

March 23, 2026

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

RE: Proposed amendments to rule 8.321.10 NMAC, “Opioid Treatment Programs”

On behalf of the Vital Strategies Overdose Prevention Program, we write to express our support for the New Mexico Health Care Authority (HCA) Behavioral Health Services Division’s (BHSD) proposal to repeal and replace 8.321.10 NMAC, regarding treatment for opioid use disorder (OUD) in federally certified opioid treatment programs (OTP). 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 disorder (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 September 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 Treatment for OUD with agonist medications buprenorphine and methadone⁴ is most effective at reducing overdose and serious opioid-related acute care relative to other treatments, such as naltrexone or inpatient detoxification or residential services.⁵ Agonist medications for OUD (hereinafter referred to as “medications for opioid use disorder” or “MOUD”) are associated with an estimated mortality reduction of 50% among people with OUD, supporting the conclusion of the National Academies of Sciences, Engineering, and Medicine in 2019 that “[t]he verdict is clear: effective agonist medication used for an indefinite period of time is the safest option for treating OUD.”⁶

¹ [Provisional Drug Overdose Death Counts](#). Centers for Disease Control and Prevention. Last reviewed February 11, 2026. Accessed March 3, 2026.

² [Provisional Drug Overdose Death Counts](#). Centers for Disease Control and Prevention. Last reviewed February 11, 2026. Accessed March 3, 2026.

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 Also referred to throughout as “MOUD,” meaning medications for opioid use disorder. MOUD is synonymous with medication assisted treatment (“MAT”) and medications for addiction treatment.

⁵ Wakeman SE, Laroche MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. JAMA Network Open. 2020;3(2):e1920622.

⁶ National Academies of Sciences, Engineering, and Medicine. Medications for opioid use disorder save lives. (Leshner AI, Mancher M, eds.). Washington, DC: The National Academies Press; 2019.



Vital Strategies commends HCA for seeking to align the state’s rules governing OTPs with the revised federal regulations at 42 CFR Part 8, and for incorporating many of the recommendations outlined in our July 2024 public comment on proposed amendments to rule 8.321.2 NMAC, “Specialized Behavioral Health Provider Enrollment and Reimbursement.” These changes and greater overall alignment with federal regulations are critical to expanding access to lifesaving, evidence-based methadone treatment for OUD. Although Vital Strategies fully supports HCA’s efforts, we caution that proposed amendments presumably intended to narrow the applicability of the rule may inadvertently cause confusion among OTPs and their patients and will likely result in *fewer* protections for OTP patients treated with medications other than methadone (see Section II.a below).

Vital Strategies submits this comment to outline its support for key changes in the proposed rule and to offer recommendations to further clarify and strengthen the proposed rule.

I. Key improvements in proposed 8.321.10 NMAC

a. Overall promotion of a more patient-centered approach to treatment.

Vital Strategies supports the substantive and linguistic changes made by the proposed rule to promote a more patient-centered approach to treatment in OTPs. This includes, for example, the elimination of stigmatizing language and emphasis on shared decision-making among patients and providers.

b. Protecting access to MOUD when a patient refuses counseling.

Although some patients may benefit from more intensive counseling supports, evidence does not support policies mandating that patients receive a pre-determined amount and type of counseling – or, in many cases, any counseling at all.^{7,8,9,10,11} To the contrary, additional psychotherapy requirements for methadone treatment are associated with significantly lower retention rates.¹² Based on its review of this evidence, the National Academies concluded in 2019 that “psychosocial supports required at OTPs

⁷ National Academies of Sciences, Engineering, and Medicine. Medications for opioid use disorder save lives. (Leshner AI, Mancher M, eds.). Washington, DC: The National Academies Press; 2019. “studies of the effectiveness of this counseling [in OTPs] have not demonstrated differences in treatment retention or opioid use among patients randomized to receive little or no interaction with clinic drug counselors.”

⁸ Centers for Disease Control and Prevention. Linking People with Opioid Use Disorder to Medication Treatment: A Technical Package of Policy, Programs, and Practices. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Department of Health and Human Services, 2022. “Engaging in social supports or behavioral health interventions alongside MOUD does not consistently improve treatment outcomes and may not be an appropriate requirement or pre-requisite for MOUD.”

⁹ Weiss RD, Potter JS, Fiellin DA, et al. Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence: A 2-Phase Randomized Controlled Trial. *Arch Gen Psychiatry*. 2011;68(12):1238–1246.

¹⁰ Fiellin DA, Pantalon MV, Chawarski MC, Moore BA, Sullivan LE, O’Connor PG, Schottenfeld RS. Counseling plus buprenorphine-naloxone maintenance therapy for opioid dependence. *N Engl J Med*. 2006 Jul 27;355(4):365-74.

¹¹ Fiellin DA, Barry DT, Sullivan LE, Cutter CJ, Moore BA, O’Connor PG, Schottenfeld RS. A randomized trial of cognitive behavioral therapy in primary care-based buprenorphine. *Am J Med*. 2013 Jan;126(1):74.e11-7.

¹² Hochheimer M, Unick GJ. Systematic Review and meta-analysis of retention in treatment using medications for opioid use disorder by medication, race/ethnicity, and gender in the United States. *Addictive Behaviors*. 2022;124:107113.

should be recalibrated.”¹³ The proposed rule effectuates such a recalibration by requiring that OTPs ensure the *availability* of counseling while making clear that a patient’s access to medication will not be contingent upon the patient’s engagement in counseling services.¹⁴ This approach is also consistent with federal law,¹⁵ and with the American Society of Addiction Medicine’s (ASAM) National Practice Guidelines, which recommend that a patient’s decision to decline behavioral health treatment should not impede their access to medication treatment for OUD.¹⁶ We offer additional recommendations in Section II.c below on how HCA can ensure consistency and further strengthen this critical protection.

c. Removal of nonevidence-based admission criteria.

Under existing rules, patients requesting maintenance treatment generally must have “been addicted for at least 12 months before the admission.”¹⁷ Additionally, minor patients must have “had two documented unsuccessful attempts at short term opioid treatment withdrawal procedures or drug-free treatment within a 12-month period.”¹⁸ Treatment with agonist medications is the safest, most effective option for people with OUD,¹⁹ and requiring that an individual have become addicted at least 1 year before admission does not reflect current clinical standards.²⁰ Additionally, facilitating access to evidence-based medication treatment for young people is particularly important considering youth overdose rates and research showing that most young people with OUD do not receive effective treatment.²¹ Vital Strategies strongly supports the proposed removal of these unnecessary and nonevidence-based admission criteria.

d. Authorization for expanded take-home methadone.

The proposed rule makes permanent and expands the take-home flexibilities first implemented during the COVID-19 public health emergency. More specifically, OTP patients would be permitted up to a 7-day take-home supply during the first 14 days of treatment, a 14-day supply starting on day 15 of treatment, and a 28-day supply starting on day 31 of treatment,²² based on criteria aligned with federal

¹³ National Academies of Sciences, Engineering, and Medicine. Medications for opioid use disorder save lives. (Leshner AI, Mancher M, eds.). Washington, DC: The National Academies Press; 2019.

¹⁴ Proposed NMAC 8.321.10.20(B)(2)(I), 8.321.10.21(F)(4), 8.321.10.27(B).

¹⁵ 42 CFR § 8.12(f)(5)(i) (“Patient refusal of counseling shall not preclude them from receiving MOUD.”)

¹⁶ American Society of Addiction Medicine. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. 2020:37; Accessed March 10, 2026. <https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline> (“A patient’s decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacological treatment of opioid use disorder, with appropriate medication management.”)

¹⁷ NMAC 8.321.10.19(A)(3).

¹⁸ NMAC 8.321.10.19(A)(3)(d).

¹⁹ National Academies of Sciences, Engineering, and Medicine. Medications for opioid use disorder save lives. (Leshner AI, Mancher M, eds.). Washington, DC: The National Academies Press; 2019.

²⁰ See 87 Fed. Reg. 77340 (“A significant change in OTP access is the removal of the requirement that patients must have had an addiction to opioids for at least one year prior to admission for MOUD; this is a vestige of prior versions of the DSM and has posed a barrier to access to treatment.”)

²¹ Andrew Terranella, Gery P. Guy, Christina Mikosz; Buprenorphine Dispensing Among Youth Aged ≤19 Years in the United States: 2015–2020. *Pediatrics* 2023; e2022058755.

²² Proposed NMAC 8.321.10.24(H)-(J).

regulations.²³ Studies show that increased take-home doses are associated with improved treatment retention, reduced urine drug screens positive for opioids, and reduced stigma.^{24,25,26} Additionally, increased take-home doses do not increase medication non-adherence, diversion, methadone-related overdoses, or other negative treatment outcomes.^{27,28,29} Vital Strategies strongly supports the proposed changes to increase patient access to take-home methadone. We offer additional recommendations in Section II.d below on how HCA can further strengthen and expand access to take-home methadone.

e. Explicit authorization for medication and mobile units.

OTP patients often must travel substantial distances to access treatment services,³⁰ which can directly and negatively affect treatment outcomes. A study in a U.S. metropolitan area found that even a “10-min drive was associated with a 33% reduction in the completion of methadone treatment plans.”³¹ Fixed-site and mobile medication units are critical to addressing these treatment barriers and many are equipped to provide the full range of OTP services. Vital Strategies supports proposed amendments that would explicitly allow OTPs to apply to add a medication unit to their existing registration,³² and to allow the full range of OTP services be provided in such medication unit(s) if there is appropriate privacy and adequate space.³³ We also appreciate HCA’s incorporation of two recommendations from Vital Strategies’ July 2024 public comments: (1) clarifying that the reference to “a single location” in the definition of “Opioid treatment program” is inclusive of medication units;³⁴ and (2) clarifying that

²³ Proposed NMAC 8.321.10.24(C); 42 CFR § 8.12(i)(2).

²⁴ Suen LW, Castellanos S, Joshi N, Satterwhite S, Knight KR. “the idea is to help people achieve greater success and Liberty”: A qualitative study of expanded methadone take-home access in opioid use disorder treatment. *Substance Abuse*. 2022;43(1):1147-1154.

²⁵ Hoffman KA, Foot C, Levander XA, et al. Treatment retention, return to use, and recovery support following COVID-19 relaxation of methadone take-home dosing in two rural opioid treatment programs: A mixed methods analysis. *Journal of Substance Abuse Treatment*. 2022;141:108801.

²⁶ Walters SM, Perlman DC, Guarino H, Mateu-Gelabert P, Frank D. Lessons from the first wave of covid-19 for improved medications for opioid use disorder (MOUD) treatment: Benefits of easier access, extended take homes, and new delivery modalities. *Substance Use & Misuse*. 2022;57(7):1144-1153.

²⁷ Amram O, Amiri S, Panwala V, Lutz R, Joudrey PJ, Socias E. The impact of relaxation of methadone take-home protocols on treatment outcomes in the COVID-19 ERA. *The American Journal of Drug and Alcohol Abuse*. 2021;47(6):722-729.

²⁸ Figgatt MC, Salazar Z, Day E, Vincent L, Dasgupta N. Take-home dosing experiences among persons receiving methadone maintenance treatment during COVID-19. *Journal of Substance Abuse Treatment*. 2021;123:108276.

²⁹ Pessar SC, Boustead A, Ge Y, Smart R, Pacula RL. Assessment of state and federal health policies for opioid use disorder treatment during the COVID-19 pandemic and beyond. *JAMA Health Forum*. 2021;2(11).

³⁰ Rosenblum A, Cleland CM, Fong C, Kayman DJ, Tempalski B, Parrino M. Distance traveled and cross-state commuting to opioid treatment programs in the United States. *Journal of Environmental and Public Health*. 2011;2011:1-10.

³¹ Alibrahim A, Marsh JC, Amaro H, Kong Y, Khachikian T, Guerrero E. Disparities in expected driving time to opioid treatment and treatment completion: Findings from an exploratory study. *BMC Health Services Research*. 2022;22(1).

³² Proposed NMAC 8.321.10.18(A)-(B).

³³ Proposed NMAC 8.321.10.18(B)(4)(a)-(f).

³⁴ Proposed NMAC 8.321.10.7(S) (“means a single location (**may include approved medication units operating under the certified and licensed OTP**) at which opioid use disorder treatment with methadone and rehabilitative services, are provided to patients as a substantial part of the activity conducted on the premises”) (emphasis added).

medication and mobile units are not limited to expanding access to methadone in exclusively rural communities.³⁵

f. Authorization for screening and full examinations to be completed via telehealth and by non-OTP practitioners.

Research demonstrates the value and efficacy of telehealth-based access to MOUD treatment.³⁶ Patient access to OUD treatment via telehealth is associated with “improved MOUD retention and lower odds of medically treated overdose,”³⁷ and audio-only telehealth access is particularly important for reaching underserved populations.^{38,39} Vital Strategies strongly supports provisions in the proposed rule authorizing the use of telehealth to conduct the screening examination and full examination to the full extent permitted by federal law,⁴⁰ including audio-only telehealth when evaluating patients for treatment with buprenorphine (and when evaluating patients for treatment with methadone if certain conditions are met).^{41,42}

Vital Strategies also strongly supports the proposed rule’s alignment with federal regulations authorizing non-OTP practitioners to complete both the initial screening and full physical examination, including screenings and examinations that occur outside of OTP settings.^{43,44} These changes have the potential to improve patient access to OTP services by allowing a patient’s initial screening and full

³⁵ Compare NMAC 8.321.2.31(D)(7)(a)(i) (“a written letter of intent that demonstrates how this service will increase access to methadone in rural communities and avoid duplication with other OTP services”) with proposed NMAC 8.321.10.18(B)(1)(a) (“a written letter of intent that demonstrates how this service will increase access to methadone in rural **or difficult to reach communities** and avoid duplication with other OTP services”) (emphasis added). HCA should align NMAC 8.321.2.31(D)(7)(a)(i) with proposed NMAC 8.321.10.18(B)(1)(a) in future rulemaking.

³⁶ Brian Chan, Christina Bougatsos, Kelsey C. Priest, Dennis McCarty, Sara Grusing & Roger Chou (2022) Opioid treatment programs, telemedicine and COVID-19: A scoping review, *Substance Abuse*, 43:1, 539-546.

³⁷ Jones CM, Shoff C, Hodges K, et al. Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the COVID-19 Pandemic. *JAMA Psychiatry*. 2022;79(10):981–992.

³⁸ Frost MC, Zhang L, Kim HM, Lin L. Use of and Retention on Video, Telephone, and In-Person Buprenorphine Treatment for Opioid Use Disorder During the COVID-19 Pandemic. *JAMA Netw Open*. 2022;5(10):e2236298.

³⁹ Clark SA, Davis C, Wightman RS, Wunsch C, Keeler LAJ, Reddy N, Samuels EA. Using telehealth to improve buprenorphine access during and after COVID-19: A rapid response initiative in Rhode Island. *J Subst Abuse Treat*. 2021 May;124:108283.

⁴⁰ Proposed NMAC 8.321.10.20(A)(2)(b), (A)(3).

⁴¹ Proposed NMAC 8.321.10.20(A)(3)(a)-(b).

⁴² Vital Strategies also supports the authorization for medication and mobile units to provide many OTP services via telehealth. Proposed NMAC 8.321.10.18(B)(4)(f) (“in units that provide appropriate privacy and have adequate space, other OTP services, such as counseling, may be provided directly or when permissible through use of telehealth services”).

⁴³ Proposed NMAC 8.321.10.20(A)(1), (A)(4).

⁴⁴ 42 CFR § 8.12(f)(2)(ii) (“If the licensed practitioner is not an OTP practitioner, the screening examination must be completed no more than seven days prior to OTP admission. Where the examination is performed outside of the OTP, the written results and narrative of the examination, as well as available lab testing results, must be transmitted, consistent with applicable privacy laws, to the OTP, and verified by an OTP practitioner”); (f)(2)(iii) (“The full exam can be completed by a non-OTP practitioner, if the exam is verified by a licensed OTP practitioner as being true and accurate and transmitted in accordance with applicable privacy laws”); (f)(2)(v) (“The screening and full examination may be completed via telehealth for those patients being admitted for treatment at the OTP with either buprenorphine or methadone, if a practitioner or primary care provider, determines that an adequate evaluation of the patient can be accomplished via telehealth”).

examination to occur in settings such as emergency departments and other hospital settings, primary care clinics, correctional facilities, or even through street medicine programs.

g. Authorization for interim treatment in alignment with federal regulations.

The most recent changes to 42 CFR Part 8 included notable improvements regarding interim treatment.⁴⁵ Studies show that interim treatment reduces illicit drug use and increases the likelihood that patients will enter comprehensive treatment.⁴⁶ Vital Strategies supports the proposed rule's explicit authorization for interim treatment in full alignment with current federal regulations.⁴⁷

h. Incorporation of additional changes consistent with recommendations from Vital Strategies' July 2024 public comment.

Vital Strategies supports and appreciates the proposed rule's alignment with additional recommendations from our July 2024 public comment, including:

- Clear authorization for guest dosing, including language emphasizing the importance of guest dosing, the requirement to minimize administrative burdens for patients,⁴⁸ and the requirement that OTPs make "every reasonable effort to maintain the patient's current dose."⁴⁹
- Clarifying that a qualified health care practitioner other than a program medical director may determine that a patient meets admissions criteria.⁵⁰
- Clear authorization for medication treatment to commence after the screening exam, without needing to first conduct the full examination.⁵¹

⁴⁵ These changes include (1) increasing the maximum length of interim treatment from 120 to 180 days in any 12-month period; (2) reducing the minimum number of required drug screens; (3) authorizing take-home doses for patients in interim treatment; (4) requiring OTPs to provide information on "locally available, community-based resources for ancillary services;" and (5) prohibiting the discharge of a patient in interim treatment without the approval of an OTP practitioner. *Compare* 42 CFR § 8.12(j)(4)(ii) ("Interim treatment cannot be provided for longer than 180 days in any 12-month period") *with* 42 CFR § 8.12(j)(4)(v) (2023) ("Interim maintenance cannot be provided for longer than 120 days in any 12-month period"). *Compare* 42 CFR § 8.12(j)(1) ("At least two drug tests shall be obtained from patients during the maximum of 180 days permitted for interim treatment") *with* 42 CFR § 8.12(j)(1) (2023) ("An initial and at least two other urine screens shall be taken from interim patients during the maximum of 120 days permitted for such treatment"). *Compare* 42 CFR § 8.12(j)(4) (no prohibition on take-home doses for patients in interim treatment) *with* 42 CFR § 8.12(j)(4)(i)-(ii) (2023) (providing that "[t]he opioid agonist treatment medication is required to be administered daily under observation" and that "[u]nsupervised or 'take-home' use is not allowed"); *see also* 89 Fed. Reg. 7543 (SAMHSA's Final Rule also repealed the language previously codified at 42 CFR § 8.12(i)(4) that provided that no medications may be dispensed to patients in short-term detoxification or interim maintenance treatment for unsupervised or take-home use). 42 CFR §§ 8.12(j)(4)(iv), (f)(2)(iv).

⁴⁶ McCarty, D., Chan, B., Bougatsos, C., Grusing, S., & Chou, R. (2021). Interim methadone – effective but underutilized: A scoping review. *Drug and Alcohol Dependence*, 225, 108766.

⁴⁷ Proposed NMAC 8.321.10.25; 42 CFR §§ 8.11(f), 8.12(j).

⁴⁸ Proposed NMAC 8.321.10.20(G).

⁴⁹ Proposed NMAC 8.321.10.20(G)(2).

⁵⁰ Proposed NMAC 8.321.10.20(A) ("The program sponsor shall ensure through policy and procedure that an individual is only admitted for opioid use disorder treatment with methadone after the program medical director **or other qualified healthcare practitioner** conducts the following:") (emphasis added).

⁵¹ *Compare* NMAC 8.321.10.19(D) ("A program sponsor shall ensure that the program medical director or medical practitioner designee conducts a complete, fully documented physical examination of an individual who requests admission to the program

- Aligning methadone dosage requirements and limitations with 42 CFR Part 8 and repealing the requirement for additional documentation if an OTP provides an initial dose of buprenorphine that deviates from the medication package insert.⁵²
- Elimination of the requirement that patients in long-term opioid treatment withdrawal procedure receive an initial and monthly random drug testing.⁵³
- A prohibition on using administrative discharge to involuntarily terminate a patient's treatment based on the patient's non-prescribed substance use.⁵⁴
- Elimination of the requirement to submit a needs assessment with an application to operate an OTP.⁵⁵

II. Recommendations to further clarify or strengthen proposed 8.321.10 NMAC

a. Clarify (or reverse) proposed changes making various provisions and defined terms specific to methadone.

The proposed rule makes numerous defined terms and substantive provisions applicable exclusively to methadone rather than to medication treatment for OUD in OTPs more generally. Although HCA does not describe the specific intent of these changes, we presume they reflect an attempt to narrow the scope and applicability of the proposed rule. Vital Strategies appreciates efforts to reduce unnecessary regulatory constraints on MOUD, but we have serious concerns that the proposed changes will cause confusion among OTPs and OTP patients regarding the applicability and scope of various provisions, reduce protections for OTP patients receiving MOUD other than methadone (e.g., buprenorphine), and conflict with federal regulations. Appendix I includes a more comprehensive accounting of provisions made specific to methadone in the proposed rule.

1. The proposed rule is not strictly limited to methadone treatment for OUD.

Proposed NMAC 8.321.10.7(S) defines "Opioid treatment program" as, in part, a "location ... at which opioid use disorder treatment with methadone and rehabilitative services are provided to patients *as a substantial part of* the activity conducted on the premises."⁵⁶ In other words, OTPs do not *exclusively*

before the individual receives a dose of opioid dependency treatment medication") *with* proposed NMAC 8.321.10.20(A)(1)(a) ("assuming no contraindications, a patient may commence methadone medication treatment after the screening examination has been completed").

⁵² Compare NMAC 8.321.10.21 *with* proposed NMAC 8.321.10.22.

⁵³ Compare NMAC 8.321.10.22(B) ("long-term opioid treatment withdrawal procedure patients receive an initial and monthly random tests") *with* proposed NMAC 8.321.10.23(B) (excluding such language).

⁵⁴ Proposed NMAC 8.321.10.26(D) ("agency providers are prohibited from utilizing administrative discharge (involuntary termination of services) for a patient pursuant to non-prescribed substance use, or for any instance of displaying symptoms of mental or physical illness").

⁵⁵ This requirement is currently codified at NMAC 8.321.10.10(I). Although Vital Strategies' July 2024 public comments did not specifically address this provision, we believe its elimination is consistent with our overall recommendation to reduce regulatory barriers to agonist MOUD.

⁵⁶ Proposed NMAC 8.321.10.7(S) (emphasis added). See *also* proposed 8.321.10.2 ("This rule is applicable to opioid treatment programs").

provide OUD treatment with methadone. This is confirmed by other provisions in the proposed rule addressing the use of other MOUD such as buprenorphine.^{57,58}

2. By making certain definitions and substantive provisions applicable exclusively to methadone, the proposed rule will *reduce* treatment access and protections for OTP patients receiving MOUD other than methadone (e.g., buprenorphine).

For example, the proposed rule now defines “Administrative discharge” specifically to mean “involuntary discharge from *methadone* treatment services.”⁵⁹ By our read, the result of this change is that for OTP patients receiving MOUD other than methadone, OTPs are not required to establish procedures for conducting an administrative discharge,⁶⁰ are not limited in when they may initiate withdrawal treatment for a patient,⁶¹ are not required to provide a copy of the program policy regarding withdrawal against medical advice,⁶² may use administrative discharge for a patient due to non-prescribed substance use or for displaying symptoms of mental or physical illness,⁶³ and are not required to refer or transfer a discharged patient to a program that is more capable of or suitable for meeting the patient’s needs.⁶⁴ Similarly, several provisions emphasizing that medication access cannot be contingent on a patient’s participation in counseling services are specific to methadone and thus do not extend the same protections to OTP patients receiving MOUD such as buprenorphine.⁶⁵ Other examples include:

⁵⁷ See, e.g., proposed NMAC 8.321.10.7(P) (defining “Medication for opioid use disorder (MOUD)” to include all FDA-approved medications for use in the treatment of OUD), 8.321.10.7(R) (defining “Opioid treatment medication” to include all medications approved by the FDA and under 42 CFR 8.12 for use in the treatment of OUD), 8.321.10.18(B)(4)(a) (authorizing mobile medication units to administer and dispense “medications for opioid use disorder treatment”), 8.321.10.18(B)(4)(e) (authorizing mobile medication units to engage in the “initiation of methadone *or buprenorphine*”) (emphasis added), 8.321.10.20(A)(3)(b) (authorizing the use of telehealth to evaluate patients for treatment with Schedule III medications such as buprenorphine or non-controlled medications such as naltrexone).

⁵⁸ See also proposed NMAC 8.321.10.6 the rule objective section stating that “[t]his rule establishes standards for opioid treatment programs, *in their provision of methadone treatment services...*” (emphasis added). We do not view this statement of objectives as sufficient to narrow the scope of the proposed rule when operative provisions unambiguously contemplate regulation of services other than methadone treatment services.

⁵⁹ Compare proposed NMAC 8.321.10.7(B) (defining “Administrative discharge” as, in part, “involuntary discharge from **methadone treatment services**”) with current NMAC 8.321.10.7(B) (defining “Administrative withdrawal” as, in part, “involuntary discharge from **opioid treatment**”) (emphasis added).

⁶⁰ Proposed NMAC 8.321.10.19(E)(10)

⁶¹ Proposed NMAC 8.321.10.26(B)(1) (“for a patient involved in **methadone continuous medication treatment**, is only initiated as **administrative discharge** or when voluntarily requested by the patient and approved by a program medical director or prescribing practitioner”) (emphasis added).

⁶² Proposed NMAC 8.321.10.26(C)(3) (“receives a copy of the program policy regarding withdrawal of opioid treatment medication (**methadone**) against medical advice and a verbal explanation of that policy”) (emphasis added).

⁶³ Proposed NMAC 8.321.10.26(D) (prohibiting “administrative discharge” on such grounds, but where “administrative discharge” is defined specifically as discharge from methadone treatment).

⁶⁴ Proposed NMAC 8.321.10.26(G) (required for patients “experiencing administrative discharge,” but where “administrative discharge” is defined specifically as discharge from methadone treatment).

⁶⁵ Proposed NMAC 8.321.10.20(B)(2)(I) (“the patient’s access to **methadone medication** will not be contingent upon the patient’s engagement in counseling services”) (emphasis added), 8.321.10.21(F)(4) (“recommendations for treatment needed by the patient, such as psychosocial counseling (though the patient’s access to **methadone medication** will not be contingent upon their engagement in psychosocial counseling) or mental health treatment, if indicated”) (emphasis added). *But see* NMAC 8.321.10.27(B) (“behavioral health counseling services must be made available to a patient but the patient’s **access to medication** cannot be contingent upon their engagement in counseling services”) (emphasis added).

- The explicit authorization to begin medication treatment following a screening examination does **not** extend to patients treated with an MOUD other than methadone.⁶⁶
- Patients treated with MOUD other than methadone are **not** protected from denied admissions based on their refusal to undergo lab testing for co-occurring physical health conditions.⁶⁷
- Patients treated with MOUD other than methadone are **not** protected from medication doses being used to reinforce positive behavior or punish negative behavior.⁶⁸
- The requirement to screen and provide treatment and/or referrals for co-occurring mental health disorders does **not** apply to OTP patients seeking OUD treatment with medications other than methadone.⁶⁹
- The prohibition on discrimination based on race, ethnicity, gender, age, or sexual orientation and the requirement to provide treatment “with consideration for a patient’s individual needs, cultural background, and values” do **not** apply to OTP patients treated with medications other than methadone.⁷⁰
- Priority admissions for pregnant individuals are limited to those seeking treatment with methadone,⁷¹ as is the requirement to “coordinate opioid use disorder treatment with methadone and prenatal and post-partum care.”⁷²
- OTPs are **not** required to make efforts to obtain approval from the criminal justice system to continue SUD treatment with an MOUD other than methadone for a patient while the patient is incarcerated.⁷³

⁶⁶ Proposed NMAC 8.321.10.20(A)(1)(a) (“assuming no contraindications, a patient may commence **methadone medication treatment** after the screening examination has been completed”) (emphasis added).

⁶⁷ Proposed NMAC 8.321.10.20(A)(2)(a) (“a patient’s refusal to undergo lab testing for co-occurring physical health conditions should not preclude them from access to **methadone treatment**, provided such refusal does not have potential to negatively impact treatment with medications”) (emphasis added).

⁶⁸ Proposed NMAC 8.321.10.22(D)(6)(c) (“a patient receives subsequent doses of **methadone medication**: ... that are not used to reinforce positive behavior or punish negative behavior”) (emphasis added).

⁶⁹ Proposed NMAC 8.321.10.27(D) (“each patient seeking opioid use disorder treatment **with methadone** is screened for the presence of a co-occurring mental health disorder by means approved by the HCA, and if indicated, referred for assessment and possible treatment if the program is not able to provide mental health services”) (emphasis added).

⁷⁰ Proposed NMAC 8.321.10.28(A)(1) (“opioid use disorder treatment **with methadone** is provided regardless of race, ethnicity, gender, age, or sexual orientation”), (A)(3) (“opioid use disorder treatment **with methadone** is provided with consideration for a patient’s individual needs, cultural background, and values”) (emphasis added).

⁷¹ Proposed NMAC 8.321.10.28(C)(1) (“be given to pregnant individuals seeking opioid use disorder treatment **with methadone**”) (emphasis added).

⁷² Proposed NMAC 8.321.10.28(C)(5).

⁷³ Proposed NMAC 8.321.10.28(D)(1) (“makes efforts to obtain approval from the criminal justice system for the continued substance use disorder treatment **with methadone** for the patient by the program while the patient is incarcerated”) (emphasis added).

- Multiple preparedness planning provisions designed to ensure continuity of care no longer protect OTP patients treated with MOUD other than methadone.⁷⁴
- 3. **OTPs and OTP patients are likely to experience confusion about the proposed rule's scope and applicability due to inconsistent changes rendering certain definitions and substantive provisions specific to methadone.**

The following is a non-exhaustive list of examples of provisions that may cause confusion for OTPs and OTP patients:

- Proposed NMAC 8.321.10.6's statement of objective suggests that the rule applies only to methadone within OTPs despite many provisions applying to OTP operations irrespective of medication.
- The required admissions process is unclear for patients seeking OUD treatment with medications other than methadone. Various provisions within proposed NMAC 8.321.10.20, including the primary operational provision at proposed NMAC 8.321.10.20(A), are specific to methadone,⁷⁵ yet other provisions within this section clearly contemplate the use of medications other than methadone.⁷⁶ There are no generally applicable provisions outlining the admissions process for patients not seeking treatment with methadone.
- Due to the definition of "Administrative discharge" being specific to methadone,⁷⁷ it is unclear under what circumstances an OTP may involuntarily terminate treatment for a patient treated with an MOUD other than methadone and what requirements and/or limitations, if any, apply to such terminations.
- Due to the definition of "Opioid treatment" being specific to methadone,⁷⁸ the requirement that a physician licensed to practice in New Mexico has "authority over all medical aspects of opioid treatment" as medical director does not apply to treatment with MOUD other than methadone.⁷⁸

4. **The proposed rule creates inconsistencies with 42 CFR Part 8.**

Several of the proposed rule's changes to make definitions and substantive provisions specific to methadone result in the proposed rule being inconsistent, if not in direct conflict, with the federal OTP regulations at 42 CFR Part 8. For example:

⁷⁴ Proposed NMAC 8.321.10.29(A)(1) ("a written plan to ensure uninterrupted dispensing **of methadone** in the event of dispensing staff turnover") (emphasis added), (A)(2) ("a written agreement with at least one other provider for the provision of opioid use disorder treatment **with methadone** to program patients in the event that the program is unable to provide services") (emphasis added), (B)(1) ("includes steps for the orderly transfer of patients to other programs, individuals, or entities that provide opioid use disorder treatment **with methadone**") (emphasis added).

⁷⁵ See, e.g., proposed NMAC 8.321.10.20(A) ("admitted for opioid use disorder treatment with methadone"), (A)(1)(a) ("a patient may commence methadone medication treatment"), (A)(2)(a) ("should not preclude them from access to methadone treatment"), (A)(2)(b) ("for those patients being admitted for methadone treatment").

⁷⁶ See, e.g., proposed NMAC 8.321.10.20(A)(3)(b).

⁷⁷ Proposed NMAC 8.321.10.7(B).

⁷⁸ Proposed NMAC 8.321.10.7(Q), 8.321.10.19(A).

- The proposed rule requires OTPs to ensure patients undergo a screening and full history and physical examination only when the individual “is ... admitted for opioid use disorder treatment with methadone,” while the corresponding federal regulation requires such actions for all OTP patients, regardless of the medication in use.⁷⁹
- Multiple provisions in the proposed rule providing that access to methadone cannot be contingent upon a patient’s participation in counseling services are inconsistent with 42 CFR § 8.12(f)(5)(i), which more broadly provides that refusal of counseling “shall not preclude [the patient] from receiving MOUD.”⁸⁰
- 42 CFR § 8.12(f)(6) requires all OTP patients to undergo a minimum of eight random drug screens per year regardless of which MOUD a patient uses whereas proposed NMAC 8.321.10.23(B) only requires a minimum of eight random drug screens per year for patients “in methadone continuous treatment.”
- 42 CFR § 8.12(f)(3) requires OTPs to maintain policies and procedures that provide priority admissions to patients with OUD who are pregnant regardless of with which MOUD the patient is treated with, whereas proposed NMAC 8.321.10.28(C)(1) provides priority only to pregnant individuals seeking OUD treatment with methadone.
- 42 CFR § 8.12(c)(2) requires OTPs to maintain a diversion control plan applicable to all dispensed MOUD whereas proposed NMAC 8.321.10.32 requires a diversion control plan only for methadone.

Vital Strategies strongly recommends that HCA’s final rule clarify or reverse these changes to minimize confusion, maintain consistency with 42 CFR Part 8, and ensure all OTP patients benefit from robust substantive and procedural protections regardless of which medication they use to treat their OUD. To the extent these changes are intended to clarify that the rule does not require non-methadone MOUD be prescribed, administered, and/or dispensed by an OTP, HCA can better effectuate this intent by amending the scope statement in proposed NMAC 8.321.10.2 and the definition of “Opioid treatment program” in proposed NMAC 8.321.10.7(S). More specifically,

- A modified version of proposed NMAC 8.321.10.2 could read (new text underlined):

This rule is applicable to opioid treatment programs required to obtain a separate registration under 21 USC § 823(h). These regulations are not intended to require that controlled substances in Schedule III, IV, or V used for the treatment of opioid use

⁷⁹ Compare proposed NMAC 8.321.10.20(A) with 42 CFR §§ 8.12(e)(1), (f)(2). See also proposed NMAC 8.321.10.7(N) (defining “Intake screening” specifically as “determining whether an individual meets the initial criteria for receiving **methadone treatment**”) (emphasis added).

⁸⁰ Compare proposed NMAC 8.321.10.20(B)(2)(l), 8.321.10.21(F)(4) with 42 CFR § 8.12(f)(5)(i). 42 CFR § 8.2 defines “Medication for Opioid Use Disorder” as medications approved by the FDA for use in the treatment of OUD.

disorder or opioid withdrawal be prescribed, administered, or dispensed by an opioid treatment program and these regulations do not apply to the prescribing, administering, or dispensing of controlled substances in Schedule III, IV, or V for the treatment of opioid use disorder or opioid withdrawal outside of an opioid treatment program registered under 21 USC § 823(h). These regulations are not intended to preempt county or municipal ordinances that supplement and do not conflict with these regulations. County and municipal ordinances are preempted when they conflict with these regulations.

- A modified definition of “Opioid treatment program” in proposed NMAC 8.321.10.7(S) could read (new text underlined):

“Opioid treatment program” (OTP), for the terms of this rule, means a single location (may include approved medication units operating under the certified and licensed OTP) registered under 21 USC § 823(h) at which opioid use disorder treatment with methadone and rehabilitative services, are provided to patients as a substantial part of the activity conducted on the premises.

b. Improve the clarity of the proposed rule, including by using consistent terminology and defined terms throughout the proposed rule.

Vital Strategies recommends that HCA conduct a comprehensive review of the proposed rule to ensure consistent use of terminology, including by ensuring the language in substantive provisions aligns with defined terms. Appendix II provides a non-exhaustive list of examples in which the proposed rule uses undefined terms despite the existence of a relevant defined term and/or inconsistency in terminology among different provisions. We also recommend HCA:

- **Ensure accurate cross-references and numbering.** For example, proposed NMAC 8.321.10.20(E)(2) continues to reference “Subsection F of 8.321.10.19 NMAC” despite this no longer being a relevant provision,⁸¹ and proposed NMAC 8.321.10.24 skips from Subsection C to Subsection H.
- **Avoid the inclusion of substantive requirements in definitions.** For example, the proposed definitions for “In-take assessment” and “Psycho-Social Diagnostic Assessment” establish substantive time limits for when actions may be completed.⁸² These requirements are more appropriately addressed in the substantive provisions, as the proposed rule already accomplishes for these and other requirements.⁸³

⁸¹ Proposed NMAC 8.321.10.19(F) requires a program sponsor to ensure that “[a] written quality assurance plan is developed and implemented” and is thus immaterial to confirming “the patient is not receiving treatment from any other OTP in the state.”

⁸² Proposed NMAC 8.321.10.7(F) and (Y).

⁸³ Proposed NMAC 8.321.10.21(A) (requiring each patient to receive an intake assessment within 24 hours of admission), 8.321.10.21(B) (requiring a full psychosocial diagnostic assessment be completed within 14 calendar days of admission).

c. Establish and/or strengthen patient protections against punitive actions by OTPs.

Punitive practices in SUD treatment can lead to stigmatization and reduced treatment engagement,⁸⁴ and patients' fatal overdose risk is increased in the period following termination from treatment.⁸⁵ Return to use (also commonly referred to as "relapse"), polysubstance use, missed appointments, and declining ancillary services are common reasons for providers to discharge patients from treatment. Effective, evidence-based treatment should employ compassionate, patient-centered responses to return to use as a normal feature of the recovery process and the high prevalence of polysubstance use among people with OUD.^{86,87} As an American Society of Addiction Medicine's (ASAM) consensus statement makes clear, "[d]rug testing should be used as a tool for supporting recovery rather than exacting punishment."⁸⁸

The proposed rule establishes a solid foundation, prohibiting use of medication dosage "to reinforce positive behavior or punish negative behavior,"⁸⁹ prohibiting the conditioning of medication on a patient's participation in counseling services,⁹⁰ prohibiting administrative discharge based on non-prescribed substance use,⁹¹ and requiring OTPs to establish "a process for resolution of patient complaints."⁹²

Vital Strategies strongly recommends HCA build on this foundation by including provisions to:

- Prohibit an OTP from conditioning a patient's access to medication on the patient's participation in ancillary services *other than* counseling,⁹³ or from otherwise taking adverse action (e.g.,

⁸⁴ Substance Abuse and Mental Health Services Administration. [Low Barrier Models of Care for Substance Use Disorders](#). *Advisory*. Publication No. PEP23-02-00- 005. Rockville, MD. 2023.

⁸⁵ Sordo L, Barrio G, Bravo M J, Indave B I, Degenhardt L, Wiessing L et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies *BMJ* 2017; 357:j1550.

⁸⁶ The National Institute on Drug Abuse defines addiction as "a chronic, relapsing disorder."

<https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction>.

⁸⁷ In a sample derived from a nationally representative database, nearly 6 in 10 people with OUD had polysubstance use. Hassan AN, Le Foll B. Polydrug use disorders in individuals with opioid use disorder. *Drug Alcohol Depend.* 2019 May 1;198:28-33.

⁸⁸ American Society of Addiction Medicine. *Appropriate Use of Drug Testing in Clinical Addiction Medicine*. Adopted by the ASAM Board of Directors on April 5, 2017. Accessed March 11, 2026. Available at <https://www.asam.org/quality-care/clinical-guidelines/drug-testing>. See also 89 Fed. Reg. 7534-7535 ("Toxicology testing is a clinical tool that is used to inform the treatment process, *should never be used punitively*, and must be conducted in a way that is respectful of the individual and in accordance with clinical and professional standards") (emphasis added).

⁸⁹ Proposed NMAC 8.321.10.22(D)(6)(c).

⁹⁰ Proposed NMAC 8.321.10.20(B)(2)(I), 8.321.10.21(F)(4), NMAC 8.321.10.27(B).

⁹¹ Proposed NMAC 8.321.10.26(D) ("agency providers are prohibited from utilizing administrative discharge (involuntary termination of services) for a patient pursuant to non-prescribed substance use").

⁹² Proposed NMAC 8.321.10.19(E)(20).

⁹³ A revised NMAC 8.321.10.20(B)(2)(I) could read: "the patient's access to medication will not be contingent upon the patient's engagement in counseling *or other ancillary services*." A revised NMAC 8.321.10.21(F)(4) could read: "recommendations for treatment needed by the patient, such as psychosocial counseling (though the patient's access to medication will not be contingent upon their engagement in psychosocial counseling *or other ancillary services*) or mental health treatment, if indicated." A revised NMAC 8.321.10.27(B) could read: "behavioral health counseling services must be

restricting take-home medication) based on non-participation in counseling or other ancillary services.

- Prohibit an OTP from discharging or otherwise taking adverse action against a patient based solely on clinical outcomes, missed appointments, drug screening, or other laboratory results.
- Clearly state that involuntary and/or administrative discharge should be a sanction of last resort regardless of the alleged violation.⁹⁴
- Establish more specific requirements and guardrails for OTP policies regarding the resolution of patient complaints. This should include a requirement that OTPs provide patients with notice and an opportunity to appeal any adverse action and a prohibition on an OTP taking adverse action during the pendency of any appeal(s) absent documentation of a serious medical risk or an immediate and substantial threat of physical harm to other patients or program staff that cannot be eliminated or reduced by reasonable accommodation.⁹⁵

d. Strengthen and expand access to take-home methadone.

New Mexico's OTP rules continue to grant OTPs vast discretion to determine the number of take-home doses a patient is permitted, or even whether to allow a patient to receive take-home doses at all. Although the proposed rule requires OTPs to develop, implement, and comply with policies and procedures that include "criteria for determining when a patient is ready to receive take-home medication" and "criteria for when a patient's take-home medication is increased or decreased," it does not specify what these criteria should or must be apart from the considerations required by federal law.⁹⁶ Many OTPs continue to treat take-home doses as a privilege to be earned by patients rather than a routine aspect of evidence-based care. OTPs are also frequently disinclined to support increased take-home doses due to financial incentives or outdated beliefs about effective treatment approaches,^{97,98} making it unlikely their policies and procedures will enable most patients to be eligible for the maximum number of take-home doses.

made available to a patient but the patient's access to medication cannot be contingent upon their engagement in counseling or other ancillary services."

⁹⁴ See, e.g., W. Va. Code R. § 69-12-17.3 ("Administrative withdrawal shall be used only as a sanction of last resort").

⁹⁵ See, e.g., 105 CMR 164.311-.312 (establishing detailed procedural requirements, limitations, and protections regarding involuntary termination from an opioid treatment program).

⁹⁶ Proposed NMAC 8.321.10.24(A)(1)-(2), (B)-(C), (H)-(J), (L). See also NMAC 8.321.2.31(D)(8)(a), (b)(i)-(ii).

⁹⁷ Joseph A. Under new rules, methadone clinics can offer more take-home doses. will they? STAT.

<https://www.statnews.com/2022/12/22/new-rules-methadone-clinics-take-home-doses/>. Published December 22, 2022.

"[C]linics have a financial incentive to maintain the status quo. They can bill insurance or charge patients (many clinics take cash) for more services, from drug tests to counseling sessions, when people come in more frequently. Giving patients more take-homes could amount to lost revenue...."

⁹⁸ Madden EF, Christian BT, Lagisetty PA, Ray BR, Sulzer SH. Treatment provider perceptions of take-home methadone regulation before and during COVID-19. *Drug and Alcohol Dependence*. 2021;228:109100. "[P]ost-pandemic efforts to extend looser methadone distribution policies will have to address apprehensive professionals if such policy changes are to be meaningfully adopted in community services."

Vital Strategies recommends that New Mexico reverse this framework by establishing a presumption that OTP patients are eligible for the maximum number of take-home doses corresponding with their time in treatment. OTP practitioners would still retain clinical discretion to allow fewer take-home doses or even deny take-home doses entirely, consistent with their responsibilities under state and federal law. However, the OTP practitioner would be required to justify and document any downward departure in allowable take-homes for *each individual patient* based on the criteria in 42 CFR § 8.12(i)(2) and state rules. Requiring OTP practitioners to justify why a patient should *not* receive take-home doses would more appropriately reflect the evidence base by establishing that take-home doses should be the norm, not the exception. It would also reduce the likelihood of OTP providers systematically denying clinically appropriate take-home doses, a practice that was common during the COVID-19 flexibilities.⁹⁹

Additionally, Vital Strategies recommends that HCA:

- Require OTPs to make their take-home policies and procedures publicly available and to disclose them to all patients prior to and upon admission.¹⁰⁰
- Establish a presumption that a patient may maintain their current take-home medication doses upon transferring from one OTP to another.¹⁰¹

e. Repeal unnecessary provisions related to local authority and community relations.

Language retained in the proposed rule places substantial and unnecessary emphasis on community relations and local authority, and, in doing so, reinforces unfounded stereotypes about OTPs and the

⁹⁹ Joseph A. Under new rules, methadone clinics can offer more take-home doses. will they? STAT. <https://www.statnews.com/2022/12/22/new-rules-methadone-clinics-take-home-doses/>. Published December 22, 2022. Accessed March 11, 2026.

¹⁰⁰ The proposed rule currently requires OTPs to inform patients of the “requirements to receive take-home medication” only upon admission. Proposed NMAC 8.321.10.20(B)(2)(h). This means that a patient would not have this information when determining from which OTP to seek admission.

¹⁰¹ This approach would be consistent with other provisions of the proposed rule, such as proposed NMAC 8.321.10.20(G)(2)'s requirement that OTPs make every reasonable effort to maintain a patient's current dose during guest dosing.



people who receive care from them.^{102,103} Community opposition to the establishment and operation of OTPs is rooted in stigma and discrimination against people who use drugs and often untethered from any objective assessment as to the impact of OTPs on communities. Additionally, local governments have a long history of using zoning and other regulatory measures to impede access to OTPs, including in ways that violate federal anti-discrimination laws.¹⁰⁴

Vital Strategies is concerned that the proposed rule continues to reinforce these problematic assumptions and invite unwarranted scrutiny and regulation of OTPs throughout the state. Our concern is underscored by the fact that we could not identify any instance in which HCA rules impose analogous requirements on other healthcare facilities. Methadone treatment for opioid use disorder is lifesaving, evidence-based health care, and HCA's rules should ensure facilities providing such care are treated the same as any other medical provider.

f. Establish a patient advisory structure.

HCA's proposed changes to 8.321.10 NMAC reflect a shift toward a more patient-centered model of care at OTPs. Various provisions of the proposed rule emphasize shared decision-making between patients and OTP practitioners and the voluntariness of services. **Vital Strategies recommends that HCA extend the shift toward patient-centered models of care even further so that people with**

¹⁰² For example, current and proposed NMAC 8.321.10.2 goes out of its way to note that counties and municipalities may adopt supplemental ordinances so long as they do not conflict with the rule. See current and proposed NMAC 8.321.10.2 ("These regulations are not intended to preempt county or municipal ordinances that supplement and do not conflict with these regulations. County and municipal ordinances are preempted when they conflict with these regulations"). We could not identify any other HCA rule on health care facilities or services in which it actively invites supplemental local regulation in such a broad manner. Compare NMAC 8.321.10.2 (broad disclaimer of preemptive intent) with NMAC 8.370.12.41 (limited to building codes); 8.370.14.37(F) (narrowly addressing more stringent local laws governing food service establishments), 8.370.14.42 (limited to building codes), 8.370.14.46 (limited to water supply systems); 8.370.16.71 (limited to building codes). See also NMAC 8.370.12.8(Q) (requiring hospitals to comply "with all other applicable state laws and local ordinances" but without disclaiming preemptive intent or attempting to limit the scope of preemption). We also note that the New Mexico Supreme Court recently emphasized the broad preemptive nature of the Health Care Code, under which HCA derives its authority to regulate OTPs, NMSA 24A-1-12, with respect to the licensing and regulation of health care facilities, even in the absence of a direct conflict. *State ex rel. Torrez v. Bd. of Cty. Comm'rs for Lea Cty.*, 572 P.3d 837 (NM 2025).

¹⁰³ See current and proposed NMAC 8.321.10.6(C) (stating that the HCA's rule is intended, in part, to "consider the possible adverse impact on communities in which OTP providers are located in making application approval decisions," presupposing that OTPs have a negative impact on communities); current NMAC 8.321.10.29(A)(1) and proposed NMAC 8.321.10.31(A)(1) (requiring OTPs to establish "a mechanism for eliciting input from the community about the provider's impact on the community"); current NMAC 8.321.10.29(A)(5) (requiring OTPs to establish "a mechanism for addressing and resolving community concerns about opioid treatment or the program's presence in the community") and proposed NMAC 8.321.10.31(A)(5) (same but specifying "opioid use disorder treatment with methadone" in place of "opioid treatment"); current NMAC 8.321.10.29(C) and proposed NMAC 8.321.10.31(C) (requiring OTP program sponsors to comply with "county and municipal ordinances regarding community relations" and expressly providing that the HCA "may consult with local governmental entities when enforcing this section").

¹⁰⁴ See, e.g., *New Directions Treatment Servs. v. City of Reading*, 490 F.3d 293 (3d Cir. 2007) ("We agree with the Sixth and Ninth Circuits that a law that singles out methadone clinics for different zoning procedures is facially discriminatory under the ADA and the Rehabilitation Act"); *Bay Area Addiction Research & Treatment, Inc. v. City of Antioch*, 179 F.3d 725 (9th Cir. 1999); *MX Grp., Inc. v. City of Covington*, 293 F.3d 326 (6th Cir. 2002). See generally Sally Friedman, [Overcoming Opposition to Substance Use Programs: Leveraging Anti-Discrimination Law](#), Legal Action Center, July 2025. Accessed March 22, 2026.

direct experience receiving services at OTPs can guide the policies, procedures, and practices that directly affect them on a more systemic level. This could be accomplished by establishing a Patient Advisory Board at the state level to inform the work of HCA, including the state’s opioid treatment authority (SOTA).

g. Establish the provision of naloxone as the standard of care for all OTP patients.

Naloxone should be widely accessible to communities, particularly people who use drugs and their networks, yet access remains almost universally inadequate in the United States.¹⁰⁵ The proposed rule includes the distribution of opioid overdose reversal medications in the definition of “Harm reduction,”¹⁰⁶ and the Medical Assistance Division’s reimbursement rules for OTPs include very limited requirements related to the provision of naloxone or information about opioid antagonists.¹⁰⁷ There are no universally applicable requirements for the provision of opioid antagonists.¹⁰⁸ **We recommend HCA strengthen its rules by explicitly requiring OTPs to provide naloxone to all patients.** Establishing the provision of naloxone as a standard of care among OTPs will better meet the needs of patients and importantly gets this lifesaving tool directly into the hands of those at risk. HCA can also consider expanding requirements related to the provision of harm reduction services and supports more generally.¹⁰⁹

h. Ensure provisions throughout 8.321.10 NMAC are clear and encourage patient-centered practices that lower barriers to treatment and respect patient autonomy.

Vital Strategies recommends HCA’s final rule incorporate the following recommendations:

- **Modify the proposed definition of “Harm reduction” to clarify or exclude the explicit reference to SAMHSA.** As currently drafted, the proposed rule defines “Harm reduction,” in

¹⁰⁵ Irvine MA, Oller D, Boggis J, Bishop B, Coombs D, Wheeler E, Doe-Simkins M, Walley AY, Marshall BDL, Bratberg J, Green TC. Estimating naloxone need in the USA across fentanyl, heroin, and prescription opioid epidemics: a modelling study. *Lancet Public Health*. 2022 Mar;7(3):e210-e218.

¹⁰⁶ Proposed NMAC 8.321.10.7(L).

¹⁰⁷ See NMAC 8.321.2.31(B)(7) (requiring provision of a relapse prevention program that includes naloxone for patients undergoing medically managed withdrawal from medication or other opioids); 8.321.2.31(B)(15)(a) (requiring a health care practitioner who prescribes, distributes, or dispenses an opioid analgesic to a patient for the first time to “inform the patient of the availability of an opioid antagonist); 8.321.2.31(B)(15)(b) (imposing similar requirements on an annual basis); 8.321.2.31(B)(15)(c) (requiring a health care practitioner who *prescribes* a 5-day supply or greater of an opioid analgesic to co-prescribe an opioid antagonist). Importantly, the co-prescribing requirement will never apply to a patient receiving methadone from an OTP because methadone cannot be prescribed for the treatment of opioid use disorder. 21 CFR § 1306.07(a).

¹⁰⁸ Although N.M. Stat. Ann. § 24-23-3(A)(2) imposes a generally applicable requirement for OTPs to directly provide naloxone to patients, the requirement is contingent on “agency funding and agency supplies of naloxone” and thus does not ensure that naloxone is universally provided to all OTP patients.

¹⁰⁹ The current proposed rule includes “harm reduction interventions” among the potential actions for a patient to meet their goals and requires OTPs to provide information about the availability of harm reduction services upon a patient’s admission. Proposed NMAC 8.321.10.7(L), 8.321.10.7(Y), 8.321.10.20(B)(2)(i), 8.321.10.21(B). A modified rule could, for example, (1) require the direct provision of harm reduction resources, products, and services such as fentanyl and other drug testing supplies; (2) ensure each patient receives education on harm reduction strategies for reducing the risks of substance use; and/or (3) require OTPs provide direct referrals for on-site or off-site harm reduction information, resources, and services, such as harm reduction providers authorized pursuant to the New Mexico Harm Reduction Act. See NMSA § 24-2C-1 et seq., NMAC § 7.4.6.

part, by quoting the definition of “harm reduction” from SAMHSA’s 2023 Harm Reduction Framework.^{110,111} Unfortunately, SAMHSA has since disavowed this framework and harm reduction more broadly.¹¹² Although it is critical that New Mexico continue to support and advance lifesaving harm reduction practices, we caution against codifying a definition merely by general reference to a federal agency that no longer backs the definition. Vital Strategies recommends HCA modify the definition in the proposed rule to either specifically reference the definition as published in SAMHSA’s 2023 Harm Reduction Framework or simply adopt the definition without attribution to SAMHSA.

- **Exclude proposed NMAC 10.321.10.7(O)(4)**, which defines, in part, a “medical practitioner” as an individual who “may be a physician, physician’s assistant, registered nurse, nurse practitioner, or licensed practical nurse.” HCA should exclude this language to ensure the definition of “medical practitioner” is inclusive of all licensed health care professionals with a sufficient scope of practice.
- **Reconsider whether proposed NMAC 10.321.10.20(B)(1)(a) accurately describes New Mexico state law regarding minors’ ability to consent to OTP treatment without the consent of a parent and/or legal guardian.** As currently drafted, proposed NMAC 10.321.10.20(B)(1)(a) establishes an *absolute* prohibition on the ability for a minor to consent to OTP treatment without the approval of a parent or legal guardian.¹¹³ This unqualified prohibition, however, appears inconsistent with New Mexico state law. The prohibition would, for example, apply even to an emancipated minor who is authorized by state law to consent to medical care without parental approval.¹¹⁴ Moreover, NMSA 24-7A-6.2 authorizes an *unemancipated* minor

¹¹⁰ Proposed NMAC 8.321.10.7(L) (“This definition refers to SAMHSA’s definition of harm reduction as ‘a practical and transformative approach that incorporates community-driven public health strategies—including prevention, risk reduction, and health promotion—to empower people who use drugs (PWUD) and their families with the choice to live healthier, self-directed, and purpose-filled lives. Harm reduction centers the lived and living experience of PWUD, especially those in underserved communities, in these strategies and the practices that flow from them.’”)

¹¹¹ Substance Abuse and Mental Health Services Administration: Harm Reduction Framework. Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2023.

¹¹² See, e.g., [SAMHSA Strategic Priorities](#). SAMHSA website. Last updated September 10, 2025. Accessed March 4, 2026 (“SAMHSA grants will ... deprioritize ... so-called ‘harm reduction’ ... efforts”). See also [July 29, 2025 SAMHSA Dear Colleague Letter](#). Accessed March 4, 2026 (“Moving forward, SAMHSA funds will no longer be used to support poorly defined so-called ‘harm reduction’ activities”).

¹¹³ Proposed NMAC 8.321.10.20(B)(1)(a) (“NM state law does not grant persons under 18 years of age the ability to consent to OTP treatment without the consent of another, including parent and/or legal guardian. As such, no person under 18 years of age may be admitted to OTP treatment unless a parent, legal guardian, or responsible adult designated by the relevant State authority consents in writing (electronically or hard copy) to such treatment”).

¹¹⁴ This conflicts with N.M. Stat. Ann. § 32A-21-5(A), providing that “[a]n emancipated minor shall be considered as being over the age of majority for” the purpose of “consenting to medical, dental or psychiatric care without parental consent, knowledge or liability”). See also N.M. Stat. Ann. § 24-10-1 (providing that “[n]otwithstanding any other provision of law, ... any emancipated minor or any minor who has contracted a lawful marriage may give consent to the furnishing of hospital, medical and surgical care to such minor, and the consent is not subject to disaffirmance because of minority. The consent of a parent of an emancipated minor or of a minor who has contracted a lawful marriage is not necessary in order to authorize hospital, medical and surgical care”) (emphasis added).

fourteen years of age or older with the capacity to consent to give consent for medically necessary health care if the minor lives apart from their parents or legal guardian or has a child.¹¹⁵ NMSA 32A-6A-15 provides even broader authorization, establishing a presumption that a child fourteen years of age or older has capacity to consent to “treatment,” including “substance abuse treatment,” without the consent of the child’s legal custodian.¹¹⁶ While we recognize that there may be additional intricacies to the scope and application of these authorities, it appears evident that there is not an unqualified and absolute prohibition on persons under 18 years of age consenting to OTP treatment without the consent of a parent or legal guardian at all times and under all circumstances.¹¹⁷

- **Amend proposed NMAC 10.321.10.20(B)(2)(e)**, which requires OTPs to inform patients of “the requirement for a staff member to report suspected or alleged abuse or neglect of a child or an incapacitated or vulnerable adult according to state law.” We do not object to the general requirement that OTPs inform patients of their responsibilities as mandated reporters. However,

¹¹⁵ N.M. Stat. Ann. § 24-7A-6.2(A). See also N.M. Stat. Ann. § 24-7A-6.2(B) (defining “medically necessary health care” to include “mental or behavioral health services”), (C) (providing that “[t]he consent of the unemancipated minor to examination or treatment pursuant to this section shall not be disaffirmed because of minority”).

¹¹⁶ N.M. Stat. Ann. § 32A-6A-15(A) (“A child fourteen years of age or older is presumed to have capacity to consent to treatment without consent of the child’s legal custodian, including consent for individual psychotherapy, group psychotherapy, guidance counseling, case management, behavioral therapy, family therapy, counseling, substance abuse treatment or other forms of verbal treatment that do not include aversive interventions”). See also N.M. Stat. Ann. § 32A-6A-4(DD) (the Children’s Code defines “treatment” as the “provision of **behavioral health services** based on evaluation of the child, aimed at assisting the child to prevent, correct or ameliorate a mental disorder. The purpose of treatment is to enable the child to attain, maintain or regain maximum functioning”), (B) (defining “behavioral health services” as “a **comprehensive array of professional and ancillary services for the treatment**, habilitation, prevention and identification of mental illnesses, behavioral symptoms associated with developmental disabilities, **substance abuse disorders** and trauma spectrum disorders”) (emphasis added). Treatment at an OTP would *not* fall within the definition of “aversive interventions” to which the presumptive capacity to consent for children fourteen years of age or older does not apply. See N.M. Stat. Ann. § 32A-6A-4(A) (“aversive intervention” means any device or intervention, consequences or procedure intended to cause pain or unpleasant sensations, including interventions causing physical pain, tissue damage, physical illness or injury; electric shock; isolation; forced exercise; withholding of food, water or sleep; humiliation; water mist; noxious taste, smell or skin agents; and over-correction”). Moreover, even if medications for opioid use disorder such as methadone and buprenorphine were classified as psychotropic medications, the statute would require only notification of the child’s legal custodian, not the legal custodian’s consent. N.M. Stat. Ann. § 32A-6A-15(B) (“Psychotropic medications may be administered to a child fourteen years of age or older with the informed consent of the child. When psychotropic medications are administered to a child fourteen years of age or older, the child’s legal custodian shall be notified by the clinician”). See also N.M. Stat. Ann. § 24-7A-6.2(F) (providing that NMSA 24-7A-6.2 shall not be read to limit the rights of children pursuant to the Children’s Mental Health and Developmental Disabilities Act, Chapter 32A, Article 6A NMSA).

¹¹⁷ Federal regulations previously imposed a similar absolute prohibition. 42 CFR § 8.12(e)(2) (2023) (“No person under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the relevant State authority consents in writing to such treatment”). Current federal regulations now defer to state law on minors ability to consent to OTP treatment. 42 CFR § 8.12(e)(2) (“*Except in States where State law grants persons under 18 years of age the ability to consent to OTP treatment without the consent of another*, no person under 18 years of age may be admitted to OTP treatment unless a parent, legal guardian, or responsible adult designated by the relevant State authority consents in writing to such treatment”) (emphasis added). Nothing in the text or history of the federal regulation suggests the relevant state law must be *specific* to OTP treatment. A state law granting some or all persons under 18 years of age the ability to consent to medical treatment generally can satisfy 42 CFR § 8.12(e)(2) so long as it is inclusive of OTP treatment, whether implicitly or explicitly.



HCA should clarify that illicit drug use and issues related to an individual's participation in treatment (e.g., medication adherence, actual or suspected diversion, declining services including prenatal services) do *not* necessarily constitute sufficient grounds on their own for suspecting child abuse or neglect.

- **Amend proposed NMAC 8.321.10.23(C)** to clarify that the requirement to ensure that “[l]aboratory drug detection tests and other toxicological testing specimens are collected in a manner that minimizes falsification” does not require the use of observed urine screenings, and that HCA does not encourage the use of observed screenings.
- **Amend proposed NMAC 8.321.10.28(B)(1)** to emphasize bodily autonomy and the need to obtain informed consent. More specifically, the provision should read: “(1) pregnancy tests shall be administered *with the patient’s informed consent* and reviewed for all *people* of childbearing age prior to initiating a opioid treatment withdrawal procedure or medically supervised withdrawal.”¹¹⁸
- **Engage in additional rulemaking to ensure NMAC 8.321.2.31 aligns with the proposed rule.** For example, NMAC 8.321.2.31(D)(5) requires more frequent random drug screening (at least once per month) than is required by proposed NMAC 8.321.10.23(B) (at least eight random drug screens annually, consistent with federal regulations).¹¹⁹

Vital Strategies commends HCA’s efforts to expand access to evidence-based treatment for opioid use disorder. We encourage you to consider our suggestions for improving the state’s rules governing opioid treatment programs. Our organization also stands ready to provide technical assistance to HCA to help it advance these shared goals. Should you have any questions, please do not hesitate to contact jrwan@vitalstrategies.org.

Sincerely,

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¹¹⁸ Vital Strategies strongly supports the new language in proposed NMAC 8.321.10.28(B)(2) providing that “a refusal of pregnancy testing should not preclude access to treatment.”

¹¹⁹ NMAC 8.321.2.31 governs Medical Assistance coverage for services provided at OTPs.

Appendix I: Provisions Made Specific to Methadone

8.321.10.6. OBJECTIVE

- Proposed NMAC 8.321.10.6 specifies that the "rule establishes standards for opioid treatment programs, *in their provision of methadone treatment services*, to be consistent with the SAMHSA/CSAT regulations" rather than "rule establishes standards for opioid treatment programs to be consistent with the SAMHSA/CSAT regulations"

8.321.10.7. DEFINITIONS¹²⁰

Term	Current Rule	Proposed Rule
Administrative Discharge (“Administrative withdrawal”)	“withdrawal of a patient’s <u>opioid treatment medication</u> coinciding with the patient’s involuntary discharge from opioid treatment”	“withdrawal of a patient’s <u>methadone</u> coinciding with the patient’s involuntary discharge from <u>methadone treatment services</u> ”
Application Form	"approval to operate an <u>opioid</u> treatment program"	"approval to operate an <u>methadone</u> treatment program"
Methadone Continuous Medication Treatment program (“Comprehensive maintenance treatment”)	“dispensing or administering an <u>opioid treatment medication</u> ”	“dispensing or administering <u>methadone</u> ”
Dosage	“number of doses of <u>medication</u> for an individual”	“number of doses of <u>methadone</u> for an individual”
Dose	“a single unit of <u>opioid treatment medication</u> ”	“a single unit of <u>methadone</u> ”
Intake screening	“criteria for receiving <u>opioid</u> treatment”	“criteria for receiving <u>methadone</u> treatment”
Opioid treatment	“(1) <u>opioid</u> treatment withdrawal procedure/treatment; and (2) <u>comprehensive maintenance</u> treatment.”	“(1) <u>methadone</u> treatment withdrawal procedure; and (2) <u>methadone continuous medication</u> treatment.”
Opioid treatment program	“a single location at which <u>opioid dependence treatment medication</u> , such as methadone and rehabilitative services, are provided to patients”	“a single location ... at which opioid use disorder treatment <u>with methadone</u> and rehabilitative services, are provided to patients

¹²⁰ The definitions of “Opioid treatment medication” and “Medication for opioid use disorder (MOUD)” are not limited to methadone. Proposed NMAC 8.321.10.7(P), (R).

<i>Opioid treatment withdrawal procedure</i>	“dispensing or administering an <u>opioid dependence</u> treatment medication in decreasing medication levels”	“dispensing or administering <u>methadone</u> treatment medication in decreasing medication levels”
<i>Short-term opioid treatment withdrawal procedure</i>	“designed to dispense <u>opioid</u> treatment medication to a patient in decreasing doses”	“designed to dispense <u>methadone</u> treatment medication to a patient in decreasing doses”
<i>Take-home medication</i>	“one or more doses of an <u>opioid</u> treatment medication dispensed to a patient for use off the premises”	“one or more doses of a <u>methadone</u> treatment medication dispensed to a patient for use off the premises”

8.321.10.10. APPLICATION FOR APPROVAL TO OPERATE AN OPIOID TREATMENT PROGRAM

- Proposed NMAC 8.321.10.10(A) specifies “an application for approval to operate a methadone treatment program” rather than “an application for approval to operate an opioid treatment program”

8.321.10.19. ADMINISTRATION

- Proposed NMAC 8.321.10.19(E)(9) specifies “procedures for conducting methadone treatment withdrawal” rather than “procedures for conducting opioid treatment withdrawal.”¹²¹
- Several other provisions in proposed NMAC 8.321.10.19 use defined terms that are specific to methadone in the proposed rule. For example, proposed NMAC 8.321.10.19(E)(10) refers to “procedures for conducting an administrative discharge” and the term “administrative discharge” is defined specifically in relation to methadone.

8.321.10.20. ADMISSION (previously 8.321.10.19)

- Proposed NMAC 8.321.10.20(A) specifies “admitted for opioid use disorder treatment with methadone” rather than “admitted for opioid dependency treatment”
- Proposed NMAC 8.321.10.20(A)(1)(a) specifies that “a patient may commence methadone medication treatment after the screening examination has been completed”
- Proposed NMAC 8.21.10.20(A)(2)(a) provides that “a patient's refusal to undergo lab testing for co-occurring physical health conditions should not preclude them from access to methadone treatment”
- Proposed NMAC 8.321.10.20(A)(2)(b) provides that “the screening examination and full physical examination may be completed via telehealth for those patients being admitted for methadone treatment”

¹²¹ This change is made despite “opioid treatment withdrawal procedure” still being a defined term in the proposed rule. See proposed NMAC 8.321.10.7(T).

- Proposed NMAC 8.321.10.20(B)(2)(I) provides that “the patient’s access to methadone medication will not be contingent upon the patient’s engagement in counseling services”

8.321.10.21. ASSESSMENT AND TREATMENT PLANS

- Proposed NMAC 8.321.10.21(F)(4) specifies that “the patient’s access to methadone medication will not be contingent upon their engagement in psychosocial counseling”
- Proposed NMAC 8.321.10.21(G) requires treatment plans be updated in specified intervals for “continuous methadone medication treatment” rather than “continuous treatment”

8.321.10.22. DOSAGE

- Proposed NMAC 8.321.10.22(A) specifies “dose of methadone” rather than “dose of opioid dependency treatment medication”
- Proposed NMAC 8.321.10.22(B) specifies “dosage of methadone” rather than “dosage of opioid dependency treatment medication”
- Proposed NMAC 8.321.10.22(C) specifies “dose of methadone” rather than “dose of opioid dependency treatment medication”
- Proposed NMAC 8.321.10.22(D) specifies “dose of methadone” rather than “dose of opioid dependency medication”
- Proposed NMAC 8.321.10.22(D)(3) specifies “receiving continuous medication treatment with methadone receives an initial dose of methadone” rather than “receiving comprehensive maintenance treatment receives an initial dose of opioid dependency treatment medication”
- Proposed NMAC 8.321.10.22(D)(6) specifies “subsequent doses of methadone medication” rather than “subsequent doses of opioid dependency treatment medication”
- Proposed NMAC 8.321.10.22(D)(6)(d) specifies “benefits from and desires continuous treatment with methadone” rather than “benefits from and desires comprehensive maintenance treatment”

8.321.10.23. DRUG SCREENING

- Proposed NMAC 8.321.10.23(B) specifies “patient in methadone continuous treatment receives at least eight random laboratory drug detection tests per year” rather than “patient in comprehensive maintenance treatment receives at least eight random laboratory drug detection tests per year”

8.321.10.24. TAKE-HOME MEDICATIONS

- All provisions in proposed NMAC 8.321.10.24, except for Subsections M and N, are specific to methadone, either by their specific wording or because the definition of “Take-home medication” is made specific to methadone.

8.321.10.26. WITHDRAWAL TREATMENT AND MEDICALLY SUPERVISED DOSE REDUCTION

- Proposed NMAC 8.321.10.26(B)(1) specifies “a patient involved in methadone continuous medication treatment” rather than “a patient involved in comprehensive maintenance treatment”
- Proposed NMAC 8.321.10.26(C)(3) specifies “withdrawal of opioid treatment medication (methadone) against medical advice” rather than “of opioid medication against medical advice”
- Proposed NMAC 8.321.10.26(E) specifies “the patient is permitted to begin methadone continuous medication treatment” rather than “the patient is permitted to begin comprehensive maintenance treatment”
- Several other provisions in proposed NMAC 8.321.10.16 use defined terms that are specific to methadone in the proposed rule. For example, proposed NMAC 8.321.10.26(D) refers to “utilizing administrative discharge” and the term “administrative discharge” is defined specifically in relation to methadone.

8.321.10.27. COUNSELING AND MEDICAL SERVICES

- Proposed NMAC 8.321.10.27(D) specifies “each patient seeking opioid use disorder treatment with methadone is screened for the presence of a co-occurring mental health disorder by means approved by the HCA” rather than “each patient seeking opioid treatment is screened for the presence of a co-occurring mental health disorder by means approved by the HCA”

8.321.10.28. DIVERSE POPULATIONS

- Proposed NMAC 8.321.10.28(A)(1) specifies “opioid use disorder treatment with methadone is provided regardless of race, ethnicity, gender, age, or sexual orientation” rather than “opioid treatment is provided regardless of race, ethnicity, gender, age, or sexual orientation”
- Proposed NMAC 8.321.10.28(A)(3) specifies “opioid use disorder treatment with methadone is provided with consideration for a patient’s individual needs, cultural background, and values” rather than “opioid treatment is provided with consideration for a patient’s individual needs, cultural background, and values”
- Proposed NMAC 8.321.10.28(A)(9) uses the term “opioid treatment,” which is defined specifically with respect to methadone.
- Proposed NMAC 8.321.10.28(A)(10) specifies “requires administration of opioid use disorder treatment with methadone only for relief of chronic pain” rather than “requires administration of opioid treatment medication only for relief of chronic pain”
- Proposed NMAC 8.321.10.28(A)(10)(b) specifies “not admitted for opioid use disorder treatment with methadone” rather than “not admitted for opioid medication treatment”

- Proposed NMAC 8.321.10.28(B)(1) uses the defined term “opioid treatment withdrawal procedure,” which is specified to methadone, to determine when a pregnancy test is required.
- Proposed NMAC 8.321.10.28(C)(1) specifies “priority be given to pregnant individuals seeking opioid use disorder treatment with methadone” rather than “priority be given to pregnant individuals seeking opioid treatment”
- Proposed NMAC 8.321.10.28(C)(5) specifies “to coordinate opioid use disorder treatment with methadone and prenatal and post-partum care” rather than “to coordinate opioid treatment and prenatal care”
- Proposed NMAC 8.321.10.28(D)(1) specifies “efforts to obtain approval from the criminal justice system for the continued substance use disorder treatment with methadone for the patient” rather than “efforts to obtain approval from the criminal justice system for the continued treatment of the patient”

8.321.10.29. PREPAREDNESS PLANNING

- Proposed NMAC 8.321.10.29(A)(1) specifies “a written plan to ensure uninterrupted dispensing of methadone” rather than “a written plan to ensure uninterrupted dispensing of medication”
- Proposed NMAC 8.321.10.29(A)(2) specifies “for the provision of opioid use disorder treatment with methadone to program patients” rather than “for the provision of opioid treatment medication to program patients”
- Proposed NMAC 8.321.10.29(B)(1) specifies “steps for the orderly transfer of patients to other programs, individuals, or entities that provide opioid use disorder treatment with methadone” rather than “steps for the orderly transfer of patients to other programs, individuals, or entities that provide opioid treatment”

8.321.10.30. PATIENT RECORDS

- Proposed NMAC 8.321.10.30(B)(9) specifies “efforts to learn of multiple methadone treatment program enrollment” rather than “efforts to learn of multiple opioid treatment program enrollment”
- Proposed NMAC 8.321.10.30(B)(10) specifies “patient has received and understood information regarding the harmful effects of diversion of methadone” rather than “patient has received and understood information regarding the harmful effects of diversion of opioid treatment medication”

8.321.10.31. COMMUNITY RELATIONS

- Proposed NMAC 8.321.10.31(A) specifies “promote understanding in the community about opioid use disorder treatment with methadone” rather than “promote understanding in the community about opioid treatment”
- Proposed NMAC 8.321.10.31(A)(5) specifies “mechanism for addressing and resolving community concerns about opioid use disorder treatment with methadone” rather than “mechanism for addressing and resolving community concerns about opioid treatment”

8.321.10.32. DIVERSION CONTROL

- Proposed NMAC 8.321.10.31 specifies “prevent diversion of methadone” and “reporting of theft or diversion of methadone” rather than “prevent diversion of opioid treatment medication” and “reporting of theft or diversion of medication”

Appendix II: Examples of Inconsistent Terminology in the Proposed Rule

- Proposed NMAC 8.321.10.7(N) defines the term “Intake screening” but no substantive provision uses that term. Based on context, we presume “Intake screening” is intended to mean the “screening examination” referenced in proposed NMAC 8.321.10.20(A)(1), (A)(1)(a), and (A)(2)(b) and “screening” in proposed NMAC 8.321.10.18(B)(4)(e). We recommend either amending the definition to reflect the terminology used in the substantive provisions or amending the substantive provisions to use the defined term.
- Proposed NMAC 8.321.10.7(Q) defines “Opioid treatment” as, in part, “methadone treatment withdrawal procedure.” The proposed rule includes the defined terms “Opioid treatment withdrawal procedure” and “Short-term opioid treatment withdrawal procedure” but not “methadone treatment withdrawal procedure.”¹²² One substantive provision also uses the undefined term “methadone treatment withdrawal.”¹²³
- Numerous provisions refer to “opioid use disorder treatment” (often as “opioid use disorder treatment with methadone”),¹²⁴ but the defined term is “Opioid treatment” rather than “opioid use disorder treatment.”¹²⁵ Importantly, some provisions do use the defined term “Opioid treatment” so merely changing the term to “Opioid use disorder treatment” would not resolve the inconsistency unless these substantive provisions were also amended.¹²⁶
- Several provisions refer to “methadone treatment medication” or “opioid use disorder treatment medication,”¹²⁷ yet the only defined terms are “Medication for opioid use disorder (MOUD)” and “Opioid treatment medication.”¹²⁸

¹²² Proposed NMAC 8.321.10.7(T), (Z).

¹²³ Proposed NMAC 8.321.10.19(E)(9).

¹²⁴ See, e.g., proposed NMAC 8.321.10.7(S) (defining “Opioid treatment program” as, in part, “opioid use disorder treatment with methadone”), 8.321.10.8 (“shall be permitted to provide opioid use disorder treatment services with methadone”), 8.321.10.18(B)(4)(a) (“medications for opioid use disorder treatment”), 8.321.10.19(E)(1) (“receiving opioid use disorder treatment”), 8.321.10.20(A) (“admitted for opioid use disorder treatment with methadone”), 8.321.10.27(D) (“each patient seeking opioid use disorder treatment with methadone”), 8.321.10.28(A)(1) and (A)(3) (“opioid use disorder treatment with methadone”), 8.321.10.28(A)(10) (“who requires administration of opioid use disorder treatment with methadone”), 8.321.10.28(A)(10)(b) (“not admitted for opioid use disorder treatment with methadone”), 8.321.10.28(C)(1) (“seeking opioid-use disorder treatment with-methadone”), 8.321.10.29(A)(2) (“provision of opioid use disorder treatment with methadone”).

¹²⁵ Proposed NMAC 8.321.10.7(Q).

¹²⁶ See, e.g., proposed NMAC 8.321.10.19(A), 8.321.10.26(C)(1)(a), 8.321.10.28(A)(9).

¹²⁷ See, e.g., proposed NMAC 8.321.10.7(T) (“methadone treatment medication”), 8.321.10.7(Z) (“methadone treatment medication”), 8.321.10.7(BB) (“methadone treatment medication”), 8.321.10.20(B)(2)(d) (“opioid use disorder treatment medication”), 8.321.10.20(E)(1) (“opioid use disorder treatment medication”), 8.321.10.22(D)(6)(e) (“opioid use disorder treatment medication”).

¹²⁸ Proposed NMAC 8.321.10.7(P), (R).

- Numerous provisions use the terms “methadone treatment,” “methadone medication treatment,” “methadone treatment program,” or “methadone treatment services” despite these not being defined terms in proposed NMAC 8.321.10.7.¹²⁹
- Proposed NMAC 8.321.10.7(Y) defines “Psycho-Social Diagnostic Assessment” whereas proposed NMAC 8.321.10.21(B) refers to “psychosocial diagnostic assessment” (i.e., no hyphen).
- The proposed rule uses a variety of terms to refer to healthcare practitioners operating within an OTP. These include: (1) appropriately licensed practitioner; (2) counselor; (3) health care practitioner; (4) health care practitioner designee; (5) medical practitioner designee; (6) OTP medical practitioner; (7) OTP practitioner; (8) OTP prescribing practitioner; (9) prescribing medical practitioner; (10) prescribing practitioner; (11) program prescriber (12) qualified healthcare practitioner; and (13) qualified professional. Additionally, the defined term “Program clinician” is not used anywhere in the proposed rule.
- Proposed NMAC 8.321.10.25(A), (C), and (G) refer to “comprehensive treatment” despite this not being a defined term or otherwise used in the proposed rule.¹³⁰

¹²⁹ See, e.g., proposed NMAC 8.321.10.6 (“in their provision of methadone treatment services”), 8.321.10.7(B) (“involuntary discharge from methadone treatment services”), 8.321.10.7(C) (“approval to operate an methadone treatment program”), 8.321.10.7(N) (“the initial criteria for receiving methadone treatment”), 8.321.10.10(A) (“approval to operate a methadone treatment program”), 8.321.10.20(A)(1)(a) (“may commence methadone medication treatment”), 8.321.10.20(A)(2)(a) (“should not preclude them from access to methadone treatment”), 8.321.10.20(A)(2)(b) (“admitted for methadone treatment”), 8.321.10.30(B)(9) (“documentation of the agency’s efforts to learn of multiple methadone treatment program enrollment”)

¹³⁰ The proposed “comprehensive treatment” language is consistent with federal regulations, but the proposed rule opts to instead use the term “methadone continuous medication treatment program.”