting to address resource access for families impacted by substance use. However, the draft rules as they currently stand will do more harm than good, and will further exacerbate issues facing families in New Mexico. My previous work involved training medical and social service providers on stigma, patient centered care, and the harms of pregnancy/ family criminalization. In this work I was focused on training providers in states across the Southeastern United States. It is from this experience that I have witnessed the harms that occur when states take a punitive and coercive approach to substance use during pregnancy. Extensive research has demonstrated that punishing people for substance use via family separation and undo requirements through CYFD only diminishes access to prenatal care. It sows fear in pregnant people and pushes an already stigmatized population further underground.

The current rules mandate substance use treatment for people who have not been diagnosed with a substance use disorder and/or are not ready for treatment. Coerced or unnecessary care will not improve a person's ability to parent. These requirements only add to an undue burden that will further overwhelm new parents instead of focusing on tailoring support to the individual person and their needs. This is neither trauma-informed nor patient centered. It is also not evidence based, and will further burden the systems I work in by mandating that people who aren't in need of treatment engage in it.

I'm also concerned that the rules will perpetuate stigma towards people who are on Medication for Opioid Use Disorder (MOUD). People on MOUD have taken steps to care for themselves and address their medical needs on a safe and beneficial medication. Penalizing people on MOUD is dangerous as it encourages people to ween off or stop MOUD during pregnancy which is harmful to the person as well as the fetus. Stopping MOUD or weening off too quickly or without support can put people at risk of instability, relapse, and overdose.

The proposed rules state that Plans of Safe Care need to include a description of any and all substance use during pregnancy. This information will be shared with CYFD if they are involved. This seems to be a

violation of privacy and I have concerns that the threat of CYFD will coerce people into signing POSC and forfeiting their privacy around deeply personal information.

We know that current practices around mandated reporting, drug testing infants and parents, and resource access are inequitable. These rules will only further inequitable treatment of people who seek help and support. As they currently stand there is much room for bias and racism to impact who is burdened.

The current rules are not evidence based, trauma informed, or tailored to what families and their newborns really need. What people need and deserve is non-judgmental, stigma-free care that prioritizes support, choice, and voice.

Warmly,

"Low" Savanah S. Low, LMSW
(pronouns: they, them, theirs)
Counselor Social Worker
UNMH Milagro Clinic & ASAP Clinic
(505) 994-7993
salow@salud.unm.edu

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COMMENT 40

Eugene Jiron
Governor

Charles Jojola, 1st Lt. Governor
Michael Rodney Jones, 2nd Lt. Governor

PUEBLO OF ISLETA
OFFICE OF THE GOVERNOR
P.O. Box 1270
Isleta, New Mexico 87022
Telephone: 505-869-3111

April 8, 2026

Sent via email

Native American Liaison Pharon Morgan
HCA Medical Assistance Division
Pharon.Morgan@hca.nm.gov

RE: Pueblo of Isleta Comments on New Mexico Proposed NMAC Rule 8.3.2., Family Health and Well Being, Plan of Safe Care for Substance Exposed Infants

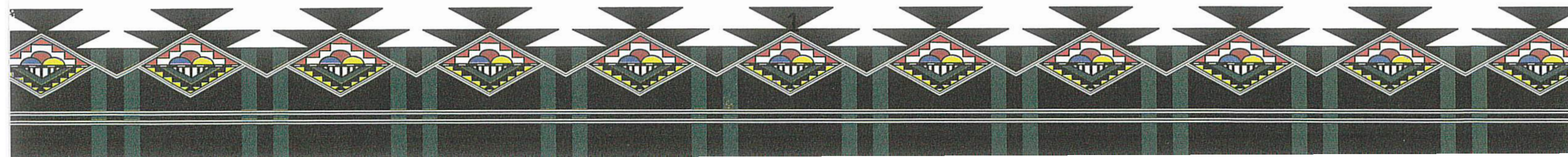
Dear Pharon Morgan,

On behalf of The Pueblo of Isleta ("Pueblo"), I respectfully provide the following comments regarding the proposed NMAC Rule 8.3.2., *Family Health and Well Being, Plan of Safe Care for Substance-Exposed Infants.* The Pueblo sincerely appreciates the opportunity to provide input on this important rulemaking and recognizes how great responsibility the implementation of such a rule is for the Health Care Authority.

The Pueblo continues to respectfully urge the Health Care Authority (HCA) for a separate government-to-government consultation with the Tribes, Nations, and Pueblos of New Mexico as clearly required under the State-Tribal Collaboration Act. Having meaningful consultation prior to any drafting can ensure there are no violations of federal or state laws that directly impact and have potential to harm native children, families, and tribes. The Pueblo stands firm for the effective implementation and compliance with the Federal Indian Child Welfare Act and Indian Family Protection Act of New Mexico in any rule, policy, procedure and/or future legislation.

I am submitting the following comment pursuant to HCA's April 9, 2026, deadline and with the hope of keeping our children and families safe while maintaining connection with family, community, and culture.

The Rule is Overly Broad

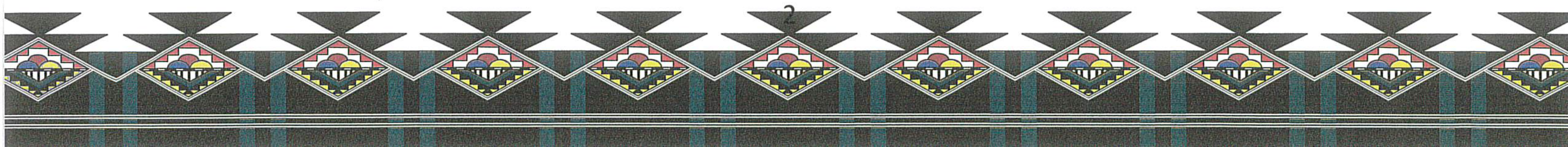


I am concerned that is that the Proposed Rule is overly broad and not detailed enough to meet its intent of effectively assisting infants born drug exposed *and* their families. This new rule will be implemented within the doors of the HCA, which is new to the oversight of the Comprehensive Addition and Recovery Act (CARA) program. A detailed rule that provides as much guidance as reasonable is necessary to successfully execute the rule without unnecessary confusion and error which harms rather than helps families. Unfortunately, after reviewing the rule, the Pueblo is very concerned that the rule is not aligning with the intent of Senate Bill 42, and there are several areas where the proposed rule contradicts what the bill entails.

For many years the Pueblo has understood the CARA program to be a designated support for families whose infants are been born exposed to substances, the goal of which is to provide wraparound care for the family as a whole. I am concerned that the proposed rule deviates from this goal by focusing exclusively on infant safety. While the Pueblo does not disagree that prioritizing the safety of our children is critical, we recognize that providing care and supports to families as a whole is necessary for children to be safe and to thrive. As proposed, the language of the rule indicates that parents, guardians, and custodians come as a second priority which is not productive in maintaining a family unit. The Pueblo is concerned that this will lead to less trauma informed care and instead a harsher and more punitive approach that may to an increase in CYFD referrals. This is deeply concerning given the history of existing disparities that are likely to disproportionately impact our Native families, increasing the risk and likelihood of unnecessary removals and family separation.

For example, Section 8.3.2.9 requires an "evidence-based verbal screening brief intervention with referral to treatment (SBIRT) model at all prenatal or perinatal medical visits and live births to identify substance use in pregnancy." The proposed language is overly broad and does not provide a thorough definition at 8.3.2.7(3), or anywhere else in the rule, to indicate the scope and content of these screenings. I am concerned that this leaves room for ambiguity and could cause unintentional error, misstep, or intimidation of a patient seeking medical care. I urge the HCA to include clear parameters in the rule to describe what the universal screenings do *and* do not entail. I also urge the HCA to require that care providers explain these parameters to each patient at each visit prior to the screening so they may understand the process and their patient rights.

The proposed rule mandates a Plan of Safe Care ("POSC") for *any* exposure to substances including prescribed medication, marijuana, alcohol, and tobacco, which were not previously included in CARA response programming. The rule requires a POSC and mandated treatment following any verbal admission, but because the proposed rule is drafted so broadly, there is no indication of actual substance use screening or proper diagnosis on dependency done to determine the level of care required. The Pueblo is concerned that this may lead to excessively burdensome testing that may lead expectant mothers and families to feel ill-judged and deterred from seeking necessary prenatal care. For example, with the current language, families accessing medication assisted treatment will require a POSC just the same as a person with an addiction to street drugs. The Pueblo is concerned that the screening process is not thorough enough for successful or fair implementation. Prescribed medication, medical marijuana, alcohol, or tobacco alone, should not be included in the requirement for a POSC, especially if there is no diagnosis of dependency.



Section 8.3.2.7(S)(1) is overly broad in that it requires "a comprehensive assessment prepared by the Children, Youth, and Families Department to determine the needs of a child and the child's parents, relatives, guardians, custodians, or caregivers." The section is unclear on how many or which of these relatives and/or caregivers must be assessed, leaving room for ambiguity, mandated but unnecessary efforts, and error. Further, there is no guidance provided on how to determine which of CYFD's many assessments should be used as families and their needs vary greatly. The Pueblo recommends that such guidance be included in the rule.

Lastly, Senate Bill 42 requires the establishment of a multilevel response system and services to provide a child and/or family.[1] This response system may include an alternative to an investigation. The intent of the multilevel response is to provide supports and resources in a non-punitive approach that would directly address the underlying causative factors that may jeopardize the child's safety or wellbeing. Instead, the rule clearly moves to an overly broad and invasive surveillance and enforcement model triggering an abuse and neglect referral. A multilevel response can be beneficial and effective for children and families if implemented in a supportive manner that is not threatening and forceful of child removal. I urge this multilevel response system to be better structured to meet the intent.

Ambiguity Surrounding HCA's Intended Extent of Referrals to CYFD

The Pueblo attended the public listening session held on April 1, 2026, and gathered information regarding HCA's intended involvement of CYFD which is contrary to the rule as written. The Pueblo is concerned that the HCA intends to incorporate Governor Lujan Grisham's July 2025 Directive on Immediate Removals of Drug Exposed Infants. When that Directive was issued, the Pueblo previously identified a number of concerns about its potential to violate both the state Indian Families Protection Act and the federal Indian Child Welfare Act, concerns that the state has not remedied to date.

During the public listening session held on April 1, 2026, HCA representatives stated that the HCA intends to implement Governor Lujan Grisham's Directive to CYFD workers regarding immediate removals of drug exposed infants into their procedures, despite the Directive lacking the force of regulation and potentially violating state and federal law. The July 2025 Directive stated: "For all screened in investigations involving children born exposed to methamphetamines, fentanyl, polysubstance, or diagnosed with fetal alcohol syndrome, the child must be taken into custody and an abuse/neglect petition must be filed prior to discharge from the hospital." During the listening session, Mr. Bartsch stated CYFD will be called on "those tier 1 cases," referencing the Directive. If this is accurate, the rule as currently proposed underinclusive and inconsistent with HCA's intended implementation plan as the rule ultimately states that CYFD will not be called unless the family is not compliant with their POSC or there is suspicion of abuse or neglect.

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[1] *See generally* https://www.nmlegis.gov/Sessions/25%20Regular/final/SB0042.pdf

The HCA is not in any way bound to the Directive and should not implement the Directive into its processes as the Directive directs CYFD workers to complete their investigations out of compliance with the law, specifically the Indian Family Protection Act ("IFPA"). Pursuant to NMSA 1978 § 32A-28-12(B)(3), (C), and (D), CYFD is required to make active efforts to maintain an Indian family *at the inception* of an investigation. This means that an Indian child should not be removed from his or her family unless and until active efforts to maintain the family have been exhausted.

Though it is ultimately the responsibility of CYFD to make active efforts prior to removing a child and filing a legal petition, the final rule must be consistent with this critical provision of state law.

Inclusion and Contact with Tribes, Nations, and Pueblos, and Clarification on Jurisdiction

I want to thank the HCA for including communication with Tribes, Nations and Pueblos in the proposed rule under 8.3.2.10(A), 8.3.2.12((E) and (F), as our communities can provide invaluable support for our children and families. However, there appears to be ambiguity regarding tribal vs. state jurisdiction and the Pueblo has identified areas of the proposed rule which could be strengthened with the inclusion of tribes, nations and pueblos.

The rule must include a clear process for the CARA navigators and care coordinators to make appropriate and legally required contact with tribes, nations and pueblos. Bureau of Indian Affairs hosts a listserv of designated ICWA agents throughout the nation which is updated every six months.[2] The Pueblo believes this would be the most appropriate listserv to utilize for the purposes of the proposed rule. I thank the HCA and CYFD for its awareness of tribal sovereignty, tribal jurisdiction, and our right to self-govern. The rule also needs to include a clear process in supporting and providing services to families domiciled on the reservation or under the exclusive jurisdiction of the tribe/tribal court.

Section 8.3.2.12(F) of the proposed rule states that a navigator may close a case "when a nation, pueblo or tribe assumes full custody." This case closure mechanism does accurately reflect state law regarding the somewhat complex concurrent jurisdiction of tribes, nations and pueblos on child welfare matters. First, a sovereign nation will always have jurisdiction of any necessary investigations by CPS or necessary civil abuse and neglect petitions filed when the family is domiciled within the exterior boundaries of a tribe, nation, or pueblo. CYFD and a tribe have concurrent jurisdiction when an Indian family is domiciled outside of the exterior boundaries of their tribe, pueblo, or nation. *§ 32A-28-7, NMSA 1978*. When a nation, pueblo, or tribe has or takes jurisdiction of a matter rather than CYFD, this should not alone automate case closure as families should maintain the option for a POSC depending on their needs. The Pueblo urges the HCA to amend this language to reflect that a POSC is still an option for an Indian family, regardless of the jurisdiction of any potential child welfare case, and that the tribe, pueblo, or nation should be included in these important conversations.

[2] ICWA Designated Agent Listing and ICWA Notice Web Experience

The Pueblo also urges the HCA to amend the rule to clearly reflect that HCA and CARA staff, representatives, and care providers may not enter sovereign lands to conduct state business without properly following tribal protocols and permissions.

Finally, the Pueblo has identified 8.3.2.12(C)(3) and 8.3.2.9(D) as sections of the proposed rules in which tribes, pueblos, and nations should be included. The Pueblo urges the HCA to specifically include tribes, pueblos, and nations in 8.3.2.12(C)(3) and to notice a family's tribe, pueblo, or nation when meconium, cord, or other lab toxicology is determined necessary by a clinician. Notice of such testing would allow the tribe to contact the family and provide supports through any testing processes as DNA is sacred in many Indian cultures and belief systems. Historical abuses of Native American DNA in medical testing have been well documented and notice is critical to ensuring culturally appropriate testing. (See, for example *Havasupai Tribe of Havasupai Rsrv. v. Arizona Bd. of Regents*, 220 Ariz. 214, 204 P.3d 1063, 1067 (Ct. App. 2008) and notice is critical to ensuring culturally appropriate testing.

The Pueblo also requests that the rule include clarification on where any DNA acquired for testing is sent and who is involved in its handling. As previously stated, DNA is sacred to many tribes, pueblos, and nations. With this rule being proposed, we appreciate the HCA's awareness, consideration, and understanding.

Navigation Closure Criteria Requires More Clarity

The case closure process in the proposed rule is ambiguous. The Pueblo recommends strengthening the language regarding case closure to provide more structure and clarity for care coordinators, navigators, and families.

First, the proposed rule states that an infant must reach thirteen months for case closure, without a sufficient justification for this time period. If a family is ready for case closure prior to thirteen months, there doesn't appear to be a clear process to close a case earlier. It is also unclear whether a family is able to continue receiving care and supports beyond the child's thirteen month, if needed, or what the process is if a family needs to come back for care, following a relapse, for example. Such clarity is necessary to ensure a continuum of care for families.

Second, the proposed rule states there may be a mutual agreement that it is time for case closure, but does not provide guidance on what criteria a provider may consider in reaching a case closure determination. This section is very ambiguous and leaves room for providers to unintentionally, inconsistently close cases.

Finally, this section of the rule references CYFD's Family Services but it is unclear in what capacity or to what extent Family Services will be involved. The Pueblo recommends adding language to the rule to provide clarity and guidance on what exactly Family Services is responsible for during the case closure process.

Inclusion of ICWA and IFPA in Training Requirements

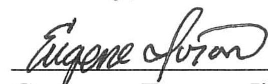
The Pueblo urges the HCA to include mandated Indian Child Welfare Act and Indian Family Protection Act trainings for HCA staff and care providers under 8.3.2.14. It is apparent that the HCA will be collaborating with CYFD in much of its work. Training HCA staff, particularly care coordinators and CARA navigators, to be familiar with ICWA and IFPA will avoid any unintentional breach of the law when caring for Indian families.

Data and Reporting Requirements

The Pueblo urges the HCA to amend the proposed rule to reflect that identified tribes included in any data reporting shall not be made of public record.

I thank you for your time in reading the Pueblo's comments and recommendations. I again reserve the right to supplement these comments and urge the HCA to host a separate government-to-government consultation with the Tribes, Nations, and Pueblos of New Mexico to ensure clear communication and open collaboration. With Respect, I ask HCA to halt rule promulgations until meaningful conversations and consultation occurs.

Sincerely,



Governor Eugene Jiron
Pueblo of Isleta

cc:
Secretary Kari Armijo, New Mexico Health Care Authority, Kari.Armijo@hca.nm.gov
Acting Medicaid Director Alanna Dancis, HCA Medical Assistance Division, Alanna.Dancis@hca.nm.gov
Secretary Josett Monette, Indian Affairs Department, Josett.Monette@iad.nm.gov
Diego Arencón Diego, Arencon@exec.nm.gov
Jacqueline Yalch, Isleta Social Services Director, Jacqueline.Yalch@IsletaPueblo.com
Stephanie Padilla, Lead Child Welfare Attorney, Stephanie.Padilla@IsletaPueblo.com