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Study of
Social Policy
Ideas into Action



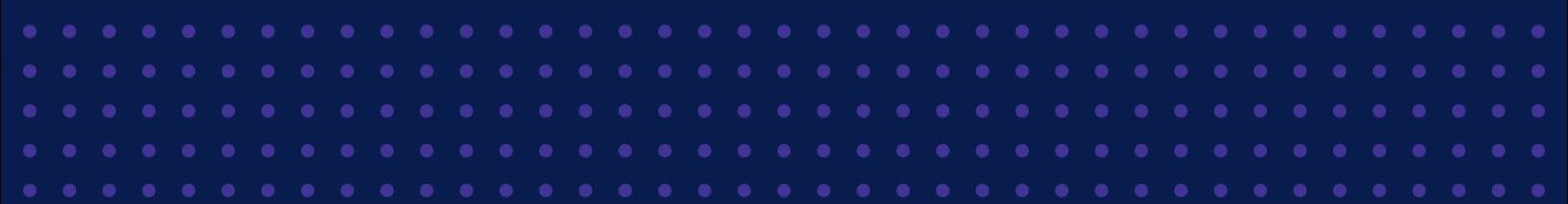
Co-Neutrals' Annual Report

Kevin S., et al. v. Blalock and Scrase

January - December 2024

Co-Neutrals

Judith Meltzer
Kevin Ryan



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I. Introduction

The *Kevin S., et al. v. Blalock and Scrase* (“*Kevin S.*”) lawsuit was filed in the U.S. District Court for New Mexico on September 22, 2018, on behalf of a class of children in the custody of New Mexico’s child welfare system and on behalf of child-serving non-profit agencies, the Native American Disability Law Center and Disability Rights New Mexico (“Plaintiffs”), Public Counsel, and associated counsel. The Defendants in the lawsuit include State officials responsible for administering and supervising New Mexico’s child welfare system – Children, Youth, and Families Department (CYFD) – and the system responsible for delivery of Medicaid services for eligible children as well as other behavioral health services for adults, children, and their families – Health Care Authority (HCA).¹ Following months of negotiations among the *Kevin S.* parties, on March 17, 2020, the parties executed a Final Settlement Agreement (“FSA,” also referred to herein as “Agreement”), and on March 26, 2020, filed a Joint Stipulation of Dismissal of the lawsuit. In reaching this Agreement, the parties acknowledged their mutual commitment to the development of a trauma-informed system of care that meets the needs of New Mexico’s diverse children and youth and their families.²

The FSA is organized in five sections. The first section states the goals of the Agreement and provides a guiding focus on the desired outcomes of the reform. It summarizes the purpose and objectives; provides definitions of terms; and outlines processes, including the appointment and role of the Co-Neutrals, FSA implementation, Performance Standard determinations, and reporting of performance. The remaining four sections of the Agreement are organized by the primary subject areas alleged as deficient in the *Kevin S.* complaint (codified as Appendices).

Specifically,

- Appendix A, titled Trauma-Responsive System of Care, requires CYFD and HCA to make good faith efforts to achieve substantial and sustained progress toward the development

¹ On July 1, 2024, the New Mexico Health Care Authority (HCA) was formed, and consolidated within it the following agencies: the Human Services Department (HSD), the State Employee Benefits team from the General Services Department, the Developmental Disabilities Supports Division, and the Division of Health Improvement from the Department of Health. HCA maintains the functions HSD held relevant to *Kevin S.*

² On January 6, 2023, following the release of the Co-Neutrals’ November 15, 2022 Report, the Plaintiffs invoked the FSA Dispute Resolution process. The Co-Neutrals mediated discussions between the parties between March and June 2023. The resulting agreement – the Corrective Action Plan (CAP) – included commitments that CYFD and HCA agreed to undertake to come into compliance with the FSA. The CAP expired on January 5, 2024. On July 15, 2024, the Plaintiffs filed an Amended Arbitration Notice related to the State’s lack of performance in the areas of case worker hiring and retention, foster family development and retention, well-child checks, and data submission. The arbitrator, Charles Peifer, held a hearing in November 2024, and issued Remedial Order No. 1 on January 21, 2025. The arbitrator has continued to maintain jurisdiction over this action. Following a status hearing on July 3, 2025, Mr. Peifer issued Remedial Order No. 2 on August 18, 2025, in which he requested the Co-Neutrals issue reports prior to arbitration status hearings in October 2025, November 2025, and January 2026, specifying whether the State has achieved the outcomes set forth in Remedial Orders No. 1 and No. 2. In response to these Orders, the Co-Neutrals issued two reports with associated appendices describing performance and outcomes toward select commitments. The CAP and Remedial Orders can be found [here](#).



and support of a trauma-responsive system of care for all children in state custody.

- Appendix B, titled Least-Restrictive and Appropriate Placements, requires CYFD and HCA to make good faith efforts to achieve substantial and sustained progress toward the development of a system for placing children in out-of-home care in stable, safe, appropriate, community-based placements in the least-restrictive environment.
- Appendix C, titled Indian Child Welfare Act, requires CYFD and HCA to make good faith efforts to achieve substantial and sustained progress to serve Native American children and families, build a relationship with each of the New Mexico Tribes and Pueblos, and comply with the Indian Child Welfare Act in its letter and intent.
- Appendix D, titled Behavioral Health Services, requires CYFD and HCA to make good faith efforts to achieve substantial and sustained progress to build a statewide, community-based mental health system that all children and families will be able to access.


Each Appendix includes a set of Implementation Targets (ITs) and Target Outcomes (TOs). The FSA defines ITs as process commitments that CYFD and HCA agreed to undertake as intermediary and necessary steps toward reaching TOs. The TOs are defined as performance commitments toward which CYFD and HCA agreed to make good faith efforts to achieve substantial and sustained progress in consideration for Plaintiffs' agreement to dismiss the *Kevin S.* litigation.

Implementation of the State's FSA obligations are validated and monitored by two Co-Neutrals, Judith Meltzer and Kevin Ryan. The Co-Neutrals function in a neutral capacity, and have the authority to validate, evaluate, and audit progress toward achievement of the Performance Standard for ITs and TOs. The Co-Neutrals are also responsible for assessing and providing approval of certain policies, plans, and efforts the State must complete related to specific ITs and TOs, as identified in the FSA.

In the FSA, the parties defined the Performance Standard as "the level of achievement [the State] must meet with respect to each Implementation Target and Target Outcome in order to fulfill the terms of the Agreement." Specifically, the parties agreed:

Meeting the Performance Standard means making good faith efforts to achieve substantial and sustained progress toward achieving the Implementation Target or Target Outcome. A finding of good faith efforts to achieve substantial and sustained progress toward achieving the Implementation Target or Target Outcome shall be based on whether Defendants have made all reasonable efforts to achieve each Implementation Target or Target Outcome. This standard is not intended to assess Defendants' subjective intentions, plans, or promises.

The FSA requires the Co-Neutrals to produce an annual report assessing the efforts of CYFD and HCA to achieve the ITs and TOs. This is the fifth annual report produced by the Co-Neutrals. The IT and TO Performance Standard determinations in this report assess CYFD and HCA's performance in 2024. The FSA dictates the period of assessment for each annual report; specifically, this report – due by November 15, 2025 – assesses the State's performance from January 1, 2024 to December 31, 2024.



This report, where possible, validates the 2024 data and information produced by the State, and documents the Co-Neutrals’ determinations whether the State met the Performance Standard for ITs and TOs in 2024.

The FSA describes the information the Co-Neutrals should consider when assessing the State’s efforts using the FSA Performance Standard, including the factors the Co-Neutrals should apply, and the due consideration of the FSA’s goals and prefatory language in each Appendix. Ultimately, ITs and TOs are meant to collectively strengthen the agencies’ practices, processes, and infrastructure, and in turn, improve outcomes for children and families served by CYFD and HCA. As required by the FSA, the Co-Neutrals have applied the FSA definition of the Performance Standard in this report to assess the State’s 2024 performance.

A. Report Structure


The report is structured as follows:

- Section I outlines the *Kevin S., et al. v. Blalock and Scrase* complaint, subsequent Agreement, the definition and role of the Co-Neutrals, and provides sources of information used and activities completed by the Co-Neutrals to prepare and compile this report.
- Section II summarizes the State’s progress on *Kevin S.* commitments due by December 2024.
- Section III provides an overview of the demographics of children in state custody in New Mexico during 2024.
- Section IV discusses the State’s performance on each of the FSA commitments due by December 2024, organized by the Agreement’s subject area Appendices.

B. Methodology

During this period, the Co-Neutrals and their team reviewed thousands of documents and records, and met regularly with the Secretaries of CYFD and HCA, the agencies’ leadership teams and staff, and provided feedback to the State on certain plans, strategies, and work products relevant to specific commitments. In January, August, and September 2024, the Co-Neutrals met in New Mexico with CYFD staff in 10 CYFD offices across the state; met with staff from CYFD’s Office of Tribal Affairs (OTA); and met with leadership and care coordinators from Presbyterian Health Plan (PHP), the sole MCO serving children in state custody, to inform the Co-Neutrals’ understanding of the State’s performance and their efforts in 2024. Additionally, throughout 2024 and 2025, the Co-Neutrals met with the Plaintiffs’ team, community advocates, private providers, Tribal representatives, and resource parents to collect information on the quality and impact of the state’s efforts.

Between July 2024 and January 2025, the Co-Neutral team conducted 92 virtual interviews with resource parents. Virtual interviews were also completed with 120 CYFD staff (supervisors and non-supervisors) between June and December 2024. In February 2025, members of the Co-Neutral team participated in CYFD’s introductory trauma training for employees – *Trauma: A*



Journey to Self-Discovery. In September and October 2025, the Co-Neutrals conducted visits to six CYFD county offices and met with case workers, supervisors, managers, and children’s court attorneys; and visited four congregate care facilities to further inform the Co-Neutrals’ understanding of the State’s performance and efforts in 2024 and 2025.

The Co-Neutrals and their team worked closely with the State’s data team and program leadership to identify and refine the guidelines for data validation and data handling described in the *Kevin S. Data Validation Plan (DVP)*.³ They also reviewed, analyzed, and validated demographic data about children served and performance data submitted by the State. The Co-Neutral team worked independently and with State staff to develop qualitative instruments to assess some metrics and to collect 2024 performance data for several TOs.

The Performance Standard determinations are focused on the State’s efforts to achieve substantial and sustained progress in 2024, even though comments regarding some commitments completed in 2025 are included in this report. The Co-Neutrals’ next report – due by November 15, 2026 – will discuss and assess the State’s performance in 2025.

³ The DVP is discussed in more detail in Section IV.A.i. of this report.

II. Overview


This is the fifth report produced by the Co-Neutrals on the State's efforts to achieve the *Kevin S. FSA* commitments. The FSA was structured with Implementation Targets (ITs) due to be completed in the first years of the reform as the foundation for improved outcomes (Target Outcomes, TOs) to be completed in subsequent years for New Mexico's children, youth, and families. The State previously met the Performance Standard for all the ITs in Appendices A and B of the FSA. The State did not meet the Performance Standard for any of the remaining five ITs in Appendix C, and met the performance standard for one of the remaining three ITs in Appendix D by December 31, 2024. The State did not meet the Performance Standard for any of the 42 TOs due in 2024.⁴ For the 42 TOs and seven ITs where the State did not meet the Performance Standard in 2024, the State's performance either remained stagnant with 2023 performance or, in numerous instances important to children, worsened.

It is important to acknowledge that a relatively new leadership team at CYFD – appointed by the Governor in September 2025 after the resignation of Secretary Theresa Casados – is working to stabilize the organization and tighten coordination with HCA. They report their focus is on workforce stability, building adequate services, and ensuring a sufficient array of safe family-based and therapeutic placements for children.

But this report, as required by the FSA, is not about 2025. This report is about 2024, and the report reflects a state system in unyielding crisis that lost significant ground, with multiple examples throughout these pages of worsening performance and deteriorating experiences and outcomes for children:

- Permanency for children in care 12 to 23 months dropped below the required target for the first time since 2020.
- The rate of placement moves in 2024 was the worst since 2020, and worse than children's experience at the outset in 2019.
- In January 2021, there were 675 licensed non-relative homes for children; as of December 2024, there were 500.
- The number of children's placements in CYFD offices exploded from the prior year, from 322 in 2023 to 709 in 2024.
- Fourteen percent of children in state custody in 2024 experienced a placement in an office or out-of-state facility, double the rate from 2023, affecting nearly 500 percent more

⁴ In 2024, the State met the performance standard for App. D, IT 1 – *Behavioral Health Workforce Development Review*. In 2022, the State met the Performance Standard for four TOs that required development of Plans. Specifically, App. A, TO 4.1 – *IPP Plan*; App. A, TO 5.1 – *QAIEP Plan*; App. B, TO 10.1 – *CYFD Workforce Development Plan*; and App. C, TO 5.1 – *ICWA/IFPA Training Plan*. The State did not meet the Performance Standard for the associated TOs with respect to implementing the plans. TOs are monitored until the Defendants have met the Performance Standard continuously for a period of at least 24 months. A list of all ITs and TOs for which the State previously met the Performance Standard can be found in Appendix ii: *FSA Implementation Targets and Target Outcomes Met in Prior Reporting Periods*.



children than in 2019. None of these placements met the *extraordinary circumstances standard* of the FSA.⁵ And for the first time, children’s records revealed that not a single one of the 709 office placements reflected that the CYFD Secretary or Protective Services Division (PSD) Director approved them as required.

- Of 762 episodes of children’s custody in 2024, 407 (53%) included a well-child checkup within 30 days of the child entering custody, more than 2023 but worse than at the outset in 2020 and 2019.
- There were significantly fewer documented timely joint clinical reviews, medical necessity determinations, shelter placement reviews, and other required care coordination and discharge planning meetings.
- And fueling much of this: an overworked CYFD staff, forced to carry unreasonably high caseloads, supervise children housed in unsuitable CYFD offices with inadequate or no training, and work mandatory overnight and weekend shifts because the agency failed to staff adequately for its 24/7 mission in 2024. Most – not some, but most – eligible case-assignable workers throughout 2024 had caseloads above the standard, including a significant number of staff carrying caseloads more than 200 percent of the standard. A significant number of CYFD workers not eligible to carry cases were assigned to do so anyway and many, unable to bear the strain of poor working conditions and unreasonable expectations, quit.

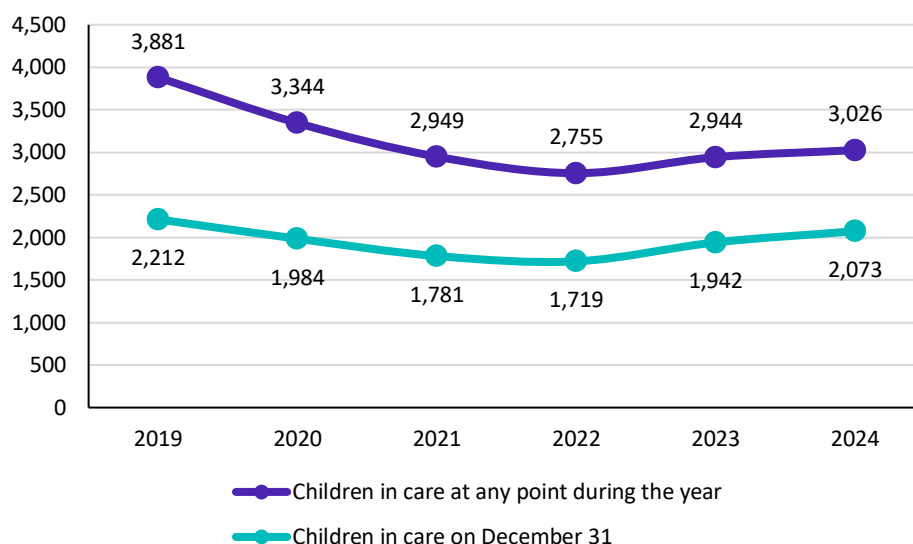
As highlighted above, the State’s 2024 performance was dismal and a discredit to the many staff, resource parents, and community partners who are committed to improving the experiences and futures of New Mexico’s children, youth, and families.

⁵ In reviewing extraordinary circumstances determinations, the Co-Neutral team assessed whether documentation in the child’s record demonstrated the placement was necessary to protect the safety and security of the child, and that the placement was approved by the CYFD Secretary or PSD Director prior to the placement occurring, consistent with the FSA. The lack of alternative or available placements is insufficient to meet the extraordinary circumstances standard set forth in the FSA.

III. Contextual Summary of Children in State Custody

Demographic data provided by CYFD on children in state custody during 2024 show that 3,026 children were in CYFD’s PSD custody at some point between January 1, 2024 and December 31, 2024. The total number of children in custody at any point during the reporting year, as well as the total number of children in custody on the last day of the reporting year, decreased each year between 2019 and 2022 and then increased each year from 2022 to 2024 (see Table 1).

Table 1: Children in State Custody at Any Point and on December 31^{6,7}
2019 - 2024



Source: Analysis of Sandbox Cohort, Jan1, Dec31, Entries, and Exits files

There were 1,933 children in state custody on January 1, 2024. During the year, there were 1,175 entries into care and 1,036 exits, leading to a total of 2,073 children in state custody on December 31, 2024 (see Table 2).⁸

⁶ Per the DVP definition of a placement, a child is considered to be in a placement on a given date if they are present in that placement at 3:00 am.

⁷ The 2024 data include four children who exited state custody on December 31, 2024.

⁸ There were two children who entered care on January 1, 2024, four children who exited care on December 31, 2024, and one child turned 18 prior to the end of the year.

Table 2: Children Entering and Exiting State Custody⁹
2024

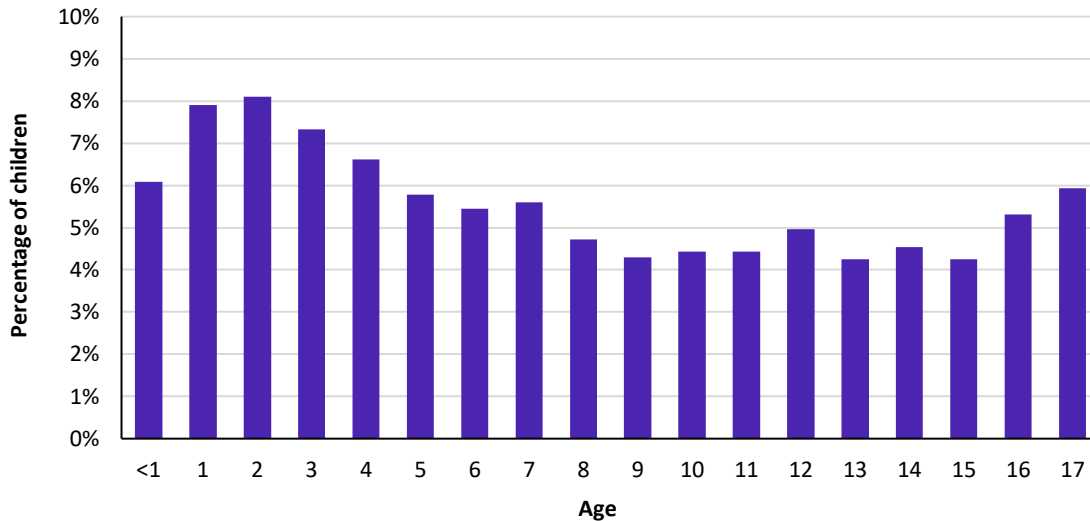
	Count
Children in care on Jan. 1, 2024	1,933
Entries during the year	1,175
Exits during the year	1,036
Children in care on Dec. 31, 2024	2,073

Source: Analysis of Sandbox Cohort, Jan1, Dec31, Entries, and Exits files

A. Age, Gender, and Race

Young children made up the largest share of children in state custody on December 31, 2024, with one year-olds and two-year-olds comprising 16 percent of all children in state custody, and three-year-olds and four-year-olds comprising 14 percent (see Figure 1). The age distribution was similar for each year from 2019 to 2024. In 2024, there were slightly more male (51%) than female children (49%) in state custody.

Figure 1: Age of Children in State Custody on December 31, 2024
N = 2,073 children



Source: Analysis of Sandbox Dec31 files

According to the State's data, the distribution of children in state custody on December 31, 2024 by race and ethnicity was as follows: 60 percent were of Hispanic ethnicity (1,243), 19 percent were White (non-Hispanic) (390), 10 percent were American Indian/Alaskan Native (non-Hispanic) (201), four percent were Black (non-Hispanic) (88), two percent were either Multiracial (non-

⁹ The data include all entries and exits for children with multiple episodes of custody.

Hispanic) or Asian (non-Hispanic) (51), and five percent were categorized as “Unknown” (100).¹⁰ Of all 2,073 children in custody, 90 percent were not documented in FACTS as having a Tribal affiliation (1,873), and 10 percent were documented as having a Tribal affiliation (200), as shown in Table 3.¹¹

Table 3: Race, Ethnicity, and Tribal Affiliation Status of Children in State Custody on December 31, 2024

N = 2,073 children

Race and ethnicity	Dec. 31, 2024	
	N	%
Hispanic (of any race)	1,243	60%
White (non-Hispanic)	390	19%
American Indian or Alaskan Native (non-Hispanic)	201	10%
Black (non-Hispanic)	88	4%
Multiracial/Other (non-Hispanic) ¹²	51	2%
Unknown	100	5%
Tribal affiliation		
Tribal affiliation (No)	1,873	90%
Tribal affiliation (Yes)	200	10%

Source: Analysis of Sandbox Dec31 and Cohort files

B. Living Arrangements

On December 31, 2024, 83 percent of children in state custody (1,725) lived in family settings, including 44 percent of children (912) in relative and fictive kin resource families, 30 percent of children (627) in non-relative resource families, seven percent of children (154) in treatment foster care (TFC) homes (relative, non-relative, and unspecified), and two percent of children (32) in pre-adoptive homes. On December 31, 2024, six percent of children (122) lived in in-state congregate settings, and one percent of children (21) lived in out-of-state facilities, as shown in Table 4.¹³

¹⁰ According to 2023 data from the US Census Bureau, 61 percent of children in New Mexico are Hispanic or Latino, 14 percent are American Indian or Alaska Native, five percent are Black or African American, and 23 percent are White. US Census Bureau, American Community Survey 1-Year Estimates for children under 18 years in New Mexico; categories are not exclusive.

¹¹ FACTS is CYFD’s current State Automated Child Welfare Information System (SACWIS).

¹² The “Multiracial/Other (non-Hispanic)” category for race includes children identified as Multiracial (non-Hispanic) and Asian (non-Hispanic). The total number of children in each of these groups is small enough to raise confidentiality concerns and is too small for the Co-Neutrals to draw conclusions about over-or-under representation for these children.

¹³ For purposes of this report, the Co-Neutrals classify the placements recorded as “Supervised Independent Living” in FACTS as “congregate placements,” subject to the best interest determination in App. B, TO 4.1, unless there was information in the case record indicating the placement was to a non-congregate setting.

**Table 4: Placement Type for Children in State Custody on December 31
2022 - 2024**

Setting	Dec. 31, 2022		Dec. 31, 2023		Dec. 31, 2024	
	N	%	N	%	N	%
Children in Placements	1,570	90%	1,761	91%	1,868	90%
Family-Based Settings						
Resource Family Home (Non-Relative)	556	32%	611	31%	627	30%
Resource Family Home (Relative & Fictive Kin)	720	42%	863	44%	912	44%
Treatment Foster Care (Non-Relative)	155	9%	147	8%	143	7%
Treatment Foster Care (Relative)	17	1%	14	<1%	10	<1%
Treatment Foster Care (Unspecified)	0	0%	0	0%	1	<1%
Pre-Adoptive Family	28	2%	16	<1%	32	2%
In-State Congregate Settings						
Facility ¹⁴	16	1%	17	<1	17	<1%
Emergency Shelter	18	1%	13	<1%	36	2%
Group Home	17	1%	16	<1%	15	<1%
Community Home	22	1%	28	1%	16	<1%
Hotel/Motel, Office, Receiving Center	0	0%	8	<1%	27	1%
Supervised Independent Living	7	<1%	10	<1%	11	<1%
Out-of-state congregate settings	14	1%	18	<1%	21	1%
Children Not in Placements	149	9%	181	9%	205	11%
Trial Home Visit	98	6%	84	4%	122	6%
Runaway	36	2%	57	3%	51	2%
Temporary Absence	0	0%	0	0%	0	0%
Acute Hospitalization	7	<1%	5	<1%	7	<1%
Protective Supervision	4	<1%	4	<1%	4	<1%
Detention	4	<1%	4	<1%	10	<1%
Unknown	0	0%	27	1%	11 ¹⁵	<1%
Total for all children in state custody¹⁶	1,719	100%	1,942	100%	2,073	100%

Source: Analysis of Sandbox Dec31 and Placements files and separate manual data files, plus adjustments informed by case record reviews

¹⁴ Though FACTS captures information on hospital stays for children in state custody, acute hospitalizations are considered temporary absences, and – consistent with the definitions in the DVP – are not counted as placements. Acute hospitalizations are identified in the State’s data as any placement for a child who is under six years old at the time of placement with an “Institution Daily Rate” service type, and any placement with this service type that is 30 days or shorter for children six years or older. Stays for children six years or older with the “Institution Daily Rate” that are longer than 30 days are counted as placements subject to the congregate care medical necessity requirement (counted as “Facility” placements).

¹⁵ There were 11 children who appeared in the Sandbox Cohort Dec31 file but whose last placement ended before December 31, 2024, with no record of a subsequent placement according to the Placements data.

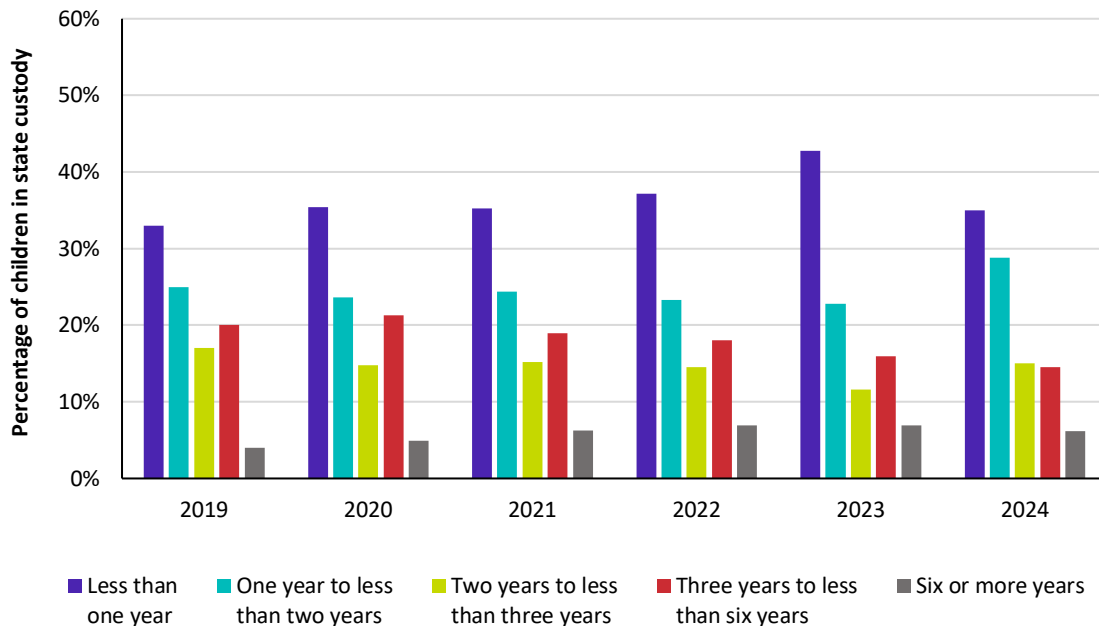
¹⁶ Percentages may not add up to 100 due to rounding.

C. Duration of Current Episode in State Custody

Of all children in state custody on December 31, 2024 (2,073), 35 percent had been in state custody for less than one year (735), 29 percent had been in state custody for one to two years (597), 15 percent had been in state custody for two to three years (312), and 21 percent had been in state custody for more than three years (429), as shown in Figure 2.

The amount of time children had spent in custody by the end of the reporting year remained consistent between 2019 and 2024, with one notable exception: the percentage of children who had been in state custody for fewer than two years by the end of the reporting period increased by six percentage points between 2019 (58%, 1,288) and 2024 (64%, 1,332), and the percentage of children who had been in state custody for two or more years decreased by six percentage points between 2019 (42%, 924) and 2024 (36%, 741).

Figure 2: Duration of Current Episode in Care for Children in State Custody as of December 31¹⁷
N = 2,212 children in 2019; 1,984 children in 2020; 1,781 in 2021; 1,719 in 2022; 1,942 in 2023; and 2,073 in 2024



Source: Analysis of Sandbox Dec31 files

¹⁷ Percentages may not add up to 100 due to rounding.

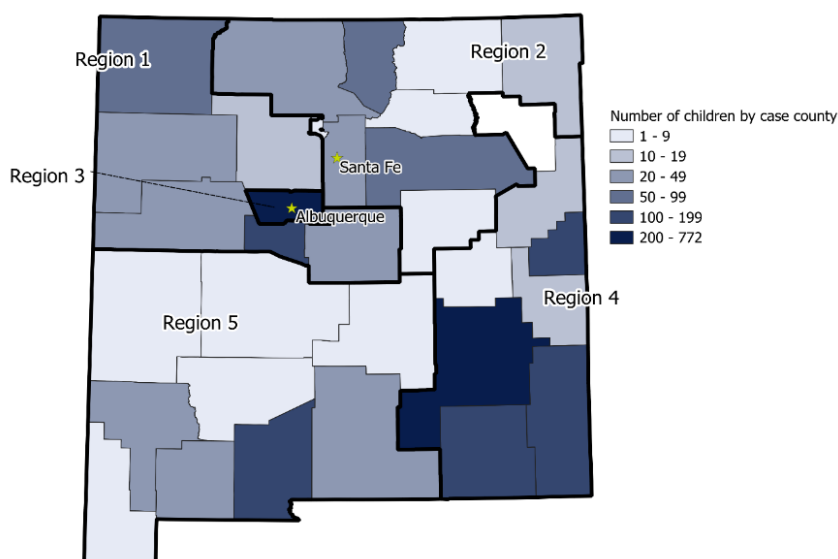
D. Geography

As of December 31, 2024, over one-third of children in care (37%) were from Region 3 (Bernalillo County). Fourteen percent of children were from Region 1 (Northwest), 11 percent of children were from Region 2 (Northeast), 26 percent of children were from Region 4 (Southeast), and 12 percent of children were from Region 5 (Southwest). Seventy-one percent of children were placed in their home region on December 31, 2024 (1,473). A total of 105 children were placed out of state (5%), including 21 children in residential settings and 84 children in family-based settings.¹⁸

Figure 3 shows the number of children in state custody on December 31, 2024 by county. Twelve counties had 10 or fewer children in care.¹⁹ Seven counties had 100 or more children in care.

Figure 3: Children in State Custody on December 31, 2024, by Case County

N = 2,073 children



Source: Analysis of Sandbox Dec31 files

¹⁸ There were 194 children who were not in an out-of-home placement on December 21, 2024, including 122 children on Trial Home Visit, 51 children who were missing or had run away, 10 children in detention, seven children who were in an acute hospitalization, and four children in Protective Supervision.

¹⁹ Harding County had no children in state custody on December 31, 2024.

E. Federal Permanency Goals and Legal Status²⁰

Of the children in care on December 31, 2024, 1,179 children (57%) had a federal permanency goal of reunification. The rate of children with a goal of reunification has steadily increased since 2019 (40% in 2019, 43% in 2020, 45% in 2021, 49% in 2022, and 56% in 2023), while the percentage of children in state custody with a federal permanency goal of adoption has decreased since 2019 (51% in 2019 and 31% in 2024).²¹

**Table 5: Federal Permanency Goals for Children in State Custody on December 31
2022 - 2024**

Federal permanency goal	2022		2023		2024	
	N	%	N	%	N	%
Reunification	844	49%	1,089	56%	1,179	57%
Adoption	657	38%	582	30%	642	31%
Guardianship	134	8%	133	7%	168	8%
Planned permanency living arrangements ²²	44	3%	45	2%	64	3%
Unknown	40	2%	90	5%	19	1%
Live with other relative(s)	0	0%	3	<1%	1	<1%
Total	1,719	100%	1,942	100%	2,073	100%

Source: Analysis of Sandbox Dec31 files

²⁰ In previous reports, the Co-Neutrals reviewed data from the State showing the legal status of children in state custody on December 31 of the reporting year. The Co-Neutrals did not include this information this year due to concerns about the accuracy of the State's data.

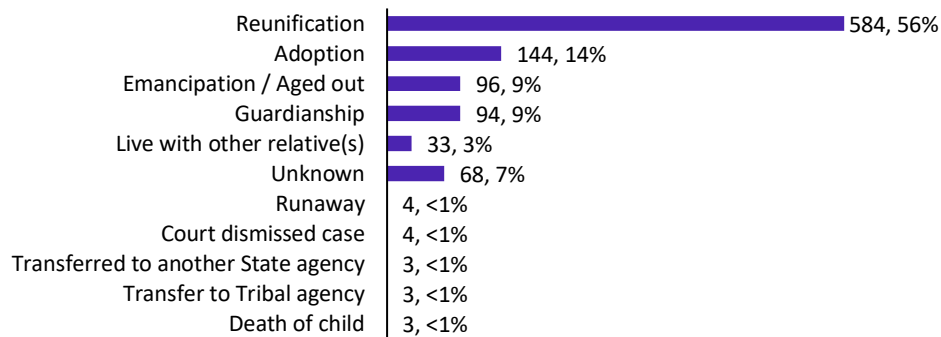
²¹ The Co-Neutrals' analysis of 2019-2024 *Cohort Exits* files, submitted by CYFD on March 31, 2022 (2019 and 2020), May 2, 2022 (2021), May 1, 2023 (2022), June 27, 2024 and August 8, 2024 (2023), and June 18, 2025 (2024).

²² In previous years, the data submitted by the State referred to this permanency goal as "long term foster care." In the data submitted by the State on June 18, 2025, the name for this permanency goal was "planned permanency living arrangements."

F. Exits from State Custody

Figure 4 shows the rate of exits from care by exit type for 2024. Most children (56%, 584 exits) who exited state custody in 2024 exited to reunification with family, followed by adoption (14%, 144 exits). In 2019, reunification and adoption accounted for 90 percent of all exits, while in 2024, reunification and adoption accounted for 70 percent of all exits. The distribution of other exit types is similar to prior years.

Figure 4: Exits from State Custody, by Exit Type^{23, 24}
2024, N=168



Source: Analysis of Sandbox Exits files

²³ Includes children who aged out of the cohort and entered Extended Foster Care.

²⁴ The Sandbox Cohort Exits file submitted by the State on June 18, 2025, was missing exit reasons for five discharges. There were 63 discharges from care with exit reasons listed as “Discharge/No Further Agency Spvrns/Jusris.”

IV. Discussion of Performance

A. FSA Section VI: Process

i. Data Validation Plan (DVP)

Section IV of the FSA requires the State to complete a written Data Validation Plan (DVP) that is approved by the Co-Neutrals. According to the FSA, the DVP should “set forth a process, including methodology and data sources, for validating Defendants’ progress toward achieving the Implementation Targets and Target Outcomes.” The DVP must also “set clear timelines for taking any intermediary steps necessary to validate progress towards the Implementation Targets and Target Outcomes and assign responsibility for supplying information necessary to fulfill the Data Validation Plan.”²⁵

The Co-Neutrals and State collaboratively developed the DVP throughout 2020 and 2021, and the Co-Neutrals approved the DVP on February 16, 2022. The DVP provides key methodological definitions, detail about core data systems and processes (including planned system changes to strengthen data collection), and presents a set of quantitative and qualitative metrics to help the State manage, and the Co-Neutrals assess and validate, progress. For each quantitative metric, the DVP specifies the data and methodology that will be used to calculate the metric for each reporting period to ensure that the State and the Co-Neutrals are working with a shared understanding of the State’s performance. For commitments that cannot be measured strictly by quantitative measures, qualitative instruments and methodologies are necessary to assess and report performance. For some items, both quantitative metrics and qualitative methodologies are necessary for a complete assessment.

The State has not developed many of the required qualitative instruments to be reviewed and approved by the Co-Neutrals.²⁶ These multi-year delays have resulted in no performance data being available for numerous qualitative metrics in 2022, 2023, and 2024, and it is very likely these delays will impact the availability of 2025 performance data for some if not all of the outstanding qualitative metrics.

As anticipated, the DVP has evolved as implementation has proceeded, and the State has made adjustments to practice and improvements to its systems and data collection practices. The Co-Neutrals worked with the State in early 2025 to modify the DVP to create clearer guidelines for calculating certain performance metrics.²⁷ The Co-Neutrals will continue to identify proposed modifications each year and to assess whether to approve changes after consultation with each party.

²⁵ FSA, pg. 6.

²⁶ Although the Co-Neutral team provided the State with options for these instruments and methodologies in the summer of 2023, the State has not, as of the writing of this report, submitted a proposed plan to the Co-Neutrals for approval.

²⁷ The approved DVP, as revised and agreed upon in March 2025, can be viewed [here](#).

ii. Production of Data

The FSA requires the State to submit all data required to validate the TOs for the previous reporting period by May 1st each year, and to submit data used to calculate baseline metrics concurrently with those reports.²⁸ Due to the timing of changes in the State’s data contractors, the State requested, and the Co-Neutrals approved, an extension of the deadline to submit 2024 data from May 1, 2025 to May 15, 2025. The May 15th submission consisted of cohort files, which show information on all children who were in state custody at any point in 2024, but not all required data. The State submitted the rest of the required data – consisting of non-cohort information, such as all licensed and active foster care providers, all State staff, and all case worker visits and IPP meetings – on June 2, 2025.

The Co-Neutral team identified many data quality issues in each of these submissions, including missing or inconsistent information about children’s placements and episodes. Documentation that the State submitted to the Co-Neutrals showed that many of these issues were ones the State identified in their own data quality checks but could not correct before the May 15th deadline. The State resubmitted data several times after June 2, 2025, based on feedback from the Co-Neutrals. The State submitted its final versions of most of the required files on June 18, 2025, but the State continued to revise and resubmit data in July and August.^{29,30}

The Co-Neutral team conducted extensive qualitative reviews of children’s records and identified discrepancies between information in children’s case records and the State data reported from its FACTS system for 2024. There were some areas in which the State was able to correct discrepancies in its data submissions, some areas in which the data issues were limited enough that validation was still possible, and some areas in which the issues precluded any validation. Further detail is provided in the discussion of performance throughout this report. The Co-Neutrals continue to work with the State and the State’s data partners to improve the quality, completeness, and consistency of the data submitted for validation.³¹

²⁸ The FSA requires the State to collect data to assess new system practices that were not previously recorded, and to use this data in new and different ways to assess the experiences of children in state custody within both the foster care system and the broader health continuum. In 2024, the State continued to develop the capacity to do this work, aided by a new external contractor (Resilient Solutions 21, or RS21) that assumed responsibility for the yearly FSA-required data production in March 2025. With RS21’s support, the State is committed to improving its data production and reporting processes in order to, among other things, prevent the delays and data quality issues described above.

²⁹ Although several quality issues remained in these data files, to avoid further delays to the validation process, the Co-Neutrals utilized these files for their performance calculations.

³⁰ On July 8, 2025, the State submitted an updated list of licensed and active foster care providers and a list of CAT/CANS screenings shared with the court and with MCOs. On July 22, 2025, the State submitted updated information on HCA’s efforts to administer trauma-responsive training to staff as well as information on traditional medicine benefits for ICWA-eligible children. On August 12, 2025, the State submitted a revised list of active State staff as well as updated information on the legal status of all children in state custody.

³¹ The structured reports produced by RS21 and submitted for validation are referred to as “Sandbox” files.



iii. Production of Reports

Section VI, paragraph C of the FSA requires the State to produce an annual written report of their progress with respect to the Target Outcomes and Implementation Targets. On August 1, 2025, the State produced its Annual Report for 2024. The report is available to the public on the State’s website.³² In many instances, the Co-Neutrals found that significant sets of the data published in the State’s August 1, 2025 report was inaccurate. The Co-Neutrals have not relied on that report meaningfully in the production of this report.³³

iv. Parties’ Meetings

The FSA requires the Co-Neutrals to “preside over a meeting between the parties at least twice a year” and stipulates the Co-Neutrals and the parties “must make every effort to have the first Parties’ Meeting no later than 30 Days after the State publishes its annual *Kevin S.* report, and the second meeting no later than 30 Days after the Co-Neutrals publish their *Kevin S.* annual report.”³⁴ The parties have the ability to provide comments on the Co-Neutrals’ annual reports prior to the second meeting.

The Co-Neutrals presided over an in-person parties’ meeting in Santa Fe on January 18, 2024. No additional parties’ meetings were scheduled in 2024 due to the parties’ involvement in arbitration. Arbitration hearings occurred throughout November 2024, including before and after the Co-Neutrals released their 2023 Annual Report on November 15, 2024.

B. FSA Appendices

i. Appendix A: Trauma-Responsive System of Care

The commitments in Appendix A of the FSA require CYFD and HCA to “build and support a trauma-responsive system of care for all Children in State Custody.”³⁵ The preamble language in Appendix A describes a trauma-responsive system as one that:

- Identifies, recognizes, understands the effects of trauma, and provides sufficient services and supports to ameliorate trauma, including secondary trauma;
- Supports and serves other stakeholders, including families and people who work for or on behalf of children, youth, and families;
- Includes culturally appropriate services and supports; and
- Incorporates a child’s voice in timely decision making about where and with whom they should live and what services they should receive.

Appendix A commits the State to building a trauma-responsive system of care to ensure children’s needs and strengths are identified as early as possible, and to offer trauma-responsive services

³² The 2024 State of New Mexico Annual Report can be found [here](#).

³³ For example, see reported performance for App. B, TO 8.1 – *Placement Stability* and App. B, TO 9.1 – *Achieving Permanency*.

³⁴ FSA IV, C.

³⁵ FSA, pg. 1a.



such that children can receive the supports they need without unreasonable delay.

Further, a trauma-responsive system “should utilize collaborative decision-making to identify strengths and needs and to develop an individualized plan for the child” and relies on “accurate, complete, and relevant evidence-based quality management tools and measures [that] are necessary for the State to implement and refine a trauma-responsive system of care.”³⁶

In 2024, the State continued to struggle to meet all commitments in Appendix A. Less than half (39%) of all children in state custody during the year received a Child and Adolescent Needs and Strengths (CANS) screening, and 22 percent received a Crisis Assessment Tool (CAT) screening.³⁷ Of all children who were in custody for at least 45 days or longer in 2024, only 11 percent had both a CAT and CANS screening completed. The parties intended these screenings to provide information to the child’s team to assist in identifying children’s service and treatment needs, and to assess children’s well-being and functioning over time. However, data show the overwhelming majority of children who entered state custody in 2024 did not receive CAT and CANS screenings. For the small number of children who received a CANS screening following entry, qualitative reviews showed gaps between information documented in the child’s FACTS case record and the child’s CANS screening scores, demonstrating a need for training and practice changes to improve the quality of the screenings. Interviews between workers and the Co-Neutral team also revealed that many case workers do not understand how the CAT and CANS screenings impact case planning, nor do they see them being used in courts or other places to drive decision making. Workers also cited that the screenings are cumbersome and require too much time to complete given their high caseloads. Lastly, concerns over the unavailability of behavioral health services recommended by the CANS screenings may have impacted staff’s willingness to complete the screenings. Of all the specific evidence-based practices (EBPs) defined in the FSA, Medicaid billing data showed only 79 individual children in state custody (3%) received either High-Fidelity Wraparound (HFW), Multi-Systemic Therapy (MST), Mobile Crisis Response (MCR), or Functional Family Therapy (FFT) interventions in 2024, which is the lowest utilization data reported by the State for these specific trauma-responsive services since 2019.

Additionally, the State’s Medicaid billing data show no services were provided to children in 2024 using the EBP-specific billing modifiers for the other services specified by the FSA, specifically, Dialectical Behavior Therapy (DBT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Eye-Movement Desensitization and Reprocessing (EMDR).

Seventy-three percent of the CYFD staff required to complete trauma responsive training did so as of December 31, 2024. Approximately one-quarter (27%) of resource parents completed both modules of the required trauma training by December 31, 2024.

Between July and December 2024, the Co-Neutral team interviewed 104 case workers and

³⁶ Ibid.

³⁷ The CANS is a widely used tool in various social service jurisdictions across the country. New Mexico worked with the developer of the CANS – the Praed Foundation – to develop a CANS specific to the needs of New Mexico CYFD. The CAT was also specialized to the needs of New Mexico, and was created from a subset of specific CANS domains and items.

supervisors who completed the trauma-responsive training and asked about their experience. Overall, staff interviewed reported that the information was helpful to them in their work with children and families, and offered information relevant to understanding the impact of trauma and the importance of de-escalating children’s crises and conflicts. Some staff identified a need for additional training that provides more case-specific examples of what they should do, as well as a desire for additional techniques to manage the secondary trauma experienced by many staff.

Consistent with the State’s 2023 performance, implementation of the State’s Quality Assurance, Improvement, and Evaluation Plan (QAIEP) was primarily stalled in 2024 due to significant staff turnover.

a. *Implementation Targets*

In prior reports, the Co-Neutrals assessed the State had met the Performance Standard for all the Appendix A ITs.³⁸

b. *Target Outcomes*

Completing Indicated Screenings (App. A, TO 1)

FSA Requirement	By December 1, 2021, every Child in State Custody will receive the screenings indicated below. CYFD and HCA will identify, and Co-Neutrals must approve, the form of the Child and Adolescent Needs and Strengths Crisis Assessment Tool (“CANS-CAT”) and comprehensive CANS screening tools to be used. CYFD will ensure that every Child in State Custody receives the indicated screenings and will provide the results of the indicated screenings to HCA (through its MCOs and/or their successors). ³⁹ HCA will ensure that MCOs and/or their successors have capacity to provide indicated screenings. (Due December 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

The Co-Neutrals approved the State’s Crisis Assessment Tool (CAT) and Child and Adolescent Needs and Strengths (CANS) screening tools on March 2, 2021, in fulfillment of FSA commitment App. A, IT 1.1 – *Establish Child and Adolescent Needs and Strengths and Functional Trauma Assessment Criteria*. The CAT and CANS screenings are intended to capture, synthesize, and communicate information about children and their functioning across various life domains, such as child development or education. The CANS consists of 11 domains, while the CAT is comprised of five domains. The domains collectively assess a child’s needs and strengths based on their chronological age by assessing a wide range of specific items. Some items or domains, such as the Independent Living domain, are only applicable for youth of a certain chronological age. CAT and

³⁸ A list of all ITs for which the State previously met the Performance Standard can be found in Appendix ii. *FSA Implementation Targets and Target Outcomes Met in Prior Reporting Periods*.
³⁹ Managed Care Organizations (MCOs) are organizations responsible for implementing HCA’s Turquoise Care contracts. Additional information about Turquoise Care and the MCOs can be found [here](#).

CANS screenings can help identify a range of supports that might be necessary to meet the needs of children, including specific behavioral health services, that can be used to guide the child’s CYFD treatment plan while in state custody.

CYFD’s requirements for completion of CAT and CANS screenings are outlined in Procedure 17 of CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC).⁴⁰ The procedure requires all children to have a completed CAT screening after an abuse or neglect petition has been filed that must be filed with the court prior to the child’s 10-day hearing. CANS screenings are required to be completed within 45 days of the child’s removal from the home, and children must be reassessed before each court hearing (or within six months, whichever comes first) to assess progress in treatment or to adjust services and supports as results may indicate. CANS screenings must also be completed any time there is an identified change in behavior or a significant life event, and upon discharge from CYFD custody. CAT screenings are to be completed by investigators, while CANS screenings are typically completed by permanency coordinators (PCs), but may be completed by any CANS-certified PSD worker such as a Community Behavior Health Clinician (CBHC).^{41,42} To administer the screenings, staff are required to be trained and subsequently certified to complete CAT and CANS screenings, and are required to take ongoing training to maintain certification each year.⁴³

On July 1, 2024, HCA’s Turquoise Care MCO contracts went into effect with Presbyterian Health Plan (PHP) as the sole MCO serving children in state custody.^{44,45} PHP is required to maintain two CANS-certified trainers responsible for training the care coordination staff as well as others in the organization on the CAT and CANS screenings. The care coordinator is responsible for utilizing completed screenings to inform a child’s Comprehensive Needs Assessment (CNA) and Comprehensive Care Plan (CCP), which identify and guide the services they receive.

DVP Metrics and Validated Performance Data

ATO1(ii) – primary metric: For all episodes of custody longer than 45 days that occurred within or overlapped with the reporting year, the percent for which a screening was conducted using the CANS screening tool.

The Co-Neutrals’ analysis of the State’s data shows that CANS screenings were completed for

⁴⁰ CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC) can be found [here](#).

⁴¹ In 2024, CYFD renamed the position of Permanency Planning Workers (PPWs) to Permanency Coordinators (PCs).

⁴² A CBHC is a behavioral health clinician who works with CYFD staff to provide clinical behavioral health consultation and review for children involved with CYFD’s Juvenile Justice (JJ) or Protective Services Division (PSD) programs.

⁴³ CYFD provides CANS training for staff, but the CANS certification exam and certificate is issued by the Praed Foundation. The Praed Foundation maintains a variety of tools that support the Praed Foundation’s Transformational Collaborative Outcomes Management (TCOM), including the CANS. Additional information about the Praed Foundation can be found [here](#).

⁴⁴ Most children in state custody eligible for Medicaid are served by PHP. Native children in state custody can choose which MCO they want to enroll in, or they can remain Fee For Service.

⁴⁵ Additional information about PHP can be found [here](#).

1,044 of the 2,651 episodes of children’s custody (39%) that occurred within or overlapped with 2024.^{46,47,48}

ATO1(iii) – primary metric: For all episodes of custody longer than 10 days that occurred within or overlapped with the reporting year, the percent for which a screening was conducted using the CAT screening tool by December 31 of the reporting year.

The Co-Neutrals’ analysis of the State’s data shows that CAT screenings were completed for 616 of the 2,770 episodes of children’s custody (22%) lasting longer than 10 days that occurred within or overlapped with 2024.

As additional information, the Co-Neutrals analyzed the number of children who newly entered custody in 2024 and who were in care for longer than 10 days in 2024 to determine the number of CAT screenings completed timely during the year, and found that CAT screenings were conducted within 10 days of a child’s removal from home for 90 (11%) of the 841 eligible episodes of custody.⁴⁹

The Co-Neutrals also examined the number of episodes of children’s custody during which a child received both CAT and CANS screenings. Of the 2,651 episodes of children’s custody that were longer than 45 days, 1,328 (50%) had no screenings completed during the episode (see Figure 5). Of these 2,651 episodes of children’s custody, 279 had only CAT screenings completed during the episode (11%), 742 had only CANS screenings completed during the episode (28%), and 302 had both a CAT and CANS screening completed during the episode of custody (11%).

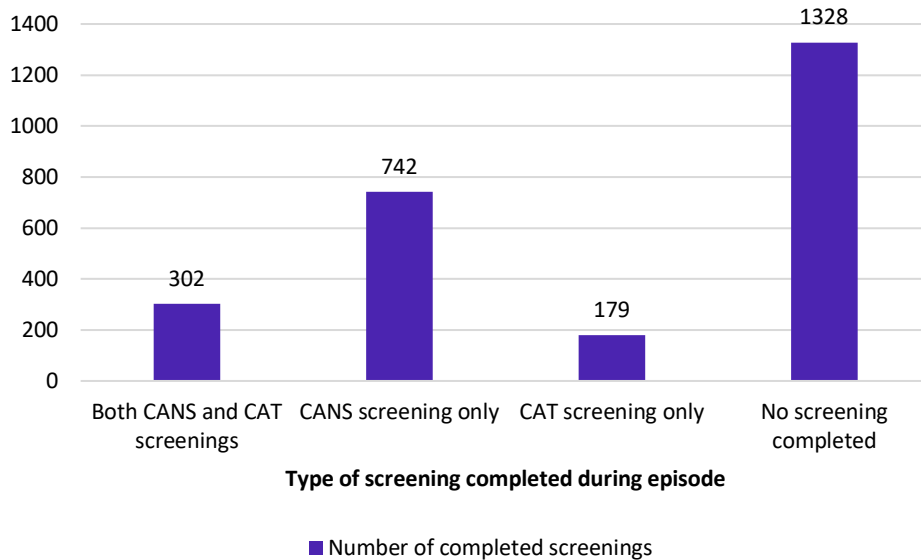
⁴⁶ There were 3,096 total CANS screenings conducted, of which 1,044 were counted for this metric. In accordance with the DVP, the remaining 2,052 were not counted because either they were completed outside of an eligible episode of custody, they were one of multiple CANS screenings conducted during the same episode of custody, or they involved an older version of the CANS screening instrument.

⁴⁷ Several commitments set goals for how the State should respond to entries into state custody, regardless of how many times a child has entered or exited state custody during the reporting year. For instance, App. A, TO 1 requires that all children receive a CANS screening within 45 days of each of their entries into state custody during the reporting year. Since some children experience more than one episode in state custody each year, the data analysis for this and other commitments focuses not just on children but on all their episodes of custody.

⁴⁸ Episodes of children’s custody were determined to be eligible for CANS screening if they were longer than 45 days and occurred within or overlapped with the reporting year. Episodes that reached their 46th day after the end of the reporting period were not counted.

⁴⁹ Eligible episodes were new episodes of custody that began in the reporting year and were longer than 10 days. Episodes that had lasted less than 10 days as of the end of the reporting year were not counted.

Figure 5: Screenings Completed for Children in State Custody for Episodes Longer Than 45 Days 2024



Source: Analysis of Sandbox EpisodesOfCustody and Screenings files

ATO1(iv) – primary metric: For all CANS screenings completed and approved by CYFD during the reporting year, the percent provided to the child's MCO or other care coordinating provider or entity within five business days.

Throughout 2024, CYFD did not share the results of the CANS screening with the MCO, which severely undermined care coordination for children. Of the 774 eligible CANS screenings completed during 2024, results for five screenings (<1%) were shared with a child's MCO. Performance remains unchanged from 2023, when two of the CANS screenings results (<1%) were shared with MCOs.

ATO1(v) – primary metric: For all CAT screenings conducted during the reporting year, the percent for which results were provided to the child's MCO or other care coordinating provider or entity within five business days.

CYFD did not share the results of CAT screenings with the MCO, which severely undermined care coordination for children. Of the 241 eligible CAT screenings completed during 2024, none (0%) were shared with a child's MCO.⁵⁰ This is the same rate as in 2023 and 2022.

⁵⁰ CAT screenings were eligible if they were completed and approved by CYFD during the reporting year, during a child's episode of custody, and during a child's time with an MCO.

ATO1(i) – qualitative metric: Qualitative review of practice used to identify and address child’s trauma-related needs.⁵¹

To collect qualitative data for this commitment, the Co-Neutral team and CYFD’s Office of Performance and Accountability (OPA) collaborated to complete a qualitative review of completed CANS and CAT screenings available in BHSD STAR and FACTS.^{52,53} The purpose of the reviews was to assess the quality of completed CANS screenings for children who entered state custody from January 1, 2024 through November 15, 2024 and remained in custody for at least 45 days. In total, a sample of 60 completed CANS screenings involving 60 unique children were reviewed.⁵⁴ The CAT screenings for 33 children were reviewed by a team of CYFD Quality Assurance Specialists, a CYFD Behavioral Health Services (BHS) program support specialist, OPA leadership, and Co-Neutral staff to assess the quality of the CAT screenings.

The review consisted of two parts: part one focused on basic process requirements (e.g., timeliness of completed screenings, whether recommendations were made, etc.) while part two consisted of a test-retest process. To complete the test-retest, reviewers completed case reviews of children’s FACTS records up to the date the CANS or CAT screening was completed, and then completed an independent CANS or CAT screening based on the information documented in the record in accordance with the CANS and CAT Reference Guides.⁵⁵ The retest scores are based only on the child’s case record, whereas the test scores may be based on additional information known to the worker that is not documented in FACTS. Based on the findings of the test-retest, quality of practice was measured using a four-point scale to rate the overall quality of screenings completed by CYFD staff.

Quality of practice scores range from “0” to “3,” with a rating of “0” meaning that actions are not necessary to strengthen practice around the CAT and CANS screenings and a rating of “3” meaning that actions are immediately necessary to strengthen practice. Specifically, a score of “0” indicates that all CAT and CANS process-related requirements were followed (e.g., CAT completed prior to CANS, 10-day CAT and 45-day CANS guidelines followed, referrals made based on CANS recommended services, screenings fully completed including ‘notes’ section, etc.), and that the screenings accurately reflect the current status of the child based on documentation found in the FACTS record. Conversely, a score of “3” indicates that no CAT and CANS process-related

⁵¹ This qualitative metric is used to validate multiple related commitments, specifically, App. A, TO 1; App. A, TO 1.a; App. A, TO 1.b; App. A, TO 1.c; App. A, TO 2.1; App. A, TO 2.2; and App. A, TO 2.3.

⁵² Additional information about OPA can be found [here](#).

⁵³ BHSD STAR is the database used by CYFD to track and record all CANS and CAT screenings for children in state custody; it is managed by Falling Colors.

⁵⁴ The CANS sample was statistically significant, representing a 95% confidence level with a 10% margin of error. CANS samples for 2022 and 2023 were not statistically significant due to data issues.

⁵⁵ The CAT Reference Guide can be found [here](#). The CANS Reference Guide can be found [here](#). As described within the guides, each domain consists of a number of items for which a CANS-certified worker scores as a 0, 1, 2, or 3, or as a “yes” or “no.” A score of a 0 or 1 indicates *no action is currently necessary* to either meet a need (needs-based scale) or to build up and/or identify a strength (strengths-based scale). A score of 2 or 3 indicates *an action is necessary* to either address the need or to build up and/or identify a strength. The Individual Strengths domain assesses on a strengths-based scale, while the other domains reviewed assess on a needs-based scale.

requirements were followed (e.g., CAT not completed or completed after CANS, 10-day CAT and 45-day CANS guidelines not followed, no referrals made, no notes completed, etc.), and that the screening scores are inaccurate based on documentation found in the FACTS record. A score of “1” indicates that some practice areas warrant on-going monitoring but that no actions are necessary to strengthen practice, while a score of “2” indicates that non-immediate actions are necessary.⁵⁶

CAT Test-Retest

Two specific CAT domains were reviewed for the test-retest: Child Protection and Life Functioning. The test-retest showed general alignment in both domains, with screening scores matching in 79 percent (4 out of 5) of items in the Child Protection Domain, and in 80 percent (5 out of 6) of items in the Life Functioning Domain. In most cases, retest scores were lower than the test scores, meaning reviewers were less likely to observe evidence of a need when compared to initial ratings.

One CAT screening was scored by a reviewer as “0,” meaning that all CAT process-related requirements were completed (e.g., CAT completed prior to CANS; 10-day CAT screening guidelines were followed), and that the screening scores accurately reflected documentation in the FACTS case record and were aligned with guidance from the CAT Reference Guide. The majority of CAT screenings (82%, 27 screenings) had a quality of practice score assigned by reviewers of “1,” showing a need for on-going monitoring to determine if interventions are needed to improve CYFD staff practice in completing the screenings with fidelity to the model. Five CAT screenings received quality of practice scores of a “2” or “3,” showing that interventions such as additional training or improved case documentation are needed to improve the quality of the CAT screenings.

Table 6: CAT Quality of Practice Scores
2024

Quality of Practice Score	Number of CAT Screenings Reviewed	Percent of CAT Screenings Reviewed
0 – No Intervention Needed to Improve Practice	1	3%
1 – Monitor for Potential Intervention Needed to Improve Practice	27	82%
2 – Intervention Needed to Improve Practice	2	6%
3 – Immediate Intervention Needed to Improve Practice	3	9%
Total CAT Screenings Reviewed	33	100%

Source: 2024 OPA CANS/CAT Qualitative Review

CANS Test-Retest

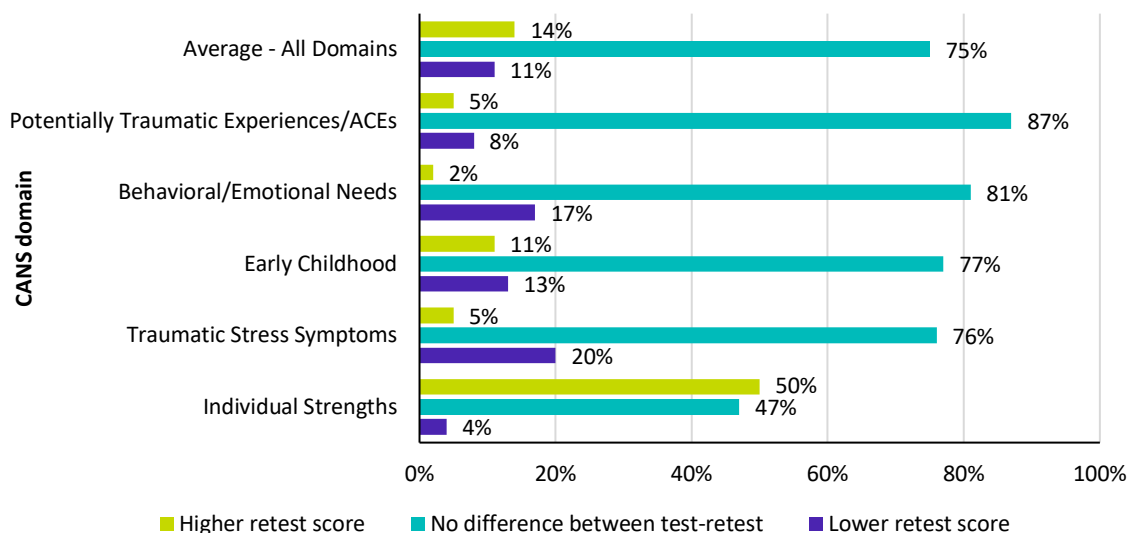
Five CANS domains were reviewed for the test-retest: Individual Strengths, Traumatic Stress Symptoms, Behavioral/Emotional Needs, Potentially Traumatic/Adverse Childhood Experiences

⁵⁶ The quality of practice score scale was jointly developed by the Co-Neutral team and OPA, and mirrors the four-point needs-based scale used in CAT and CANS screenings.

(ACEs), and Early Childhood. Items in the Early Childhood domain are applicable for children aged birth to five, while the Individual Strengths and Traumatic Stress Symptoms domains are for children aged six and older. The Behavioral/Emotional Needs and Potentially Traumatic/ACEs domains are applicable to children of all ages.

There was moderate alignment across all domains, with no change between the test scores assigned by the CYFD staff when completing the CANS and retest scores assigned by reviewers in 75 percent of items rated (see Figure 6). The test-retest demonstrated misalignment within the Individual Strengths domain, with less than half (47%) of all retest scores assigned by reviewers aligned with the test scores assigned by the CYFD staff when completing the CANS (compared to 50% in 2023). The majority of retest scores in this domain were higher, showing a discrepancy between documentation of a child’s strengths in the FACTS case record and scores based on the CANS Reference Guide. Reviewers were more likely to assign lower scores in Traumatic Stress Symptoms domain, showing a discrepancy between the documentation of a child’s symptoms in the FACTS case record and the score recommended based on the CANS Reference Guide.

Figure 6: Difference in CANS Screening Test-Retest Scores⁵⁷
2024; N = 60 CANS screenings



Source: 2024 OPA CANS/CAT Qualitative Review

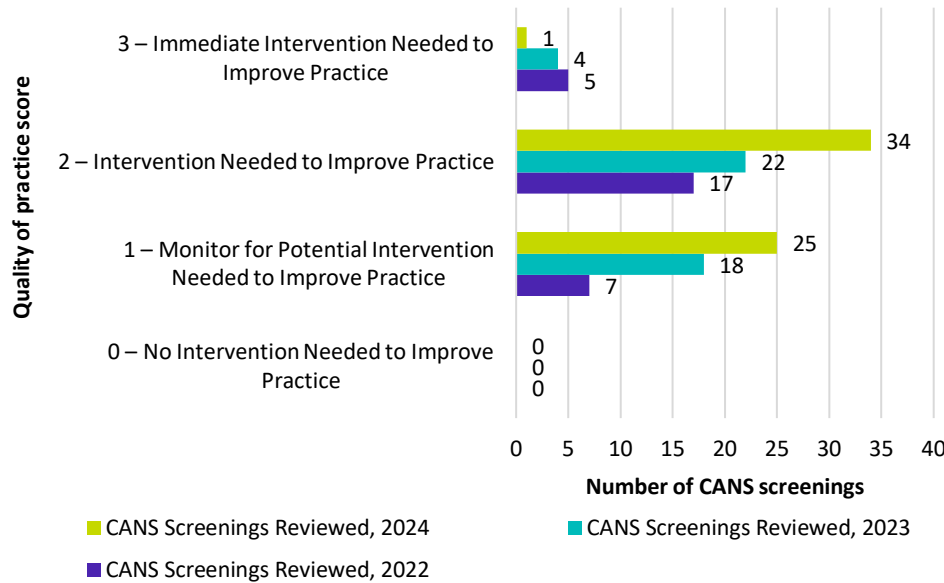
Over half of CANS screenings (57%, 34 screenings) received a quality of practice score of “2,” demonstrating that the majority did not follow basic process requirements and showed discrepancies between the CANS screening scores, information in the FACTS case record, and the CANS Reference Guide. There was a decrease in the number of CANS screenings with a quality of practice score of “3” compared to 2022 and 2023, meaning that an immediate change is needed to improve CANS practice. Consistent with prior years, no CANS screenings received a score of “0,” meaning there were no issues that require on-going monitoring or a change to improve the quality

⁵⁷ Percentages do not total 100 due to rounding.

of the CANS screenings.

Figure 7: Overall Quality of Practice Ratings for Completed CANS Screenings

2022 - 2024; N=29 CANS screenings in 2022; N=44 CANS screenings in 2023; N=60 CANS screenings in 2024




Source: 2024 OPA CANS/CAT Qualitative Review

Members of the Co-Neutral team spoke with 120 case workers and supervisors across all three case work pillars throughout the state between July and December 2024 and asked about their general experience with the CAT and CANS screenings. Most workers reported they were either currently or previously certified to complete the CANS and CAT screenings. Among the 99 case workers and supervisors who had used the CAT and CANS screenings, fewer than half (46%) stated that the tools had been useful to them in case planning and in their work with children and parents. Some staff shared they appreciated the ability to help identify strengths and needs of a child and family using a more objective, unbiased perspective and to also recommend strategies or services for addressing their needs. However, the majority of case workers and supervisors expressed that the tools were not useful to them and were a burden to complete, viewing them mostly as a required task to check off their list.

Discussion

The State's 2024 performance showed no significant change from prior years' performance for the very low number of screenings completed and shared with the MCOs, and remains well-below FSA requirements and practice expectations for all children in state custody. In 2024, only 39 percent of all children in state custody during the year received a CANS screening, and less than one-quarter (22%) received a CAT screening. Of the screenings that were completed, less than one percent of CANS screenings were shared with the child's MCO, and none (0%) of the completed



CAT screenings were shared.

The test-retest assessment of the qualitative reviews demonstrated alignment in some domains between the FACTS case documentation, the CANS screening scores, and the CANS Reference Guide. The test-retest identified the highest number of discrepancies in the individual strengths domain due to the lack of documentation in the case file to support the CANS screening scores.

The quality of practice scores showed that a majority of a sample of CAT screenings reviewed generally aligned with the instructions in the CAT Reference Guide, with on-going monitoring needed to determine if additional training or other interventions are needed to strengthen CAT screening practice. The majority of CANS screenings reviewed received a quality of practice score of “1” or “2,” demonstrating that some change is needed to strengthen case practice around the CANS screenings.

The CAT and CANS screening tools are an integral part of building the trauma-responsive system envisioned in the FSA. The screenings provide a uniform way to identify a child’s strengths and needs in multiple areas as well as information about the child’s trauma history and potential mental health concerns, and are intended to assist the child’s case worker and team with designing their CYFD treatment plan and to monitor progress over time. The screenings can also identify possible placement supports that can be implemented to increase the stability of a child’s placement. However, case workers largely expressed disdain and apprehension about the screenings, and did not fully understand their utility in work with children and families. It is unknown the degree to which pervasively unreasonable CYFD workloads colored worker’s views about the CATS/CANS screening requirements.

The State’s struggle to implement CAT and CANS screenings as defined in the FSA and in CYFD procedure can cause ripple effects across both HCA and CYFD that negatively impact children in state custody. The lack of a timely CAT or CANS screening may inhibit early identification of needs and referral to services, and can prevent case workers from being able to quickly share their comprehensive knowledge about a child and family with the child and family’s other team members. These team members can utilize the screening results to inform service delivery without having to ask a child or their caregiver to repeat their story and circumstances to yet another service provider, minimizing the risk of re-traumatization. Additionally, the algorithm results of every CANS screening score are to be collectively used by HCA to estimate the number and type of behavioral health services required to meet the needs of children in state custody.⁵⁸ The lack of consistent completed CANS screenings may lead to an underestimation of the services needed throughout the state.

⁵⁸ As identified as part of the State’s App. D, IT 2.1 *Initial Expected Service Utilization Methodology*, which can be found [here](#).

Filing Results of CAT Screenings with the Court (App. A, TO 1a)

FSA Requirement	Results of initial screening using the CANS-CAT will be filed with the court no less than 24 hours before the child’s 10-day hearing. If this deadline falls on a weekend or holiday, the screening results must be filed no less than one business day prior to the 10-day hearing. (Due December 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Paragraph 17 of CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC) states, “Once an abuse and neglect petition has been filed, all children in the case will have a CAT completed by the investigator and filed with the court 24 hours prior to the 10-day hearing.”

DVP Metrics and Validated Performance Data

ATO1.a(i) – primary metric: For all episodes of custody longer than 10 days that began within the reporting year, the percent for which CAT results were filed with the Court no less than two business days prior to a child’s 10-day hearings. If this deadline falls on a weekend or holiday, the screening results must be filed no less than one business day prior to the 10-day hearing.

Of the 481 eligible episodes of children’s custody during the reporting year, there was only one episode (<1%) for which a CAT screening result was documented as filed timely with the courts (no later than two business days before a child’s 10-day hearing or at least one business day if the deadline fell on a weekend or holiday).⁵⁹ Performance is unchanged from 2023 and 2022, when CAT screening results were filed timely with the courts for less than one percent of eligible episodes.

As supporting information, the Co-Neutrals assessed the amount of time it took for completed CAT screenings to be filed with the courts. The one compliant CAT screening was filed on the same day it was completed, which was three business days before the child’s 10-day hearing.

Discussion

Similar to the State’s performance in prior periods, the data show timely filing of completed CAT screenings with the courts did not occur in 2024. In the Co-Neutral team’s discussions with CYFD investigation staff, many staff shared a lack of understanding about how the CAT should fit into their overall work with a child. Staff did not have confidence that the CAT screenings were being used by the court to make decisions at the 10-day hearing, which may make workers less likely to prioritize sharing the CAT screening given other demands on their time.

⁵⁹ Episodes of children in custody must have begun on or after January 1, 2024, lasted longer than 10 days, and ended on or before December 31, 2024. Children’s episodes were eligible if they began and reached their 11th day in the reporting year and had a 10-day hearing during the reporting year.

Comprehensive CANS Screenings (App. A, TO 1b)

FSA Requirement	Comprehensive screening using a CANS-Trauma Comprehensive instrument or a comprehensive CANS assessment instrument with a trauma module will be conducted within 45 Days of removal from the home. Any child discharged from CYFD’s legal custody before these screenings are conducted will be provided a referral for the screenings. (Due December 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Procedure 17 of CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC) requires PSD staff to complete CANS screenings within 45 days of a child’s removal from the home. CANS screenings must also be completed any time there is a change in behavior or a significant life-changing event and upon discharge from CYFD custody, and must be completed before each court hearing (or within six months, whichever is sooner) to reassess progress and needs.

DVP Metrics and Validated Performance Data

ATO1.b(i) – primary metric: For all episodes of custody for children who were removed and remained in State custody for at least 45 days during the reporting year, the percent for which an approved screen was conducted using the CANS within 45 calendar days of removal from home. The metric will exclude children who both did not receive this screening and who were discharged in less than 45 calendar days.

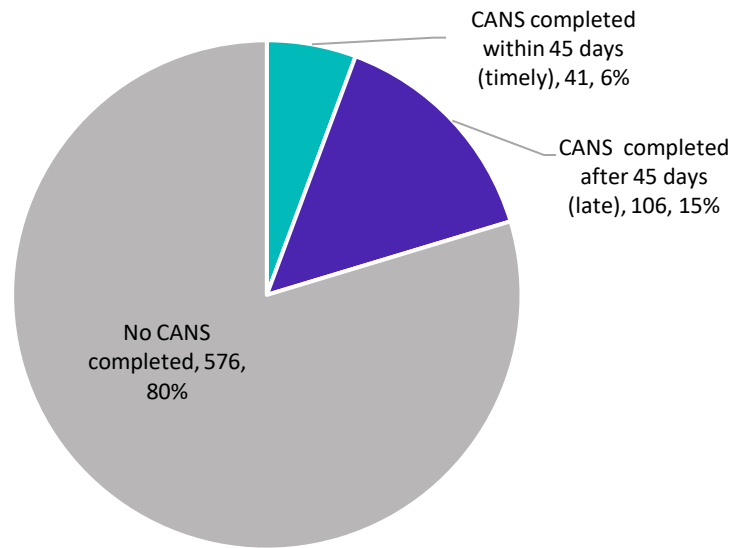
CANS screenings were conducted timely (within 45 days of a child’s removal from home) for 41 of the 723 eligible episodes of custody (6%) (see Figure 8).⁶⁰ Performance is relatively unchanged from 2023, when CANS screenings were conducted timely for 45 of 827 eligible episodes of custody (5%). For 576 episodes, there was no record of a completed CANS screening (80%). For the remaining 106 episodes, a CANS screening was completed outside of the 45-day window (15%). Of these 106 “late” episodes, 28 were completed within 46 to 60 days, and 23 were completed within 61 to 90 days.

As supporting information, the Co-Neutrals assessed the average time for a CANS screening to be completed after a child is removed from their home.⁶¹ The average time for a CANS screening to be completed, timely or not, during an episode of children’s custody was 82 days. The average for CANS screenings considered timely was 23 days, and the average for CANS screenings considered late was 106 days (see Figure 9).

⁶⁰ Eligible episodes were new episodes of custody that began and reached their 45th day in the reporting year. Episodes that began before 2024 or had lasted fewer than 45 days as of the end of the reporting year were not counted.

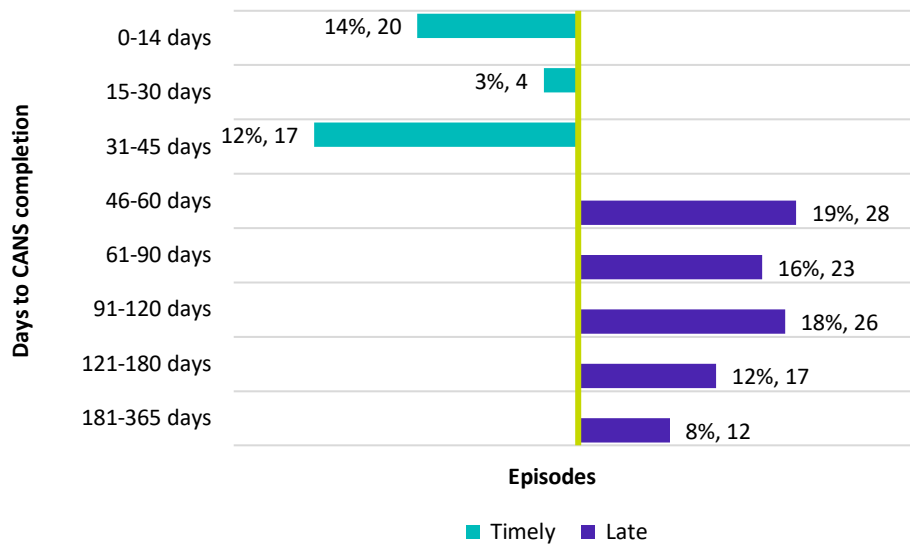
⁶¹ If there was more than one CANS screening conducted within the same eligible episode of custody, the first CANS screening was used to assess the average time to screening.

Figure 8: Timely Completion of CANS Screenings, by Episode
N = 723 episodes of custody that began in 2024 and lasted at least 45 days



Source: Analysis of Sandbox EpisodesOfCustody and Screenings files

Figure 9: Days Between a Child's Entry and CANS Completion
N=147 episodes of children's custody



Source: Analysis of Sandbox EpisodesOfCustody and Screenings files

ATO1.b(ii) – primary metric: For all episodes of custody for children who were removed during the reporting year and discharged within 45 days without a CANS screening conducted, the percent whose family received a referral for the CANS screening.

The Co-Neutrals were unable to validate 2024 data for this requirement because this metric relies on a data collection process that the State was not using consistently in 2024. In 2022, the State embedded a survey tool into FACTS to collect information on referrals for services, but the State reported that very few of these surveys had been completed in 2023 and 2024. Data from this survey tool or an alternative source will be necessary to validate this metric for 2025.

Discussion

As in prior years, CYFD did not administer timely CANS screenings for the vast majority of children who newly entered state custody in 2024. Performance in 2024 (6%) is relatively unchanged from 2023’s performance (5%), is lower than the percentage of timely CANS completed in 2022 (10%) and is far below the standard of all children receiving CANS screenings within 45 days of entry into custody required by the FSA and CYFD’s procedure. Despite CYFD’s efforts to provide additional CANS training to staff in 2024, 80 percent of 2024 children’s entries into custody did not receive a CANS screening during the year. The lack of completed CANS screenings is likely impacted by the frequent turnover and number of vacancies for case workers across CYFD. In interviews with the Co-Neutral team, case workers reported failing the certification test multiple times, which prevents them from completing CAT and CANS screenings as initial and on-going certification is necessary prior to completing the screenings. Additionally, case workers identified the length of time it takes them to complete the screenings as another barrier given their high caseloads.

Completing Follow Up Screenings (App. A, TO 1c)

FSA Requirement	Follow up screening indicated by the CANS-CAT, CANS, and/or any other information available to CYFD or HCA, including screening for intellectual and developmental disabilities and/or sexual exploitation, will be conducted immediately where possible and within 10 Days of indication otherwise. Any child discharged from CYFD’s legal custody before these screenings are conducted will be provided a referral for them. (Due December 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

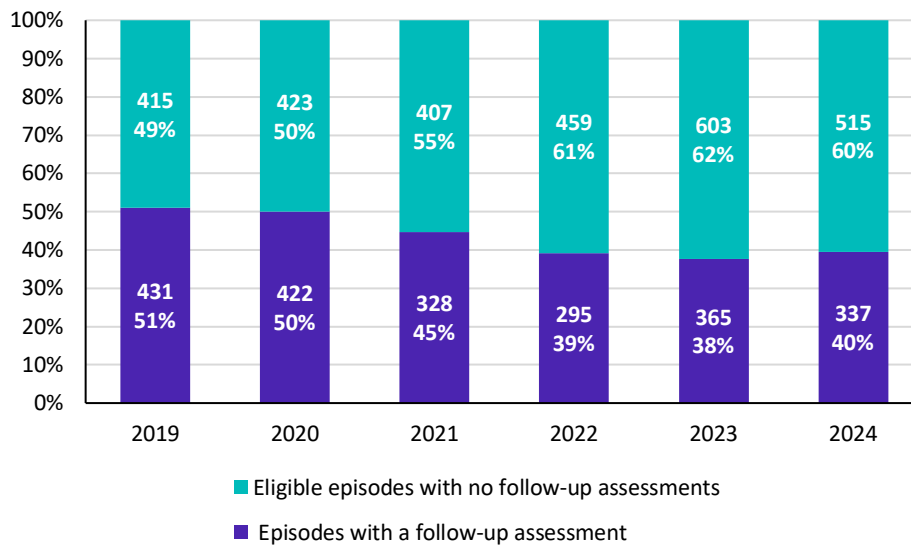
The CAT/CANS requirements outlined in Procedure 17 of CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC) require CYFD staff to arrange for follow-up screenings, evaluations, or assessments that are indicated by the CAT and CANS screenings to be conducted immediately when possible or within 10 days of indication.

DVP Metrics and Validated Performance Data

ATO1.c(i) – secondary metric: The percent of episodes of custody which included at least one assessment, as specified in the annual list of follow-up assessments provided to the Co-Neutrals.*⁶²

This metric looks at any assessments, and does not account for whether or not a follow-up screening was indicated by the CANS or CAT screening.⁶³ Of the 852 eligible episodes of children’s custody in 2024, 337 included at least one of the indicated follow-up assessments (40%).⁶⁴ This is below 2019 performance, when 51 percent of episodes of children’s custody included a follow-up assessment (see Figure 10).

Figure 10: Eligible Episodes of Custody with and without at Least One Follow-up Assessment 2019 - 2024; N=846 episodes in 2019; N=845 episodes in 2020; N=735 episodes in 2021; N=754 episodes in 2022; N=968 episodes in 2023; N=852 episodes in 2024



Source: Analysis of Sandbox EpisodesOfCustody and Encounters files

⁶² Between 2019 and 2024, this metric tracked the prevalence of the following service codes: H2010, 90791, 96130, 96131, 96132, 96133, 90885, 90792, and H2000. These include assessments such as: medication monitoring, psychiatric diagnostic evaluations, psychological testing, and comprehensive multi-disciplinary team evaluations.

⁶³ The primary metric discussed below focuses on assessments that were referred as a result of a CANS or CAT screening.

⁶⁴ Episodes of custody were eligible if they lasted 11 days or longer and began during the reporting period.

ATO1c(i) – primary metric: For all episodes where a child’s initial CANS or CAT screenings indicated a need for follow-up assessment(s) (as determined by the staffing team), the percent for which all appropriate follow-up assessments were conducted within 10 days of the completion of the initial screening. The metric will exclude children discharged from care within 10 days of the initial screening who did not receive follow-up assessment(s) prior to discharge.

ATO1c(ii) – primary metric: For all episodes where a child’s initial CANS or CAT screenings indicated a need for follow-up assessment(s), and where the child did not receive the indicated follow-up assessment(s) prior to discharge, the percent whose family received referral(s) for the follow-up assessment(s) when the discharge took place.

The Co-Neutrals were unable to validate 2024 data for these metrics because they rely on a data collection process that the State did not use consistently in 2024. In 2022, the State embedded a survey tool into FACTS to collect information on referrals for services, but the State reported that very few of these surveys had been completed in 2023 and 2024. Data from this survey tool or an alternative source will be necessary to validate this metric for 2025.

ATO1(i): Qualitative review of practice used to identify and address child’s trauma-related needs.⁶⁵

This commitment is assessed using the same qualitative review process described in App. A, TO 1 – *Completing Indicated Screenings*. Reviewers were asked to identify whether service recommendations were identified in the CANS screenings based on the CANS algorithm. While developing the CAT and CANS screening tools, CYFD worked with the Praed Foundation to create an algorithm that identifies a list of specific, individualized recommendations for services and supports a child may need based on the screening scores. The algorithm also provides a recommended foster care Level of Care (LOC) that may be used to inform a child’s CYFD LOC assessment.⁶⁶

Of the 60 CANS screenings reviewed, specific service recommendations were documented in 11 screenings (18%). Children identified as Foster Care Level 2 or 3 were likely to have more than one service recommendation identified by the screening. Due to the limited information documented in FACTS regarding referrals for and receipt of behavioral health services, the qualitative review could not assess the number of recommendations which resulted in referrals or assessments for services.

⁶⁵ This qualitative metric is used to validate multiple related commitments – App. A, TO 1.1; App. A, TO 1.a; App. A, TO 1.b; App. A, TO 1.c; App. A, TO 2.1; App. A, TO 2.2; and App. A, TO 2.3.

⁶⁶ Children in foster care are assigned a Level of Care (LOC) based on an assessment that determines their level of need.

Table 7: Number of Completed CANS Screenings with Service Recommendations⁶⁷
2024

Number of Service Recommendations	All Foster Care Levels		Foster Care Level 1		Foster Care Level 2		Foster Care Level 3	
	#	%	#	%	#	%	#	%
0	49	82%	48	91%	1	20%	0	0%
1	5	8%	3	6%	1	20%	1	50%
2	4	7%	2	4%	2	40%	0	0%
3	2	3%	0	0%	1	20%	1	50%
All	60	100%	53	100%	5	100%	2	100%

Source: 2024 OPA CANS/CAT Qualitative Review

Discussion

As with prior years, the data necessary to track the State’s progress toward meeting this commitment was again unavailable for 2024. The available data identifies the number of assessments received by children and shows that 40 percent of children received at least one indicated follow-up assessment. One significant limitation of the available data is that it does not identify the number of all applicable children who had an identified need for a follow-up assessment, and is limited to only services that were provided by HCA. Without available data to identify and track children who needed services, it is impossible to know whether children are receiving appropriate and timely follow-up assessments.

⁶⁷ Multiple services may be recommended within a single CANS screening.

Expansion and Availability of Services (App. A, TO 2)

FSA Requirement	By December 1, 2022, every Child in State Custody will receive age-appropriate trauma-responsive services, supports, and/or treatment to meet his or her individualized needs indicated by the CANS and functional trauma assessments, beginning immediately where possible and not to exceed 10 Days after the date of the screening and/or assessment. HCA and CYFD will expand and offer community-based, evidence-based, well-supported, and promising trauma-responsive services, which include mobile crisis response services, intensive case management, intensive home-based services, and trauma-based therapies including Dialectical Behavior Therapy (DBT), Multi-Systemic Therapy (MST), trauma-informed Cognitive Behavioral Therapy (CBT), Functional Family Training (FFT), and Eye Movement Desensitization and Reprocessing therapy (EMDR). These services will be available to all Children in State Custody for whom the services are medically necessary and will be available immediately where possible and within 10 Days of the determination of medical necessity otherwise. (Due December 1, 2022)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

CYFD's *Permanency Planning Procedures* (8.10.8.17 NMAC) require CYFD staff to arrange for follow-up screenings, evaluations, or assessments that are indicated by the CAT/CANS to be conducted immediately when possible or within 10 days of indication.

As part of the State's work to expand access to the evidence-based practices (EBPs) specified in the FSA, HCA developed unique billing code modifiers with increased reimbursement rates for behavioral health providers to use when billing for identified clinical services. Historically, providers utilizing clinical interventions such as Dialectical Behavior Therapy (DBT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Eye-Movement Desensitization and Reprocessing (EMDR) would bill Medicaid for non-specific psychotherapy sessions, which is typical practice.⁶⁸ The Centers for Medicaid and Medicare Services (CMS) approved the addition of the modifiers in late 2023, and eligible providers were able to bill for services using the modifiers for services provided after July 1, 2023. Specific billing codes for High-Fidelity Wraparound (HFW), Multi-Systemic Therapy (MST), Mobile Crisis Response (MCR), and Functional Family Therapy (FFT)

⁶⁸ DBT, TF-CBT, and EMDR are evidence-based therapeutic interventions used to treat individuals who have experienced trauma, including children. Additional information about DBT can be found [here](#); information about TF-CBT can be found [here](#); and information about EMDR can be found [here](#).

have been in effect in New Mexico prior to 2023.^{69,70} To be eligible to use the modifiers, the provider must be certified in the modality through the national certifying organization and enrolled with New Mexico State University’s Center of Innovation (NMSU COI) as an approved provider.⁷¹ The State partners with NMSU COI to facilitate free training for providers by hosting trainings with the certifying organization.⁷² NMSU COI also oversees the vetting and approval process regarding providers seeking to use the billing modifiers. This process acts as a form of quality control to ensure providers who use the modifiers are certified to provide the EBP intervention. The State also partners with NMSU COI as the certification trainer for HFW.

HCA reports that additional work remains to ensure the modifier rates are competitive compared to the general increase in Medicaid reimbursement rates that occurred as of January 1, 2025. With the addition of the modifiers, HCA reports it will be able to track specific trauma-responsive interventions that are provided to children in state custody.

DVP Metrics and Validated Performance Data

ATO2.2(i) – primary metric: The sum number of children in cohort who received either High Fidelity Wraparound services, Mobile Crisis Response (MCR), DBT, MST, Trauma Informed-CBT, FFT, or EMDR during the reporting year.

The State’s data shows that no services were provided using the billing codes and modifiers for DBT, TF-CBT, and EMDR in 2024.

ATO2.2(i) – secondary metric: The sum number of children in the cohort who received either High Fidelity Wraparound services, MST, MCR or FFT during the reporting year.*

Of the 3,026 children in state custody at any point in 2024, 79 unique children (3%) received at least one session of HFW, MST, MCR, or FFT in 2024. The number of children in state custody who received any indicated modality decreased for the second consecutive year, and was lower in 2024 than in any other year since reporting began in 2019 (see Table 8).⁷³

**Table 8: Children Who Received at Least One Session of HFW, MST, MCR, or FFT
2019 - 2024**

Year	Children in state custody who received any indicated modality ⁷⁴	Children who received listed modality			
		HFW	MST	MCR	FFT
2019	175	149	35	0	2
2020	196	171	20	0	8
2021	144	127	19	0	0
2022	152	135	18	0	1
2023	121	100 ⁷⁵	21	0	1
2024	79	53	26	1	0

Source: Analysis of Sandbox Encounters, EpisodesOfCustody, and Cohort files

HCA postulated that children may have received some of these services, but the services were not billed with the specific Medicaid modifiers. As additional analysis to better understand the amount of non-specific therapeutic services being provided to children in state custody in 2024, the Co-Neutrals examined the number of children who received the following types of behavioral health services: psychiatric diagnostic evaluations, non-crisis behavioral health services (i.e., individual, group, or family therapy), and crisis intervention services.⁷⁶ Of the 3,026 children in state custody at any point in 2024, 1,309 unique children (43%) received at least one of these behavioral health services. A total of 870 children received at least one diagnostic evaluation (1,317 total evaluations), 1,157 children received non-crisis behavioral health services (21,231 total services), and 32 children received crisis intervention services (117 total crisis services).⁷⁷ Over half of these 1,309 unique children (56%) received more than one type of service, with the largest group receiving both diagnostic evaluations and non-crisis services (53%, 700 children). The number of children who received each type of service is shown in Figure 11.

⁶⁹ HFW is an approach to service delivery rather than an intervention and provides a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges; additional information on HFW can be found [here](#). MST is an intensive family and community-based treatment for youth involved with juvenile justice and/or with substance abuse issues; additional information about MST can be found [here](#). FFT, referred to as Functional Family Training in the FSA, is a family-based intervention specifically utilized for youth experiencing significant behavioral health and/or substance use issues; additional information about FFT can be found [here](#).

⁷⁰ HFW became a Medicaid-billable service as of July 1, 2023.

⁷¹ Additional information about NMSU COI can be found [here](#).

⁷² For example, NMSU COI offers training and certification in EMDR by hosting staff from the EMDR International Association (EMDRIA).

⁷³ Counts are based on analysis of data as submitted by the State; the Co-Neutral team has not validated each reported service.

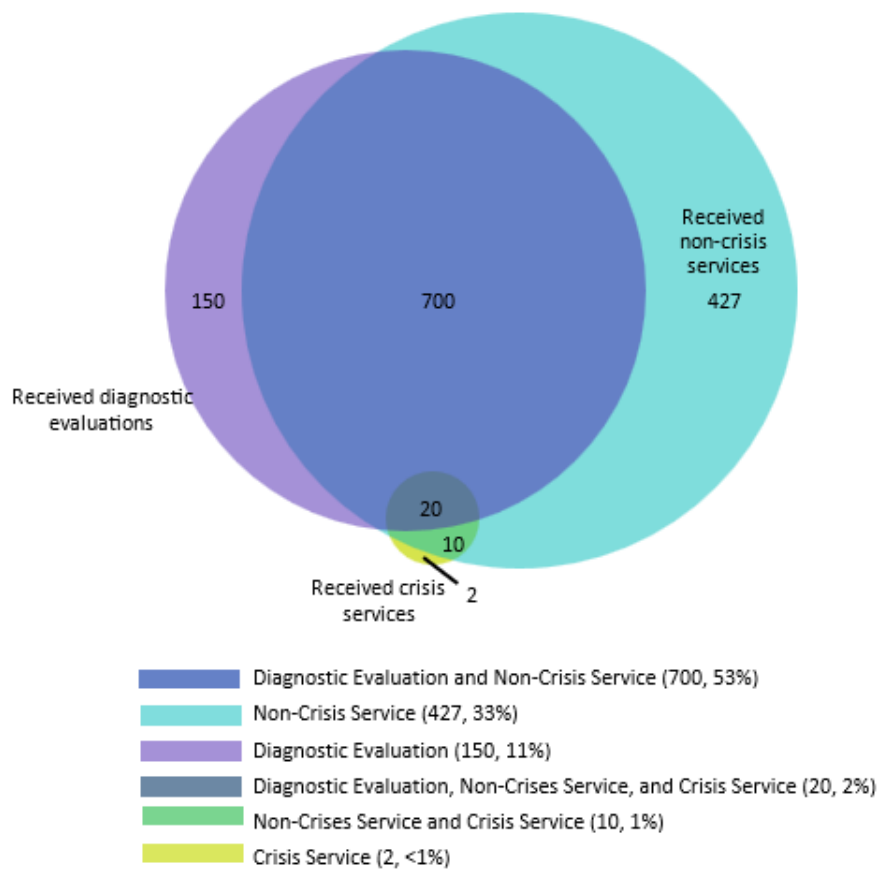
⁷⁴ The total is less than the sum of each modality as some children received more than one type of service. Children who received more than one modality were counted in each applicable modality column but counted only once in the “any indicated modality” column.

⁷⁵ HFW became a Medicaid-billable service as of July 1, 2023, and was a grant-only funded service prior to that. The State did not provide the Co-Neutrals with data and information identifying children in state custody who received HFW through a grant-funded program, but it is possible that additional children received HFW between January and June 2023 who are not reflected in this total.

⁷⁶ Non-crisis behavioral health services include services described in the State’s data as “PSYTX W PT,” “FAMILY PSYTX,” and “GROUP PSYCHOTHERAPY.” Crisis intervention services include services described in the State’s data as “PSYTX CRISIS.”

⁷⁷ To obtain the unique number of services received by children, the Co-Neutrals excluded duplicated evaluations and non-crisis services from the analysis (i.e., those listed with the same service code, start date, and end date for the same child). Crisis services listed with the same service code and date for the same child were included in the analysis, as multiple crisis services can be received by a child on the same date.

Figure 11: Children Who Received Behavioral Health Services
 2024; N = 1,309 children



Source: Analysis of Sandbox Encounters and Cohort files

ATO2.3(i) – primary metric: Of all children in state custody who received screenings or assessments that indicated a need for High Fidelity Wraparound services (HFW), Mobile Crisis Response (MCR), DBT, MST, Trauma-informed CBT, FFT, or EMDR during the reporting year, the percent that initiated or received all services for which they were indicated within 10 days of that screening or assessment.

The Co-Neutrals were unable to validate 2024 data for this metric because it relies on a data collection process the State did not use consistently in 2024. In 2022, the State embedded a survey tool into FACTS to collect information on referrals for services, but the State reported that very few of these surveys had been completed in 2023 and 2024. Data from this survey tool or an alternative source will be necessary to validate this metric for 2025.

ATO1(i): Qualitative review of practice used to identify and address child's trauma-related needs.⁷⁸

This commitment is assessed using the same qualitative review process described in App. A, TO 1 – *Completing Indicated Screenings*. Reviewers were asked to identify whether service recommendations were identified on the CANS screenings based on the CANS algorithm. Of the 60 CANS screenings reviewed, specific behavioral health service recommendations were documented in 11 (18%) screenings. The most common recommendations were for TF-CBT (10%), EMDR (8%), and Child Parent Psychotherapy (CPP) (7%).⁷⁹ Due to the limited information documented in FACTS regarding referrals for and receipt of behavioral health services, the qualitative review could not assess the number of recommendations which resulted in referrals or assessments for services.

Table 9: Algorithm-Based Service Recommendations for Completed CANS Screenings⁸⁰
2024; N=60 completed CANS screenings

Service Type	#	%
Trauma-Focused Cognitive Behavioral Therapy	6	10%
Eye Movement Desensitization and Reprocessing	5	8%
Child Parent Psychotherapy	4	7%
Multi-Systemic Therapy	2	3%
Outpatient	1	2%
Wraparound	1	2%
Any service recommendation	11	18%
No service recommendation	49	82%

Source: 2024 OPA CANS/CAT Qualitative Review

Discussion

The State's data show a cumulative total of 79 unique children in custody (3%) who received at least one session of HFW, MST, MCR, or FFT interventions in 2024, which is the lowest utilization data reported by the State for these specific trauma-responsive services since 2019. The State's billing data also show no services were provided using the EBP-specific billing modifiers for DBT, TF-CBT, and EMDR in 2024. Additional analysis by the Co-Neutrals shows that 43 percent of children in state custody in 2024 received a behavioral health service such as a diagnostic evaluation, individual/family/group therapy, or crisis intervention services, but there are no data available to determine what the child's service needs were or whether the specific interventions provided met those needs. The State has not provided information to assess referrals or timeliness for children to access services. During the qualitative review of a sample of completed CANS

⁷⁸ This qualitative metric is used to validate multiple related commitments – App. A, TO 1.1; App. A, TO 1.a; App. A, TO 1.b; App. A, TO 1.c; App. A, TO 2.1; App. A, TO 2.2; and App. A, TO 2.3.

⁷⁹ CPP is a therapeutic approach used with children aged birth through five and their caregivers; additional information can be found [here](#).

⁸⁰ Multiple services may be recommended within a single CANS screening.

screenings, 11 screenings included recommendations for further assessment for trauma-responsive behavioral health services. Due to limited information available within children’s FACTS records related to assessments for behavioral health services, it was not possible to determine whether assessments for recommended services occurred.

The guidance and training provided to case workers and supervisors on what to do with service recommendations made by the CANS and CAT screenings are inadequate. The ability to track this data is crucial to the State as the agencies work to build a trauma-responsive system equipped with an adequate amount of behavioral health services to meet children’s needs within 10 days of identification.

Completion of Trauma-Responsive Training (App. A, TO 3a)

FSA Requirement	By December 1, 2021, all CYFD employees, designated HCA employees, employees of child serving agencies that contract with CYFD or HCA to provide care to Children in State Custody, and Resource Families will receive the training identified in the Trauma-Responsive Training and Coaching Plan. All Respondents will be offered the trauma training identified in the Trauma-Responsive Training and Coaching Plan. (Due December 1, 2022)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

The State’s Trauma-Responsive Training and Coaching Plan was approved by the Co-Neutrals on December 5, 2022.⁸¹ The approved Plan provides a framework by which all CYFD staff and designated HCA staff are to receive trauma-responsive training appropriate to their role. The approved Plan commits CYFD’s Workforce Development Bureau (WDB) to develop and provide:

- Novice Trauma-Responsive training for all new and existing CYFD staff interacting with children, youth, and families;
- A needs assessment and additional tool to incorporate trauma-responsive conversations into individual and regional coaching plans;
- Ongoing advanced level trauma-informed and trauma-responsive care training for CYFD staff and leaders; and
- Additional leadership level opportunities and resources for supervisors and leaders to develop skills needed to guide staff’s development of a trauma-responsive care approach, with a focus on staff resiliency.

⁸¹ The approved Trauma-Responsive Training and Coaching Plan can be found [here](#).

The Plan commits HCA to provide trauma-responsive training appropriate to their roles to all HCA Behavioral Health Services Division (BHSD) staff, all contracted behavioral health providers who deliver professional services to children in state custody and their families, MCO training staff and care coordinators, and respondent families.^{82,83}

As part of the approved Trauma-Responsive Training and Coaching Plan, in 2022, the State reported it formed a Cross-Departmental Training Review Committee (CDTRC) composed of CYFD and HCA staff from various departments, including HCA's Deputy of Clinical Services and/or their designee(s); Director of CYFD's BHS and/or their designee(s); and as determined necessary, staff from CYFD's PSD, WDB, and Office of Tribal Affairs (OTA). A component of the committee's purpose is to promote consistency of trauma-responsive service delivery and to update the trauma-responsive training curriculum as the field evolves and additional training needs are identified.

DVP Metrics and Validated Performance Data

ATO3.a(i) – primary metric: Of all CYFD and designated HCA staff required to receive training as defined in the Trauma Training and Coaching Plan who are employed on December 31 of the reporting year, the percent who have received all trauma trainings required for that reporting year within the time frames designated for each training. The percentages will be calculated and reported separately for CYFD and HCA.

On December 31, 2024, there were 1,661 staff employed at CYFD, 702 of whom were required to receive trauma-responsive training.⁸⁴ Of those 702 staff, 510 (73%) were up-to-date on their trauma-responsive training as of December 31, 2024, regardless of whether they completed the training in 2024 or earlier.⁸⁵

The training data submitted by HCA included up to four trauma-related trainings for each staff member. The Co-Neutrals requested clarity from HCA regarding which staff are required to take which training courses as the State's submitted data showed variability around the number of trainings taken by staff. The State provided the training requirements in November 2025, however, the State did not provide the data necessary to identify the employees required to take all four trainings.

⁸² The FSA defines respondents as defendant(s) in an abuse and neglect case under the New Mexico Children's Code.

⁸³ Per the FSA, designated HCA employees are defined as Social and Community Services Coordinators; their supervisors and managers (including the Behavioral Health Services Division Director); and any HCA employee or their designee involved in care coordination activities, EPSDT services, or determinations about service utilization for children in state custody, including supervisory and management level employees

⁸⁴ On August 23, 2025, the State submitted to the Co-Neutrals a list of job titles that were required to receive trauma-responsive training.

⁸⁵ The training data submitted by the State included trainings that took place from 2023 to 2025. Of the 993 complete trainings in *Staff Training 2024_20250717* (submitted 7/22/25), 912 (92%) took place in 2023, 80 (8%) took place in 2024, and one (<1%) took place in 2025.

ATO3.a(ii) – primary metric: Of all provider and contract staff required to receive training as defined in the ‘Trauma Training and Coaching Plan’ who are employed on December 31 of the reporting year, the percent who have received all trauma training required for that reporting year within the time frames designated for each training.

The data submitted by the State did not contain enough detail for the Co-Neutrals to determine the number of external staff who received trauma training or the number who were required to receive it.⁸⁶

ATO3.a(iii) – primary metric: Of all Resource Families required to receive training as defined in the “Trauma Training and Coaching Plan” who are licensed on December 31 of the reporting year, the percent where all adults reflected on the license have received all trauma training required to maintain an active license for that reporting year within the time frames designated for each training.

The data submitted by the State listed 677 resource parents with an active license who were required to complete trauma training by the end of 2024; 190 of the resource parents (28%) completed at least one module of trauma-responsive training by December 31, 2024, and 180 (27%) completed both modules of training.^{87,88}

ATO3.a(iv) – primary metric: Of all Respondent families during the reporting year, the percent who participated in any trauma training as defined in the “Trauma Training and Coaching Plan.”

The State did not submit data that would allow the Co-Neutrals to calculate this metric involving trauma training for respondent families in 2024.

⁸⁶ The data file submitted by the State listed 195 external staff, 188 of whom were marked as up-to-date on their required trainings. However, the file did not contain enough information for the Co-Neutrals to determine whether 195 is the full universe of external staff required to receive trauma training (i.e., the denominator for this metric). Also, the Co-Neutrals could not verify the specific trauma training received by the 188 external staff who were marked up-to-date. The only structured information in the file about training completion was for trainings related to human trafficking and commercial sexual exploitation, neither of which count as trauma training based upon documents submitted by the State to the Co-Neutrals.

⁸⁷ The data submitted by the State on non-staff training (*Non-Staff Training20250619*, submitted 6/20/25) indicated that there were two trauma trainings that were offered to resource parents: “READi NM Module 10: Trauma-Informed Support” and “READi NM Module 11: Trauma-Responsive Discipline.” The approved Trauma-Responsive Training and Coaching Plan states that resource parents will receive a 90-minute pre-service training via READi NM.

⁸⁸ This calculation differs from the metric described in the DVP because the State did not implement a common identifier that would allow records in the training data to be matched to records in the Sandbox *ActiveProviders* data. The lack of a common identifier inhibited the Co-Neutrals’ ability to identify the universe of resource families with active licenses in 2024 that received training or verify that all adults associated with the license received trauma training. The Co-Neutrals analyzed data provided by the State on non-staff training to understand how many resource parents who had a training due in 2024 completed trauma training by December 31, 2024.

ATO3.a(v) – primary metric: Of all CYFD staff who were required to receive or requested coaching as defined in the Trauma Training and Coaching Plan, the percent who received required and requested coaching.

The State did not submit data that would allow the Co-Neutrals to calculate this metric involving trauma coaching for CYFD staff in 2024.

ATO3.a(vi) – primary metric: Trauma coaching for designated HCA staff.

The State did not submit data that would allow the Co-Neutrals to calculate this metric involving trauma coaching for HCA staff in 2024.

ATO3.a – validation strategies.

Between July 1 and December 31, 2024, members of the Co-Neutral team spoke with case workers and supervisors throughout the state about their workloads, including their general experience with the trauma-responsive training they received during the year. Of the 120 case workers and supervisors who were interviewed, 104 reported taking trauma-responsive training. Overall, staff who completed the training reported that the information was helpful to them in their work with children and families, and gave them information relevant to understanding the impacts of trauma and the importance of de-escalation. Some staff identified a need for additional training that provides more case-specific examples of what they should do as a worker, as well as a desire for additional techniques to manage the secondary trauma experienced by many workers.

Discussion

Since the Trauma-Responsive Training and Coaching Plan’s approval in 2022, both CYFD and HCA have experienced significant changes in leadership and staff, which have negatively impacted the State’s ability to enact certain provisions in the Plan and in the functionality of the CDTRC. Specifically, CYFD has not yet developed or rolled out the curriculum or staff training requirements for the ongoing advanced level trauma-informed and trauma-responsive care training for CYFD staff, supervisors, and leaders, nor has it identified additional leadership-level opportunities and resources for supervisors and leaders to develop skills needed to guide staff’s development of a trauma-responsive care approach, with a focus on staff resiliency. Additionally, both agencies have not yet identified a way to track trauma-responsive employee coaching.

Both agencies made efforts to deliver required training to their own staff, and data for 2024 show that most of CYFD staff received some trauma-responsive training. In April 2024, CYFD relaunched an introductory trauma-responsive training required for all staff, titled “*Trauma: A Journey to Self-Discovery*.” The training provides a virtual, self-guided introductory course which details trauma’s impact on child development, and includes multiple assessment questions embedded within the training. Similarly, HCA reports that in 2024, the trauma-responsive training was embedded within the agency’s BHSD required staff training, with on-going efforts toward creating additional trauma-responsive training modules to supplement the knowledge provided in the initial training. However, a lack of clarity around the State’s training requirements and incomplete data from the State impacted the Co-Neutrals’ ability to report data on HCA staff training.

Substantial work remains for this Target Outcome, requiring CYFD and HCA to increase training completion for key individuals responsible for serving children in state custody, including external staff and resource parents. The State did not provide sufficient data and information to indicate the number of employees of child serving agencies who were required to be trained and who were, in fact, trained. Moreover, the Co-Neutrals’ analysis indicates that of 677 resource parents with an active license who were required to complete trauma training by the end of 2024, only 190 (28%) did so. State data limitations continue to prevent the Co-Neutrals from being able to assess whether CYFD and HCA contractors completed trauma-responsive training, or whether trauma-responsive training was offered or completed by respondents. As in prior years, the State was unable to provide data on coaching for CYFD and HCA staff, and for trauma-responsive training for respondent families.

Trauma-Responsive Competency Assessments (App. A, TO 3b)

FSA Requirement	By December 1, 2021, all CYFD employees, designated HCA employees, and employees of child serving agencies that contract with CYFD or HCA who provide care to Children in State Custody will demonstrate through competency assessments and self-reporting that they have received adequate trauma-responsive training. (Due December 1, 2022)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

DVP Metrics and Validated Performance Data

ATO3.b(i) – qualitative metric: Of cases sampled, the share for which the required trauma training was reflected in case practice per all requirements articulated in the agreement.

The State had not finalized the qualitative instrument and methodology to collect data and assess performance for this metric. Thus, the Co-Neutrals are unable to report performance toward this metric for 2024.

ATO3.b(ii) – primary metric: Of all staff at CYFD and designated staff at HCA who provide care to children and who are employed on December 31 of the reporting year, the percent that score satisfactorily on a competency assessment test.

The State reports that trauma-responsive competency assessments are a required part of the trauma training, and an employee cannot be counted as having completed training without passing a competency assessment. The State has not provided the Co-Neutrals with copies of the trainings and assessment tools, and therefore the Co-Neutrals cannot validate the State’s representation. In any event, the State’s performance for this metric is the same as its performance on ATO3.a(i).

ATO3.b(iii) – primary metric: Of all provider and contract staff who provide care to children and are employed on December 31 of the reporting year, the percent that score satisfactorily on a competency assessment test.

The State did not provide sufficient data and information on the number of employees of child serving agencies who were required to be trained and who were, in fact, trained.

Discussion

The qualitative data show the majority of CYFD and HCA staff completed trauma-responsive training in 2024, which is inclusive of a required competency assessment, but the State did not provide sufficient data and information on the number of employees of child serving agencies who were required to be trained and who were, in fact, trained.

The State has not yet submitted a plan for how they intend to assess how the required trauma-responsive training impacts service delivery or staff’s engagement with children and families. It is important to note the negative impact of staff turnover, high vacancy rates, and high caseloads on staff’s ability to implement trauma-responsive casework.

Individualized Planning Meetings (App. A, TO 4.2)

FSA Requirement	Subject to the approval of the Co-Neutrals, CYFD and HSD will develop and implement a process (the Individualized Planning Meeting Plan) for convening an Individualized Planning Meeting team for making decisions and for delivering services and supports for each Child in State Custody. The Individualized Planning Meeting process shall be informed by Child and Family Teaming (CFT), collaborative decision-making, and High Fidelity Wraparound models, and shall prioritize the child’s voice and choice. The process shall also be strengths-based, connected to natural supports, and respectful of the child’s family and unique cultural heritage. The Co-Neutrals shall not withhold approval of the Individualized Planning Meeting Plan if it is reasonably calculated to achieve the Goals of this Agreement. The Individualized Planning Meeting Plan will be completed and approved by December 1, 2020, and fully implemented by December 1, 2022. (due December 1, 2022)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

The Co-Neutrals approved the State’s Individualized Planning Meeting (IPM) Plan – which the State renamed the Individualized Planning Process (IPP) – on August 17, 2022.⁸⁹ The IPP is based on the New Mexico Practice Model, which integrates the principles of a trauma-responsive approach; community-based therapeutic supports; cultural connections and Tribal sovereignty;

⁸⁹ The State intends to revise the approved IPP plan in 2025 based on feedback from the field and the Co-Neutrals’ recommendation in the last Annual Report.

youth and family voice and choice; team-based, collaborative decision-making; continual professional growth and development; and cultural humility practice. It is described in the State’s plan as “a facilitated approach to conducting teaming meetings to support children and families involved with CYFD.”⁹⁰ The IPP is applied as a framework across a number of CYFD’s child and family team meeting types.

The State’s approved IPP Plan outlines a timeline to roll out IPP training to staff across multiple CYFD divisions, including JJS, BHS, and PSD. The approved Plan identifies training that began in 2021 for select Family Centered Meeting (FCM) facilitators; PSD County Office Managers and supervisors; JJS regionals, chiefs, and supervisors; and CBHC staff. The Plan identifies training in 2022 to include all remaining PSD, JJS, and BHS staff, including case workers, with the State committing to complete the statewide roll out by December 1, 2022.

DVP Metrics and Validated Performance Data

ATO4(i) – primary metric: Of all required 90-day IPP staffings for children in foster home placements, the percentage which occurred timely.

Due to data quality concerns reported by the State, the Co-Neutrals were unable to validate the State’s performance.⁹¹

ATO4(iii) – primary metric: Of all required 30-day IPP staffings for children in state custody who are missing or under runaway status, the percentage which occurred timely.

Thirty-day reviews were required for 646 children who were missing or had run away in 2024; 83 of these reviews (13%) were conducted on time (see Figure 12).^{92,93}

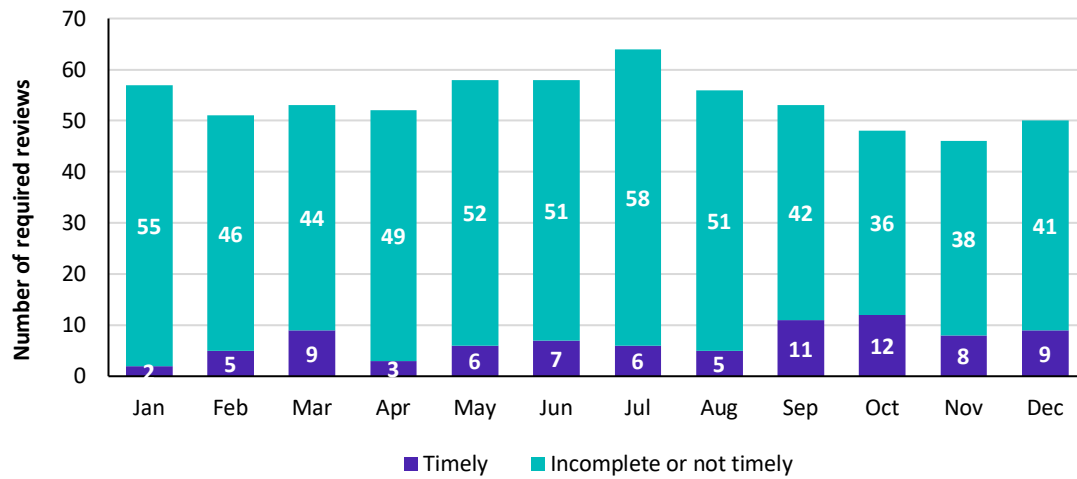
⁹⁰ IPP Plan, pg. 1.

⁹¹ The State reported a technical issue in FACTS that affected the quality of the data: When case workers attempted to select the type of meeting relevant to this metric (“90-day staffing”) in FACTS, FACTS failed to generate the IPP survey tool for the case worker to complete. As a result, CYFD instructed case workers to select other meeting types from the drop-down menu instead of “90-day staffing.” The State also reported that many meetings recorded in the Sandbox *Meetings* file as 90-day staffings were not in fact 90-day staffings. As a result, the number of 90-day meetings recorded in the Sandbox *Meetings* file is not accurate. Based on these issues, the Co-Neutrals could not validate the timely completion of 90-day staffings.

⁹² A meeting is considered “conducted” when the State’s data indicate that it was not canceled, it occurred on or before the due date, and it was a “Runaway/missing 30-day Review.” Due dates were calculated as every 30 days after the start of the runaway episode.

⁹³ There were several children in the 2024 placement data submitted by the State who were recorded as having run away in 2021 or 2022 (with no end date recorded until 2024) but did not appear in the 2023 placement data. This means the Co-Neutrals’ calculation of the number of required and completed reviews for runaway episodes in 2023, published in the Co-Neutrals’ previous report, was an undercount.

Figure 12: Completed and Required IPPs for Missing or Runaway Children, by Month
 2024; N=646 IPPs (83 IPPs completed timely; 563 incomplete or not completed timely)



Source: Analysis of Sandbox Placements, Meetings, Cohort, and CourtDisposition files, and FACTS episodes file

ATO4(ii) – qualitative metric: Of the IPP meetings reviewed for children in foster home settings, the share that reflected all requirements articulated in the Agreement.

ATO4(iv) – qualitative metric: Of the IPP meetings reviewed for children who have runaway or are missing, the share that reflected all requirements articulated in the Agreement.

The State had not finalized the qualitative instrument and methodology to collect data and assess performance for these metrics. Thus, the Co-Neutrals are unable to report performance on these metrics for 2024.

Discussion

In 2024, CYFD continued its contract with a technical assistance provider, the Child Welfare Policy and Practice Group (CWG), to assist with staff training, coaching, and implementing the IPP framework on a county-by-county basis.⁹⁴ CYFD reports the county-based rollout was planned to assist in identifying offices that could be leaders in statewide IPP implementation as well as offices where additional supports for staff were needed.

In January, August, and September 2024, the Co-Neutrals conducted visits to 10 CYFD county offices to hear directly from staff about their work, including their experiences with IPP implementation. Staff largely reported that their current workloads, which often included carrying caseloads well above the agreed upon caseload standards, prohibited them from preparing, conducting, and participating in IPPs. Many staff said they did not understand the purpose of IPPs and how they were different from other team meetings they were already holding with families.

⁹⁴ CWG is a policy and practice organization that provides technical assistance to states to improve outcomes for children and families. More information on CWG can be found [here](#).

Additional barriers were reported related to time – staff shared that it sometimes took months to be fully trained and certified to conduct IPP meetings – and also reported having to conduct multiple IPP and non-IPP meetings for the same children multiple times per month.

Staff’s experiences were reflected in the available data for 2024, which show that IPPs were conducted for children on runaway status 13 percent of the time when IPPs were required. Additionally, the Co-Neutrals collected IPP data for FSA Appendix B commitments and found that practice did not meet the outcomes as defined in the Plan.⁹⁵

Based upon the data and feedback from staff in 2023 and 2024, the Co-Neutrals recommended CYFD reexamine the original IPP Plan to determine whether revisions are necessary to streamline the number and types of required meetings for children, better ensure that staff have the skills and support needed for the meetings, and to provide additional clarity to staff on the purposes and anticipated results from meetings.

**Implementation of Quality Assurance, Improvement, and Evaluation Plan
(App. A, TO 5.2)**

FSA Requirement	CYFD and HCA will create and implement a Quality Assurance, Improvement, and Evaluation Plan, including quality management tools and measures to be used for reporting on CYFD and HCA’s capacity to meet the needs of Children in State Custody, including measures for reporting on providing and improving quality of care, collaborating across Departments, and for providing transparency and accountability. The Plan will include: consistent definitions and terms across CYFD and HCA, data exchange and matching across CYFD and HCA, clarification of existing measures and indicators, self-assessments, metrics as indicators of system performance (including process indicators, client outcomes, and system impact), a continuous quality improvement process that provides information in real time to decision-makers, and a process for responding to findings from the Plan. CYFD will develop a meaningful quality assurance process to ensure that training, policy, and procedure is being properly utilized and integrated into daily processes. The Co-Neutrals must approve the Quality Assurance, Improvement, and Evaluation Plan. CYFD and HSD will develop the Quality Assurance, Improvement, and Evaluation Plan by December 1, 2020 and fully implement it by December 1, 2021. (Due June 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

⁹⁵ Data on IPPs for Appendix B commitments can be found in App. B, TO 3.2; App. B, TO 4.1; and App. B, TO 4.2



Discussion

The State’s “Phase 1” Quality Assurance, Improvement, and Evaluation Plan (QAIEP) was approved by the Co-Neutrals on December 9, 2022, and implementation remained largely stalled in 2024.^{96,97} Phase 1 requires the State to develop internal capacity and cross-departmental coordination between CYFD and HCA. The QAIEP is described as a framework for quality improvement, and identifies key practice points to be monitored by the QAIEP Executive Leadership Team to assist in identifying where CYFD and HCA’s policies and processes are working successfully, and where practices need to be improved.

The State’s Phase 1 Plan provides specific strategies to begin the work of the QAIEP, including the creation of tiered committees that were initially formed in 2022. These committees – the Continuous Quality Improvement (CQI) Committee and the QAIEP Steering Committee – are integral parts to implementing the QAIEP and to building a culture where policy and process decisions are driven by data that are regularly shared with leadership and frontline staff to increase awareness, and create sustainable, effective changes for improvement. In 2024, staff at both agencies worked to reestablish these groups among other QAIEP-related tasks. However, significant staff turnover at both agencies inhibited progress toward implementation of the QAIEP, and remains a substantial barrier to quality.

CYFD furthered the work of CYFD’s Office of Performance and Accountability (OPA) (formerly the CYFD Quality Assurance Unit). Since late 2023, OPA has worked collaboratively with the Co-Neutral team to design and complete some of the qualitative reviews relevant to a number of *Kevin S.* commitments.^{98,99}

⁹⁶ As the State builds capacity to implement the QAIEP as described in the FSA, the QAIEP is expected to change and evolve. Thus, the QAIEP approved by the Co-Neutrals in December 2022 is considered a “Phase 1” approval.

⁹⁷ The State’s Phase 1 QAIEP can be found [here](#).

⁹⁸ OPA’s qualitative review team included one supervisor and five staff in 2024, dedicated to assessing implementation, quality, and fidelity of *Kevin S.* deliverables.

⁹⁹ The agencies requested funding through the New Mexico Legislature to expand the State’s ability to conduct Quality Service Reviews (QSRs). The funding was approved in April 2025, and the funds became available as of July 1, 2025. The State has contracted with NMSU’s Center of Innovation to use the QSR on PSD cases, with the first round scheduled to begin in October 2025. Additional information about QSRs can be found [here](#).

ii. Appendix B: Least Restrictive and Appropriate Placements

The FSA commitments in Appendix B require CYFD and HCA to “build a system for placing children in out-of-home care in stable, safe, appropriate, community-based placements in the least-restrictive environment.”¹⁰⁰ The parties describe this system as including:

- Caregivers who understand the strengths and needs of children, and who are able to support children to grow and heal;
- Placements that are the least restrictive, most connected, and most family-like as appropriate to meet the unique needs of children;
- An acknowledgement that children ages 14 and older should be consulted on their express placement preferences; and
- Stable placements that meet children’s needs and protect from the harm caused by multiple placement moves.

The State’s foster care system should be used “as temporary an arrangement as possible, with [the] goal [of] being [able] to provide children in out-of-home placements a safe, nurturing, and permanent home quickly.”¹⁰¹


For nearly every Appendix B commitment, the State’s performance declined in 2024. There were 709 documented placements of children in CYFD county offices and the Receiving Center in 2024, more than double the number from 2023 (322). There were 33 new child placements in out-of-state residential facilities, a substantial increase from the 19 new placements made in 2023. Overall, 14 percent of children in state custody experienced at least one placement in a CYFD office or out-of-state facility – this percentage doubled from 2023 (7%). None of the office placements were assessed by the Co-Neutrals as meeting the *extraordinary circumstances standard* of the FSA nor had the required prior approval of the CYFD Secretary or Protective Services Division (PSD) Director.¹⁰² The most common reason cited in children’s records for office placements was the lack of an alternative placement. For the out-of-state placements reviewed, 59 percent had documentation that supported a finding of medical necessity; however, documentation did not establish that the child’s behaviors or conditions necessitated their placement out of the state of New Mexico to ensure their safety, as required by the FSA.

The FSA requires routine and timely team meetings for children placed in out-of-state facilities, and in-state congregate care and shelter placements to monitor their safety and to plan for their movement to an appropriate in-state placement. Performance data for 2024 show declines in the completion of these meetings compared to prior years, and found that insufficient discharge planning was documented during most of the meetings that were completed. For children placed in out-of-state and in-state clinical congregate care settings, a number of children remained in

¹⁰⁰ FSA, pg. 5a.

¹⁰¹ Ibid.

¹⁰² In reviewing extraordinary circumstances determinations, the Co-Neutral team assessed whether documentation in the child’s record demonstrated the placement was necessary to protect the safety and security of the child, and that the placement was approved by the CYFD Secretary or PSD Director prior to the placement occurring, consistent with the FSA. The lack of alternative or available placements is insufficient to meet the extraordinary circumstances standard set forth in the FSA.



facilities for longer than was determined medically necessary, with the primary reason for delays in discharge being inability to secure an appropriate placement.

CYFD licensed 212 new non-relative foster homes in 2024, 80 percent of the annual target (265). Although well below the target, more homes were newly licensed than in 2023 (168).

The FSA also requires HCA to establish and meet a target for new TFC placements each year. In 2024, the number of new TFC placements was 134, 42 percent of the annual target (319). There has been a continued decline in TFC placements since 2022, even though case reviews of children's records show the need for these placements, which are often recommended in care plans. When the service is not provided, many children are placed in settings that do not meet their needs or are more restrictive than medically necessary.

Data for the total number of licensed homes – both relative and non-relative – available during 2024 shows an increase from 970 in 2023 to 1,067 in 2024. This is the highest number of homes since 2021 and is due to an increase in licensed relative homes that has outpaced the decline in licensed non-relative homes. In January 2021, there were 494 licensed relative homes; as of December 2024, there were 657. In January 2021, there were 675 licensed non-relative homes, and as of December 2024, there were 500.

Performance data for achieving permanency for children in care 12 to 23 months as of January 1, 2024 who exited care by the end of 2024 dropped below the required target for the first time since 2020. In 2023, performance was 42 percent; in 2024, performance declined to 25 percent. There are several critical factors that account for this, including workforce shortages and instability, the lack of adequate legal staffing, and the failure to provide services to both children and families. The end result was an increase in children languishing in foster care.

CYFD case worker caseloads drive much of the poor performance. When caseloads are too high, workers are unable to engage with children and families, complete needed assessments, develop and monitor case plans, assess children's safety, support efforts towards permanency, in addition to other responsibilities.

The Co-Neutrals analyzed caseload compliance at one point-in-time for each quarter in 2024 and found compliance levels ranged from 35 to 42 percent. Additionally, in December 2024, 15 percent of cases were assigned to non-case-assignable staff.¹⁰³

Staff turnover continued to be a problem. Nearly half (45%, 38 staff) who voluntarily terminated employment in 2024 had been employed at CYFD for less than one year.

In the Co-Neutrals' visits to county offices in January, August, and September 2024, case workers, supervisors, and managers described continuous workforce challenges and practice issues that created barriers to acceptable performance. They described high caseloads, staff turnover,

¹⁰³ Individuals with supervisory and managerial titles are not case-assignable, nor are staff with titles such as "Investigations Case Aide," "Kinship Specialist," and other positions that do not typically require case-carrying duties. Staff in case-assignable roles who have not completed New Employee Training (NET) are also not case-assignable.

children staying and sleeping in CYFD county offices, lack of safe and appropriate family-based placements and community-based services, multiple burdensome and inefficient data systems, and widespread confusion about roles and responsibilities. They also reported poor communication from state leaders to frontline staff and horizontally within CYFD’s organization structure.

a. Implementation Targets

In prior reports, the Co-Neutrals assessed the State had met the Performance Standard for all the Appendix B ITs.¹⁰⁴

b. Target Outcomes¹⁰⁵

Prohibition of Placements in Hotels/Motels, Out-of-State, and in Offices Except in Extraordinary Circumstances (App. B, TO 1.1)

FSA Requirement	By December 1, 2020, no child under 18 will be placed in any hotel, motel, out-of-state provider, office of a contractor, or state agency office unless in extraordinary circumstances necessary to protect the safety and security of the child as documented in the child’s record and approved by the Secretary or the Protective Services Director of CYFD. In any such extraordinary circumstance, CYFD shall provide notice to the child’s Guardian ad Litem and Youth Attorney immediately where possible, and not more than 24 hours after the placement of the child. Notification to the dependency court to which the child’s case is assigned must occur within 3 business days. When a child is placed with an out-of-state provider, notice to the child’s Guardian ad Litem, Youth Attorney, and the dependency court to which the child’s case is assigned will be given prior to the move, pursuant to statute. (Due December 1, 2020)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

DVP Metrics and Validated Performance Data

BTO1.1(i) – secondary metric: The percent of children with any office, hotel/motel, or out-of-state RTC/group placements in the cohort during reporting year.*

Fourteen percent (412 of 3,026) of children in state custody in 2024 experienced a placement to at least one of the settings covered by this commitment: a hotel/motel, office, or out-of-state

¹⁰⁴ A list of all ITs and TOs where the State previously met the Performance Standard can be found in Appendix ii. *FSA Implementation Targets and Target Outcomes Met in Prior Reporting Periods.*
¹⁰⁵ Ibid.

facility.^{106,107} As shown in Table 10, this is the second consecutive year that the rate has doubled, from three percent in 2022, to seven percent in 2023, to 14 percent in 2024. In 2024, these 412 children experienced a total of 742 applicable placements, most of which were CYFD office and Receiving Center placements (96%, 709 placements).

The number of children housed in an office or out-of-state facility grew 496 percent between 2019 (83) and 2024 (412), despite an overall reduction of 22 percent (855) in the number of children in state custody from 2019 to 2024.

**Table 10: Children with any Placement to a Hotel/Motel, Office, or Out-of-State Facility
2019 - 2024**

Category	2019 (N = 3,881)		2020 (N = 3,344)		2021 (N = 2,949)		2022 (N = 2,755)		2023 (N = 2,944)		2024 (N = 3,026)	
	#	%	#	%	#	%	#	%	#	%	#	%
Children with any placement in applicable setting¹⁰⁸	83	2%	63	2%	102	4%	82	3%	199	7%	412	14%
Children with placement to any applicable setting, by type of setting												
Out-of-state facility	57	1%	31	<1%	27	<1%	14	<1%	18	<1%	32	1%
Office (including Receiving Center)	34	<1%	32	<1%	85	3%	71	3%	185	6%	404	13%
Hotel/motel	0	0%	2	<1%	3	<1%	6	<1%	0	0%	0	0%

Source: Analysis of Sandbox Placements files, FACTS episodes files, and separate manual data files, plus adjustments based on case record reviews

This metric is reported by child, in that a child with multiple placements to a hotel/motel, office, or out-of-state facility is counted only once. As additional detail to inform the Co-Neutrals' assessment of the State's efforts, the Co-Neutrals also examined the total number of new placements by each placement type by month (see Table 11). New placements to offices increased each month for the first five months of the year, from 40 in January to 66 in May, and then stayed at a roughly similar level for the rest of the year, with an average of 61 per month from June

¹⁰⁶ The metrics reported in this section were calculated from placement data submitted by the State as validated by the Co-Neutral team's qualitative review. The Co-Neutral team's qualitative review was based on real-time data submitted monthly by the State that had not gone through the State's quality-assurance process, and there were many placements that appeared in the Sandbox placement data that were submitted by the State on May 15, 2025 (and resubmitted with revisions on June 18, 2025) but did not appear in the real-time data. As a result, the Co-Neutrals reviewed most, but not all, office placements and made manual adjustments to the Sandbox data as needed.

¹⁰⁷ During qualitative case reviews, the Co-Neutral team identified discrepancies between the State's structured data and information in children's FACTS case records for over 50 placements. The State corrected most of these discrepancies in the data resubmitted to the Co-Neutrals on June 18, 2025.

¹⁰⁸ Some children had placements to more than one setting covered by this metric. Therefore, the sum of the children with a placement to each type of placement setting is higher than the total number of unique children.

through December.

Table 11: New Placements to Hotel/Motel, Office, and Out-of-State Facility, by Month 2024

Month	Total new placements	New placements by setting		
		Out-of-state facility	Office (including Receiving Center)	Hotel/motel
January	43	3	40	0
February	58	3	55	0
March	58	2	56	0
April	68	4	64	0
May	70	4	66	0
June	68	2	66	0
July	66	3	63	0
August	66	5	61	0
September	65	0	65	0
October	51	2	49	0
November	76	4	72	0
December	53	1	52	0
Total	742	33	709	0

Source: Analysis of Sandbox Placements files and FACTS episodes files, plus adjustments based on case record reviews

BTO1.1(i) – primary metric: Percentage of children who had a placement in hotel/motel/office settings, or with out-of-state providers, that include required finding and approval of “extraordinary circumstances” and meet all notification requirements. For out-of-state RTC care settings, metric will include appropriate triage meetings.

CYFD case workers are required to document in FACTS if a child’s placement in an office or out-of-state facility meets the *extraordinary circumstances* standard. The Co-Neutral team conducted independent reviews of children’s records in an effort to validate that these placements met the extraordinary circumstances standard with required approvals. The Co-Neutral team determined that children’s placements did not meet the extraordinary circumstances standards set forth by the parties in Appendix B of the FSA.¹⁰⁹

¹⁰⁹ During the Co-Neutral team’s qualitative review of 708 office and Receiving Center placements in 2024, the case record legal tab was reviewed to determine if notice of the placement was provided to the child’s GAL or YA within 24 hours. None of the office placements included this documentation. In four (13%) of the 32 out-of-state placements made in 2024 that were assessed during the qualitative review discussed later in this section, the GAL or YA was notified of the placement prior to the child being placed out of state as they attended either the triage meeting or another team meeting that was held discussing the child’s pending out of state placement.

BTO1.1(ii) – qualitative metric: Qualitative review of extraordinary circumstance determination for placements to hotels, motels, or offices.¹¹⁰

For this metric and the other qualitative metrics discussed within this Appendix, the Co-Neutral team developed protocols and instruments and conducted reviews of children’s FACTS records to assess whether CYFD made placements pursuant to the extraordinary circumstances, medical necessity, and best interest standards in the FSA.¹¹¹

The Co-Neutral team reviewed 708 CYFD county office and Receiving Center placements experienced by 376 unique children in 2024.¹¹² Of the placements reviewed, the average age of the children at the time of office placement was 11; more than one-third (37%) of the children were age 10 or younger, 33 percent were between the ages of 11 and 14, and 30 percent were age 15 or older.

Of the 394 CYFD office placements with documentation of the specific office where the placement occurred, approximately one-quarter (26%, 183 placements) were at the Receiving Center in Bernalillo County and another 25 percent (53 placements) occurred in the Bernalillo County office itself. Fifteen percent (32 placements) of identified office placements were in the Chaves County office, 13 percent (28 placements) were in the Dona Ana County office, 13 percent (28 placements) were documented in the Otero County office, and eight percent (16 placements) were in the Valencia County office.

Approximately one-third (34%, 238) of office placements lasted no more than two nights, and

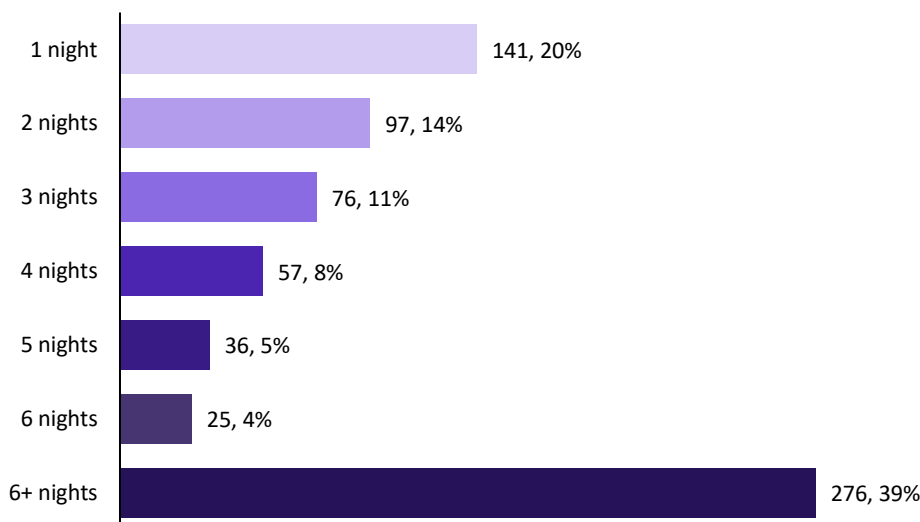
¹¹⁰ In reviewing extraordinary circumstances determinations, the Co-Neutral team assessed whether documentation in the child’s record demonstrated the placement was necessary to protect the safety and security of the child, and that the placement was approved by the CYFD Secretary or PSD Director prior to the placement occurring, consistent with the FSA. The lack of alternative or available placements is insufficient to meet the extraordinary circumstances standard set forth in the FSA.

¹¹¹ The Co-Neutrals have provided these instruments to the State for feedback, and all of the State’s suggestions were incorporated. The Co-Neutral team participated in an initial orientation and training on the FSA standards and review instruments, and participated in a FACTS training conducted by CYFD staff. The Co-Neutral team implemented a quality control process during the reviews, which included inter-rater reliability and second-level reviews of identified surveys. Findings from these reviews were provided to the State for review and feedback in advance of publication of this report.

¹¹² The Co-Neutral team conducted qualitative reviews in 2024 and early 2025 using placement data submitted monthly by the State pursuant to the MOU and CAP. The State’s full 2024 Sandbox data submission provided to the Co-Neutrals identified 86 office and Receiving Center placements that did not appear in the monthly placement data and thus were not reviewed in the Co-Neutral team’s qualitative review; similarly, the qualitative review identified and reviewed 82 office and Receiving Center placements that were not included in the State’s Sandbox data submission. Some of these discrepancies may be due to the dates of placement, or another data field, not matching exactly between the two sources (qualitative review versus Sandbox data). The number of unique children identified during the qualitative review of 708 office placements was 376, and the number of unique children identified by the State in the Sandbox data provided for the listed 709 office placements was 404, suggesting that the total number of office placements is higher than what is reported here for either the quantitative or qualitative metric.

nearly half (48%, 337) lasted five or more nights. The lengths of stay for the 708 office placements reviewed are set forth in Figure 13. In 2023, 21 percent of office placements reviewed were for more than six nights; that category rose to 39 percent in 2024.

Figure 13: Length of Stay of Office Placements Reviewed
2024



Source: Case record review of FACTS documentation conducted by the Co-Neutral team

Of the 708 office placements that were reviewed, 33 percent were made following a discharge or disruption from a non-relative resource home, and nearly one-quarter (23%, 162) served as the child's first placement upon entering foster care in 2024. The third most common prior placement type was acute hospitalization (9%, 63). In other words, according to State data, 63 children moved directly from a hospital stay to a CYFD office in 2024.

None (0%) of the 708 office placements reviewed by the Co-Neutral team documented that the placement was made due to extraordinary circumstances necessary to protect the safety and security of the child and with approval by the Secretary or PSD Director prior to placement, as required by FSA Appendix B.¹¹³ In fact, nearly all records lacked any documentation that referenced safety and security threats or extraordinary circumstances. In four of the 708 office placements reviewed, documentation in FACTS shows a Memorandum for Decision (MFD) was submitted for approval of the placement.¹¹⁴ However, for the first time since 2021, none of the MFDs for office placements showed approval by the Secretary or PSD Director prior to the

¹¹³ The Co-Neutrals determined that two placements – which included a pair of siblings – met the extraordinary circumstances standard but the records did not include approval by the Secretary or PSD Director prior to placement, as required by FSA Appendix B.

¹¹⁴ An MFD is the CYFD template that case workers complete to request approval by a Manager, Deputy Director, Director, and/or CYFD Secretary. As used in the context of approval for office stays, the assigned permanency coordinator (PC) is required to include in the MFD all efforts to identify appropriate placements for the child and the extraordinary circumstances that threaten the child's safety and security.

placement.¹¹⁵ That practice appears to have been abandoned by CYFD in 2024 despite the FSA requirement.

*BTO1.1(iii) – qualitative metric: Qualitative review of extraordinary circumstance and medical necessity determinations for placements to out-of-state congregate settings.*¹¹⁶

The number of new child placements to out-of-state facilities continued to increase sharply in 2024, rising to 32 as compared to 19 in 2023, and 14 in 2022.¹¹⁷ Demographics and other relevant information for the children placed out of state are bulleted below:

- The largest age group of children at the time of placement was 11 to 13 years old (53%), followed by 14 to 17 years old (31%). Five children (16%) were between the ages of eight and 10.
- The assigned permanency goal at the time of placement was adoption for over half of children (53%), reunification for 13 children (41%), and permanent guardianship for two children (6%).
- The most common diagnoses at the time of placement were: Attention-Deficit/Hyperactivity Disorder (ADHD) (10 children); Post-Traumatic Stress Disorder (9 children); Major Depressive Disorder (MDD) (8 children); and Disruptive Mood Dysregulation Disorder (DMDD) (6 children).¹¹⁸ Three of the children placed out of state carried a diagnosis related to intellectual functioning.
- Psychotropic prescribing patterns prior to the child's placement in the out-of-state facility were inconsistent with American Academy of Child and Adolescent Psychiatrist (AACAP) guidelines for foster children for five children; one child was prescribed medications inconsistent with three of the guidelines and another child was prescribed medications inconsistent with two of the guidelines.¹¹⁹
- For the 32 placements reviewed, over one-quarter of children (28%) were placed in another facility immediately prior to the out-of-state facility. The other most common

¹¹⁵ Two MFDs were submitted in January 2024, and two were submitted in February 2024; none were documented as approved.

¹¹⁶ In assessing extraordinary circumstances determinations, the Co-Neutral team assessed whether documentation in the child's record demonstrated the placement was necessary to protect the safety and security of the child, and that the placement was approved by the CYFD Secretary or PSD Director prior to the placement occurring. The lack of alternative or available placements is insufficient to meet the extraordinary circumstances standard set forth in the FSA.

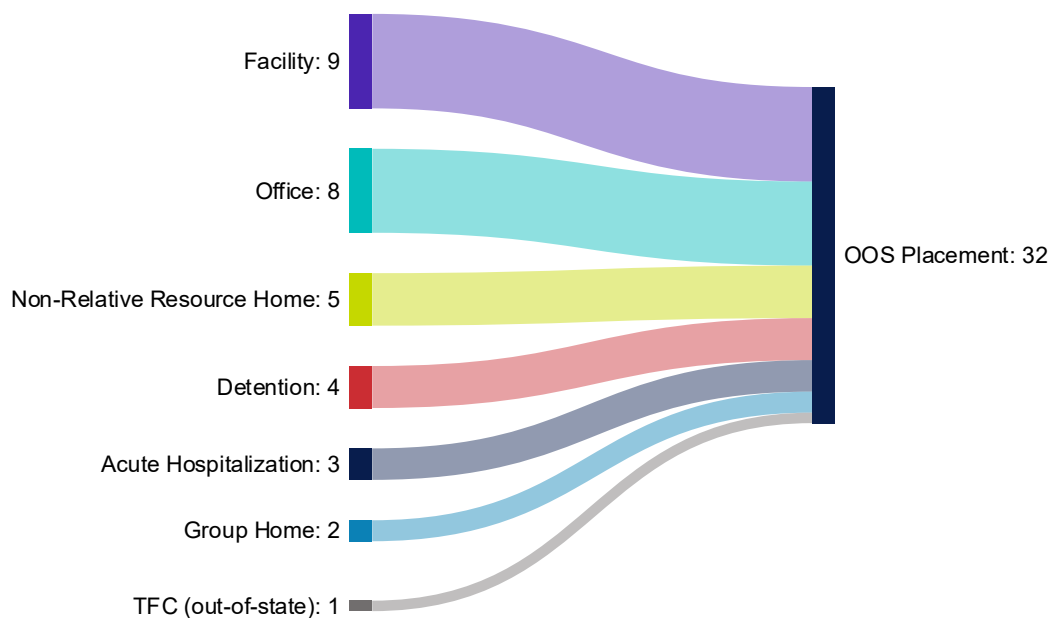
¹¹⁷ A total of 31 unique children experienced 32 new out-of-state placements in 2024; one child experienced two placements during the period. The quantitative data referenced earlier in this section cites 33 new out-of-state placements; these data include one child who entered state custody while already placed in the out-of-state facility. As the State did not make the decision to place this child within the facility, this placement was not reviewed for purposes of the qualitative metric.

¹¹⁸ Reviewers were unable to find a diagnosis for eight children prior to their out-of-state placement within the records available for the review.

¹¹⁹ Additional information from the AACAP can be found [here](#) and [here](#).

prior placement types prior to the out-of-state placement were office (25%), non-relative resource home (16%), and detention (13%).

Figure 14: Placement Prior to OOS Placement
2024



Source: Case record review of FACTS and MCO documentation conducted by CYFD staff and Co-Neutral team


Extraordinary circumstances and medical necessity

The FSA requires the State to ensure that a child’s out-of-state placement in a facility meets both the extraordinary circumstances standard and is medically necessary. “The finding of medical necessity must take into consideration whether community-based mental health services have been or could be provided.”¹²⁰

The Co-Neutrals assessed that none of the 32 out-of-state facility placements in 2024 were made pursuant to extraordinary circumstances necessary to protect the safety and security of the child, as required by FSA Appendix B. Eight of the out-of-state placements (25%) included no documented reference to safety and security threats. The most common issues noted were aggression, self-harm, runaway behaviors, and trauma evidenced by mental health and placement instability. For example, the justification for one child’s placement out of state was reported to be:

“...threatening people, destroying property, unable to regulate when told no. Foster care unable to manage [the child]. [The child] presents with passive [suicidal ideation] thoughts and expression of being unloved.”

¹²⁰ FSA, pg. 6a.



While these and other circumstances may be pertinent to a medical necessity determination and the need for therapeutic services, the Co-Neutrals were unable to determine that such conditions and behaviors necessitated a child's placement out of the state of New Mexico to ensure the child's safety. Documentation shows that an MFD was submitted to and approved by the CYFD Secretary or PSD Director prior to 12 of the 32 out-of-state congregate placements (38%).

Reviewers from CYFD and the Co-Neutral team relied on the FACTS and MCO records to determine whether a medical necessity determination had been made to support residential care for the child; such a finding requires that the MCO determine medical necessity is met for the level of care provided and, pursuant to the FSA medical necessity definition, that such determination took into consideration whether community-based mental health services have been or could be provided. Of the 32 out-of-state placements reviewed, FACTS and MCO documentation showed that the placement was made pursuant to the medical necessity standard in 19 placements (59%). Of the 13 placements for which medical necessity was not met, in six placements, there is no documented finding of medical necessity by the MCO for the placement provided during the review. Of the remaining seven placements, a determination of medical necessity was made by the MCO but such determination was not documented as taking into account if community-based services have been or could have been provided.

Triage team meeting


CYFD's procedure requires that a triage team meeting be held within 48 hours of a recommendation for a child to be placed out of state.¹²¹ The team should identify appropriate therapeutic placement options that will meet the individual child's needs based on a current assessment, and should only consider an out-of-state placement in extraordinary circumstances to protect the child's safety and security and after full consideration of other treatment options.

A triage team meeting was documented as completed prior to 18 of the 32 out-of-state placements. The following participants attended the meetings: PC worker (13 meetings); PC supervisor (14 meetings); CBHC (14 meetings); MCO care coordinator (10 meetings); child or youth (4 meetings); and the child or youth's family (1 meeting). CYFD's policy requires that the most recent behavioral health evaluation be provided to the triage team members for review prior to the meeting. Of the 18 completed triage meetings, documentation from case records show that a recent behavioral health evaluation was provided prior to two meetings.¹²² Reviewers identified in the documentation that recommendations for out-of-state placement were based on children's challenges with self-regulation and suicidal ideations; denials by in-state facilities; and challenging impulsive behavior like running away, self-harm, and what was documented as "manipulative behavior." The Co-Neutral team assessed that behavioral health information relied upon in the triage meetings was often scant, general, and referenced historical and present challenges without distinction in a few instances.

In 10 triage meetings, the team members agreed on an appropriate placement, services, and supports for the child. For the remaining eight meetings, team members did not agree, and the lack of agreement was most frequently due to poor communication with no follow-up or

¹²¹ 8.10.8 NMAC, paragraph 11.3.

¹²² For seven placements, there was no recent behavioral health evaluation available.



resolution to different recommendations and lack of reconciling a documented change in a child's needs and acuity. In one instance, the lack of agreement was due to resistance from the child for the placement.

Documentation about the information reviewed by CYFD and/or HCA about the safety record of the out-of-state facility prior to the decision to place the child in the facility was inconsistent and generally absent from the record.¹²³ Two facilities were documented as of concern to the triage team: one because it was new and the other because of historical concerns. Reviewers did not find documentation that showed follow up nor resolution of these concerns.

For 15 of the out-of-state placements, there was documentation that showed the reason why a specific out-of-state facility was chosen and the services it offered. In the remaining records that provided information about the choice of facility, only four were specific to the child's needs (i.e., culturally sensitive, treatment for autism, treatment for sexualized behaviors, and Diabetes Mellitus Type 1 care.) The remaining records included non-specific reasons (i.e., "we believe this can meet [the child's] needs"), or cited structure, supervision, and multidisciplinary teams as considerations in the choice of facility.

Discussion

Fourteen percent of children in state custody in 2024 experienced a placement to at least one of the settings covered by this commitment – office or out-of-state facility – double the rate from 2023, and nearly 500 percent more children than in 2019. The number of placements in offices increased substantially from the prior year – 322 in 2023, to 709 in 2024. Nearly half (48%) of office placements lasted five or more nights. The Co-Neutrals assess that none of the children's placements in offices or out-of-state facilities in 2024 met the extraordinary circumstances standard.

¹²³ The record for one child's placement showed an inquiry was made into allegations of child abuse and neglect at the facility in the previous 12 months. The records for two other children's placements showed that licensing violations within the facility were reviewed, and concerns were noted in one due to "practices authorized in the facility that are not permitted in New Mexico nor for children in the custody of CYFD." In six instances, the MFD indicated that the facility license was "active" and in one instance that the facility licensing status was "eligible."

Joint Clinical Reviews of Out-of-State Placements (App. B, TO 2.1)

FSA Requirement	By December 1, 2020, HCA and CYFD will conduct a joint clinical review of any out-of-state placement, where the child’s out-of-state placement is not the child’s permanency plan, at least on a monthly basis. (Due June 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

The Joint Clinical Review (JCR) process is outlined in paragraph 11.4 of CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC).¹²⁴ The procedure states that the JCR is a process utilizing the IPP framework that is required for children who are placed in out-of-state facilities to provide a forum to: review the child’s treatment plan and updates; review or create a discharge plan, including identification of in-state resources that need to be developed and in place for the child to return to New Mexico; identify any gaps in the medical and behavioral health care being provided, and create strategies to address any identified gaps.

JCR meetings are expected to occur every 30 days, are to be coordinated by the CYFD PC case worker, and must include specified participants. These participants include: the child or youth, child or youth’s parent or other family members, PC or primary assigned case worker, PC or primary assigned worker’s supervisor, CBHC staff, MCO care coordinator or other care coordinator representative, case manager from the out-of-state facility, GAL or Youth Attorney (YA), Tribal representative (as applicable), and representative from the Office of Tribal Affairs (OTA) (as applicable).

DVP Metrics and Validated Performance Data

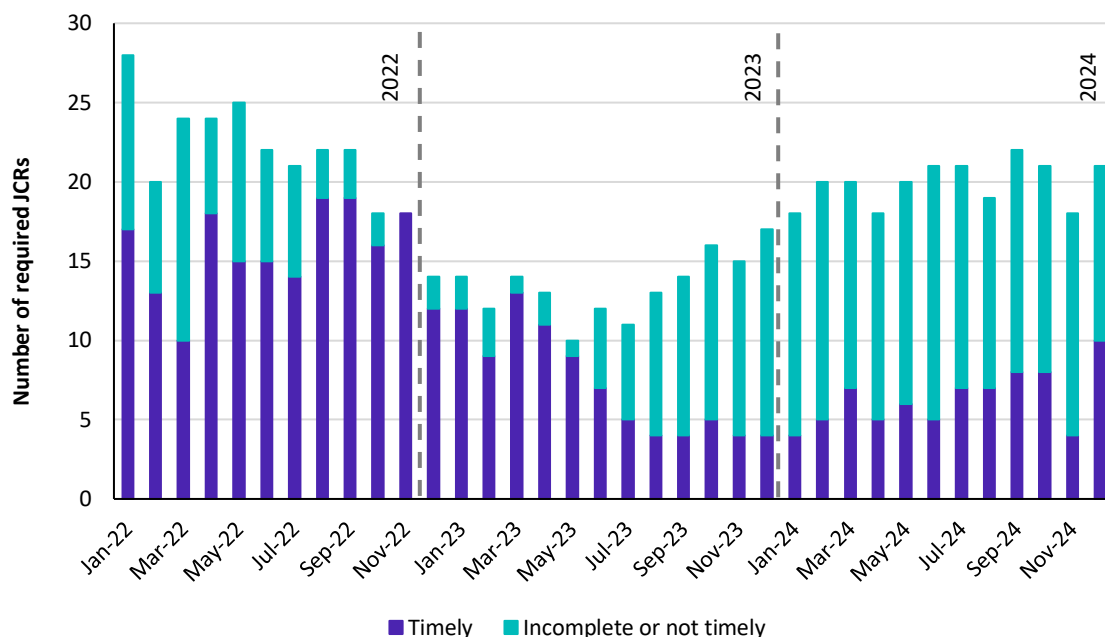
BT02.1(i) – primary metric: Of all the joint clinical reviews required during the reporting year, the percent that were conducted timely.

There were 239 JCR meetings required in 2024 for children in out-of-state placements, and about one-third (32%, or 76) were conducted on time.¹²⁵ This is a decrease in performance from prior years (see Figure 15). In 2022, 186 of 258 required JCR meetings (72%) were conducted on time, and in 2023, 88 of 161 required JCR meetings (55%) were conducted on time.

¹²⁴ CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC) can be found [here](#).

¹²⁵ A meeting is considered “conducted” when the State’s data indicate that it was not canceled, it occurred on or before the due date, and it was an “Out-of-State 30-Day Review.” Due dates were calculated as every 30 days after the start of the placement and were unaffected by a move from one out-of-state placement to another.

Figure 15: Completed and Required Joint Clinical Review Meetings for Out-of-State Residential Placements, by Month
2022-2024



Source: Analysis of Sandbox Placements and Meetings files and FACTS episodes file, plus adjustments based on case record review

BTO2.1(ii) – qualitative metric: Qualitative review of Joint Clinical Reviews for children in out of state placements.

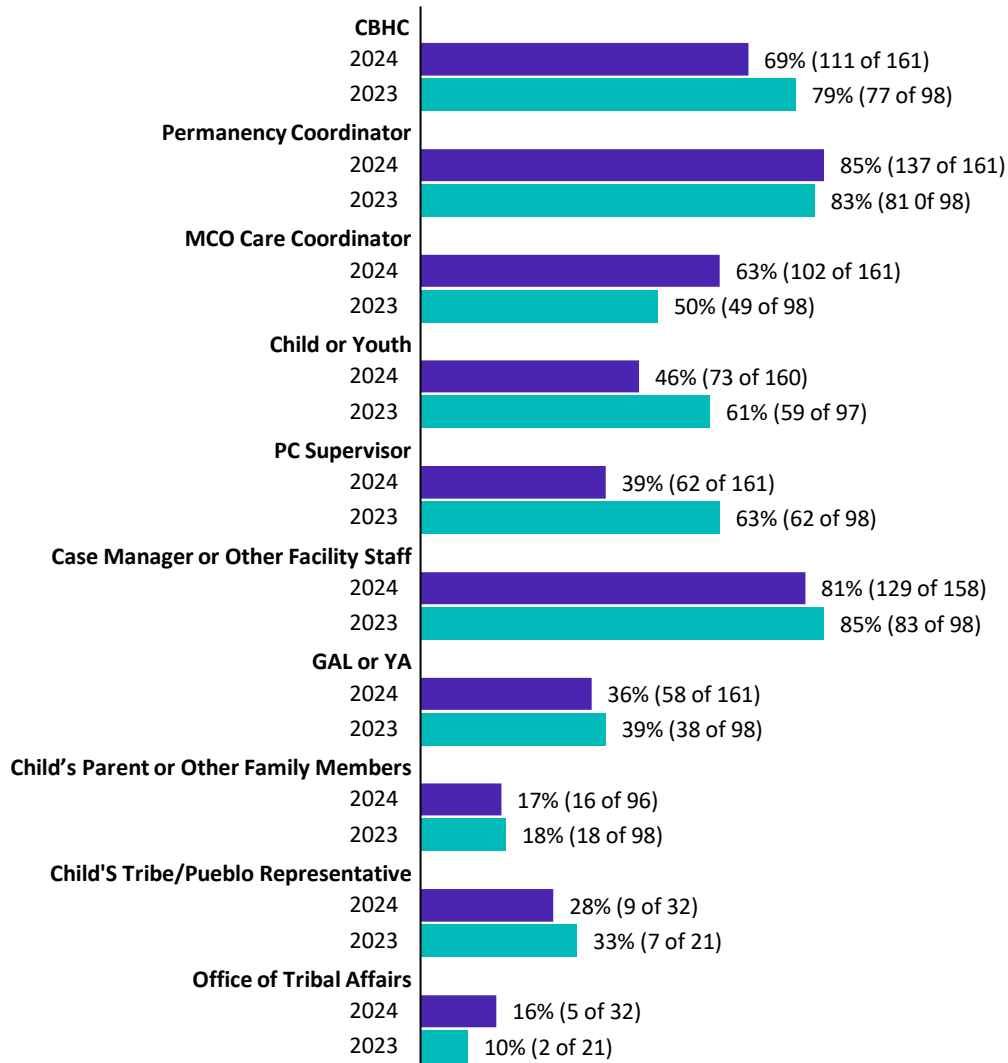
Reviewers from CYFD and the Co-Neutral team reviewed the FACTS and MCO records for all applicable placements of children who were in facilities out-of-state between January and December 2024, including children placed out-of-state in 2023 who remained in those placements for at least 30 days in 2024. For the 49 placements reviewed (involving 46 unique children), a total of 241 JCR meetings were required between January and December 2024. Reviewers confirmed that 161 JCR meetings (67%) were documented as completed.¹²⁶ None (0%) of the completed JCRs included all required attendees and documented discussion of all required meeting components including review of the child’s treatment plan, discharge plan, and identification of in-state resources that need to be developed and in place for the child to return to New Mexico.

Of the 161 JCR meetings that were documented as completed between January and December 2024, the PC case worker (85%) and case manager or other staff from the facility (81%) were the most consistently documented attendees in the meetings (see Figure 16). The CBHC worker was present in 69 percent of meetings, and the MCO care coordinator attended 63 percent of

¹²⁶ Data collected and analyzed for the qualitative metric differs from the analysis discussed earlier for the quantitative metric; the qualitative metric did not examine the 30-day timeliness component but instead identified if a JCR meeting occurred at any time during the applicable month.

meetings.

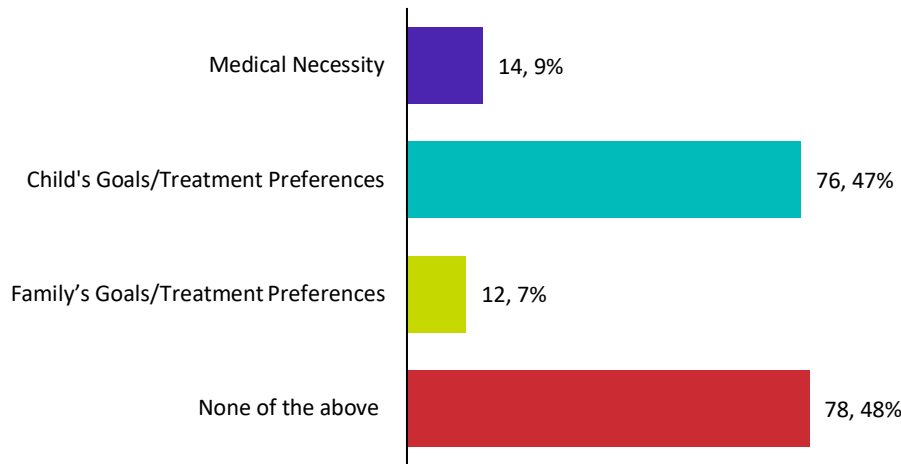
Figure 16: Documented Participants in Completed Joint Clinical Review Meetings
2023 - 2024



Source: Case record reviews of FACTS and MCO documentation conducted by CYFD staff and Co-Neutral team

As shown in Figure 17, nearly half of the meetings (48%) lacked documentation that medical necessity, the child/youth's goals of care and treatment preferences, and child/youth's family's goals of care and treatment preferences were discussed.

Figure 17: JCR Meeting Components Discussed
2024; N=161



Source: Case record reviews of FACTS and MCO documentation conducted by CYFD staff and Co-Neutral team

Discussion

The quantitative data show that timely completion of JCR meetings has steadily decreased over the last three years – 72 percent in 2022, to 55 percent in 2023, and 32 percent in 2024. Of the JCR meetings that were determined through the qualitative review to be held at any point during an applicable month, nearly half (48%) lacked documentation that any of the required meeting components were discussed.

Of the 49 out-of-state placements in 2024 that were reviewed, CYFD or MCO documentation showed that 19 of these out-of-state facility placements (39%) were either assessed by the MCO or the child's treatment team as no longer medically necessary and the child was ready for discharge but remained in the facilities. The most common reasons cited for their continued stays were lack of discharge planning and securing an appropriate placement in New Mexico.

Known Case Worker Visits to Children Placed in Out-of-State Facilities (App. B, TO 2.2)

FSA Requirement	A CYFD caseworker known to the child will conduct in-person visits every month. (Due June 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Monthly visits to children in out-of-state placements are required to assess the child's safety and well-being and to ensure the child's needs are being met. Paragraph 11.6 of CYFD's *Permanency Planning Procedures* (8.10.8 NMAC) provides that a child's assigned PSD worker or their supervisor is required to conduct these visits.¹²⁷ Paragraph 11.6 specifically states:

If the decision is to place a child or youth in an out of state congregate placement, the PSD Worker or Supervisor must visit the child monthly to assess the child/youth's safety and wellbeing and ensure the child/youth's needs are being met. When that is impossible, the PSD Worker's Supervisor may approve the monthly worker-child visit be conducted by a worker who has a relationship to the child/youth to assess the child/youth's safety and wellbeing and ensure the child/youth's needs are being met. PSD Worker and Supervisor will ensure contact is maintained between the child and their family.

In August 2024, CYFD created new unit comprised of a secondary assigned OOS triage worker and a CBHC staff who would conduct in-person visits with all children who were placed out of state. CYFD reports that the triage worker would visit monthly with the child, and the CBHC staff would visit either monthly or on a five-to-six-week cadence, depending on the needs of the child. The child's primary assigned PC were no longer allowed to travel out of state to visit with the child, and were instructed to conduct virtual visits.

By CYFD directive, staff from the OOS triage unit and the primary assigned PC should be in regular communication to monitor the child's needs, their safety, and plan for discharge.

DVP Metrics and Validated Performance Data

BTO2.2(i) – primary metric: For all of the in-person visits to any child in an out-of-state placement that is not part of a child's permanency plan required during the reporting year, the percent that were conducted timely by a caseworker known to the child.

BTO2.2(i) – secondary metric: For all of the in-person visits to any child in an out-of-state placement that is not part of a child's permanency plan required during the reporting year, the percent that were conducted timely.*

¹²⁷ CYFD's *Permanency Planning Procedures* (8.10.8 NMAC) can be found [here](#).

Per the DVP, the first visit is due by the end of the month following the child’s placement, and visits with the child are due once every month thereafter until the placement ends. For this analysis, the number of visits due was calculated based on the start of the placement until the end of the period placed out of state (or end of the reporting year).¹²⁸

In reviewing the data provided by the State for this quantitative metric in conjunction with the data collected for the corresponding qualitative metric, the Co-Neutrals were unable to validate the quantitative performance data provided by the State.^{129,130}

*BTO2.2(ii) – qualitative metric: Validation of known worker indicator.*¹³¹

Reviewers from CYFD and the Co-Neutral team reviewed the FACTS records for all children placed out-of-state for at least 30 days in 2024 to determine if a PSD worker visited the child each month they were placed out of state. If someone other than the child’s assigned PC or PC supervisor visited the child, in order to assess if the worker was “known to the child,” documentation was reviewed to determine if the supervisor approved the worker to conduct the visit and that the worker had a relationship with the child. In over half of the 49 out-of-state placements (29, 59%), the child experienced a change in their assigned primary worker during their time in the placement.

Prior to the case review, the Co-Neutrals and CYFD QA staff requested clarity from CYFD on any changes to policy or procedures for visits conducted by the OOS triage workers – assigned as secondary workers – and if these visits should meet the FSA requirement for a worker known to the child. CYFD never provided this information. Therefore, the Co-Neutrals could not assess that visits by a worker other than the assigned PC or supervisor that were not documented in the record as approved by the supervisor to meet the definition of “worker known to the child” met the FSA requirement.

Of the 240 required visits between January and December 2024 identified during the qualitative review, 92 visits (38%) were completed by the child’s primary PC (see Figure 18). An additional 12 visits (5%) were completed by the assigned worker’s supervisor, and nine visits (4%) were completed by a worker known to the child as approved by the supervisor. Thus, based upon documentation in the children’s records, 47 percent of required visits were conducted by a worker known to the child. Seventeen percent of required visits were not documented as completed at

¹²⁸ If the placement began before the start of the reporting year, the first visit was due in January.

¹²⁹ In 2024, data submitted by the State show there were 47 children in out-of-state facilities for at least 30 days during the reporting year, with a total of 226 visits required; the State’s data shows that 208 of those visits (92%) were conducted on time by any person, not limited to a case worker known to the child.

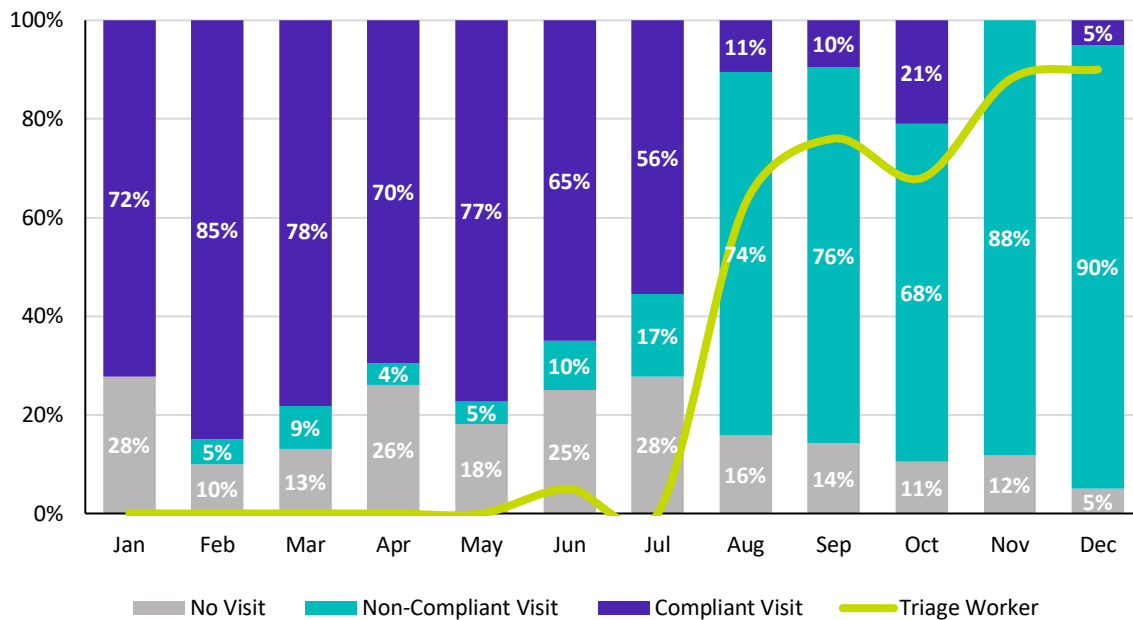
¹³⁰ Quantitative data submitted by the State for the 226 visits due for 47 children placed in out-of-state facilities show 154 visits (68%) were completed on time and by a case worker recorded in FACTS as “known to the child.” The CYFD and Co-Neutral team’s qualitative review of children’s FACTS records identified performance was 47 percent.

¹³¹ Over the last five years, the Co-Neutrals have had numerous conversations and written exchanges with the State to confirm alignment on the child’s primary PSD worker as the proxy for worker known to child, with documented exceptions as outlined in the procedure.

all.

Beginning in August 2024, most visits that were conducted were documented as completed by an OOS triage worker; in total, they completed 31 percent of required visits in 2024.

Figure 18: Worker Visits to Children Placed Out-of-State, Required and Completed
January - December 2024



Source: Case record review of FACTS documentation conducted by CYFD staff and Co-Neutral team

Discussion

Visits to children placed out of state by adults who they know and with whom they have a relationship are a critical component to assessing children's safety when they are far from home, evaluating their treatment progress, planning for their discharge, and maintaining connections.

Practices that may pose safety concerns for children while placed in restrictive settings out of state can include frequent or excessive use of physical and chemical restraints, seclusion, and abuse or neglect by facility staff. Of the 49 placements reviewed (involving 46 children) that occurred in 2024, half (24 placements) documented at least one instance of physical restraint, 21 placements documented at least one instance of chemical restraint, and in six placements, the child in CYFD custody experienced an injury while in the placement. The Co-Neutrals had numerous conversations in 2024 with CYFD and HCA about their tracking and monitoring of these incidents.

Out-of-State IPP Meeting and Development of Discharge Plans (App. B, TO 2.3)

FSA Commitment	Within the first 30 Days of the placement, the out-of-state Individualized Planning Meeting team will develop a discharge plan which includes identification of in-state resources that need to be developed for the child to return to New Mexico. The CYFD caseworker will do so by working with HCA or its designee to secure services that could be funded by Medicaid. Individualized Planning Meetings, which may take place during scheduled treatment team meetings for children in residential care, will be held every 30 Days to support the child and identify steps necessary to promote discharge. (Due June 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

CYFD's *Permanency Planning Procedures* (8.10.8 NMAC) states that discharge planning is a required component of the monthly JCR meeting for children placed in out-of-state facilities.¹³² Specifically, paragraph 11.4 states, in relevant part:

Within 30 days of a child's placement out of state, the child's Triage Team for Out of State placement will develop a discharge plan. The discharge plan is defined as a process which gives children/youth, their guardians and families' access to information that will help them to make informed decisions about their post care, while addressing their goals of care and treatment preferences, which may help to stabilize them post-placement and ultimately reduce their chances of being readmitted. The discharge plan should include identification of in-state resources that need to be developed and in place for the child to return to New Mexico.

The procedure requires that the JCR team plan for the child or youth's discharge to a less restrictive placement in New Mexico and that the plan be documented and uploaded to FACTS.


DVP Metrics and Validated Performance Data

BTO2.3(i) – primary metric: Of all the discharge plans required for an Out-of-State placement not consistent with the child's permanency plan, the percent that were done timely (within 30 days of placement).

BTO2.3(iii) – primary metric: Of all the discharge review IPM meetings required for an Out-of-State placement not consistent with the child's permanency plan, the percent that were done timely (every 30 days of placement).

The Co-Neutrals were unable to validate 2024 data for this metric because it relies on a data collection process that the State was not using consistently in 2024. In 2022, the State embedded

¹³² CYFD's *Permanency Planning Procedures* (8.10.8 NMAC) can be found [here](#).



a survey tool into FACTS to collect information on the components of and participants in meetings (including whether a discharge plan was developed or reviewed), but the State reported that very few of these surveys were completed in 2023 and 2024. Data from this survey tool or an alternative source will be necessary to validate this metric for 2025.

BTO2.3(ii) – qualitative metric: Qualitative review of discharge plans for children in out-of-state placements.

Reviewers from CYFD and the Co-Neutral team reviewed the FACTS and MCO records for all children who were in out-of-state facilities for at least 30 days in 2024 to determine if a discharge plan was developed and/or reviewed to identify next steps to promote the child's return to New Mexico. Discharge plans were reviewed to identify if they included the following components: steps necessary to promote discharge, identification of available community-based mental health services and supports that could be provided, and identification of in-state resources that need to be developed for the child to return and live safely in New Mexico.

Of the 241 required discharge plans between January and December 2024, 65 plans (27%) were documented that included at least one of the required components; none of the plans included all required components. The 65 plans were developed for 25 of the 49 placements reviewed, meaning there were no discharge plans documented for nearly half of the children's placements (49%).

Of the 65 discharge plans that were developed, 40 plans documented the steps necessary to promote discharge (pertaining to 16 of the 49 placements), 39 plans identified available community-based mental health services and supports that could be provided (pertaining to 18 of the 49 placements), and 11 plans identified in-state resources that need to be developed for the child to return to New Mexico (pertaining to 9 of the 49 placements).^{133,134} For the nine placements that had a plan which identified in-state resources that need to be developed for the child to return to New Mexico, there was documentation for two placements that the CYFD worker was working with HCA or the MCO to secure services that could be funded by Medicaid, including but not limited to a single, child-specific contract.

In-state resources identified and documented for discharge planning included: a TFC home where the child could be the only child placed; an acute hospital provider in New Mexico; and enrollment in the Developmental Disability Waiver program and New Mexico Medicaid (the child was covered by Medicaid in the state of the facility) so that durable medical equipment would continue to be provided.

¹³³ Some plans included more than one required component.

¹³⁴ Documentation for an additional 13 JCR meetings included a discharge plan, but the plan did not include any of the required components.

Discussion

Documentation of practice in 2024 shows that documented discharge planning was absent for nearly half of the out-of-state placements (49%) reviewed. The impact of inadequate discharge planning was deeply consequential for children who remained in restrictive settings far from their home communities longer than necessary (39% of placements were assessed as no longer medically necessary and the child was ready for discharge but remained in the facilities), and placement instability once they do return.¹³⁵

There were 14 children who were placed and discharged from out-of-state facilities in 2024. Upon discharge, five of these children were immediately placed in a CYFD office, four were placed in a non-relative resource home, three were placed in a shelter, one was hospitalized in a behavioral health facility, and one was placed in TFC. Since their discharge through December 31, 2024, these 14 children have experienced an average of four subsequent placements.

Prohibition of Clinical Congregate Care Placements Except When Medically Necessary (App. B, TO 3.1)

FSA Requirement	By December 1, 2021, for any child placed in a congregate care setting due to a medical necessity determination that the child requires residential treatment, the finding of a medical necessity will be clinically reviewed every 30 days, or more frequently as needed. The finding of medical necessity must take into consideration whether community-based mental health services have been or could have been provided. (Due December 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Paragraph 10.2 of CYFD's *Permanency Planning Procedures* (8.10.8 NMAC) requires that placement in clinical congregate care facilities occur only when determined to be medically necessary. New Mexico's Children's Code defines medically necessary services as clinical and rehabilitative physical, mental, or behavioral health services that are:¹³⁶

- (1) essential to prevent, diagnose or treat medical conditions or are essential to enable the child to attain, maintain or regain functional capacity;

¹³⁵ The qualitative review also identified issues in planning for older youth. Of the placements reviewed, there were at least two youth who turned 18 in 2024 and should have been discharged from the facilities, however, due to inadequate discharge planning, they remained longer than appropriate and necessary in the out-of-state facilities. Challenges documented in the records include either denials or waitlists for DD waiver services or issues with guardianship applications and SSI.

¹³⁶ NMSA § 1978, 32A-6A-4(T).

(2) delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the child;

(3) provided within professionally accepted standards of practice and national guidelines; and

(4) required to meet the physical, mental and behavioral health needs of the child and are not primarily for the convenience of the child, provider or payer.

The finding of medical necessity must be determined by the child's MCO, and pursuant to the FSA, the finding of medical necessity must take into consideration whether community-based mental health services have been or could be provided.

DVP Metrics and Validated Performance Data

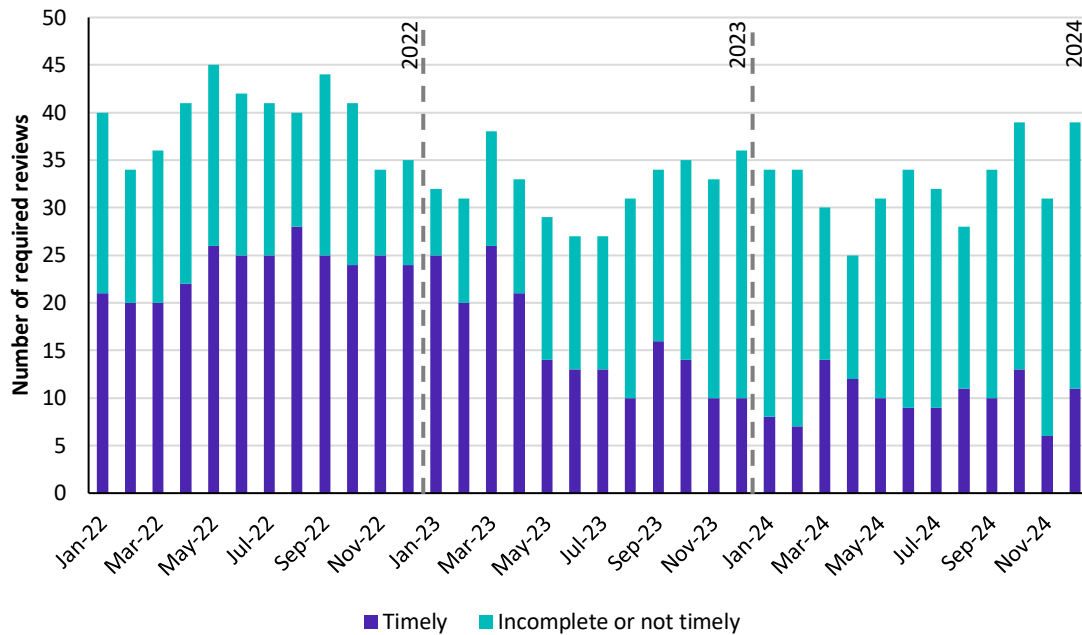
BTO3.1(i) – primary metric: Of all clinical reviews required for placements in congregate care settings due to medical necessity, the percent that occurred timely (every 30 days) and reviewed the medical necessity determination.

An IPP team is required to review the determination of medical necessity for a child's congregate care placement at least every 30 days a child spends in any clinical placement to an in-state or out-of-state facility. There were 391 required medical necessity reviews for children in clinical congregate care settings in 2024, and 120 of these (31%) were conducted on time.^{137,138} This is a continued decrease in performance from prior years (see Figure 19) – in 2022, 285 of 473 required reviews (60%) were conducted on time; and in 2023, 192 of 386 required reviews (50%) were conducted on time.

¹³⁷ A meeting is considered "conducted" when the State's data indicate that it was not canceled, it occurred on or before the due date, and it was a "30-day Congregate/Restrictive Setting" meeting or an "Out-of-State 30-Day Review." Due dates were calculated as every 30 days after the start of the placement and were unaffected by a move from one clinical congregate placement to another.

¹³⁸ Data for the qualitative metric discussed below excludes clinical congregate placements that were out of state as these placements were reviewed during the qualitative case record review for App. B, TO 1.

**Figure 19: Completed and Required Reviews for Clinical Congregate Placements, by Month
2022 - 2024**



Source: Analysis of Sandbox Placements and Meetings files and FACTS episodes file, plus adjustments based on case record review

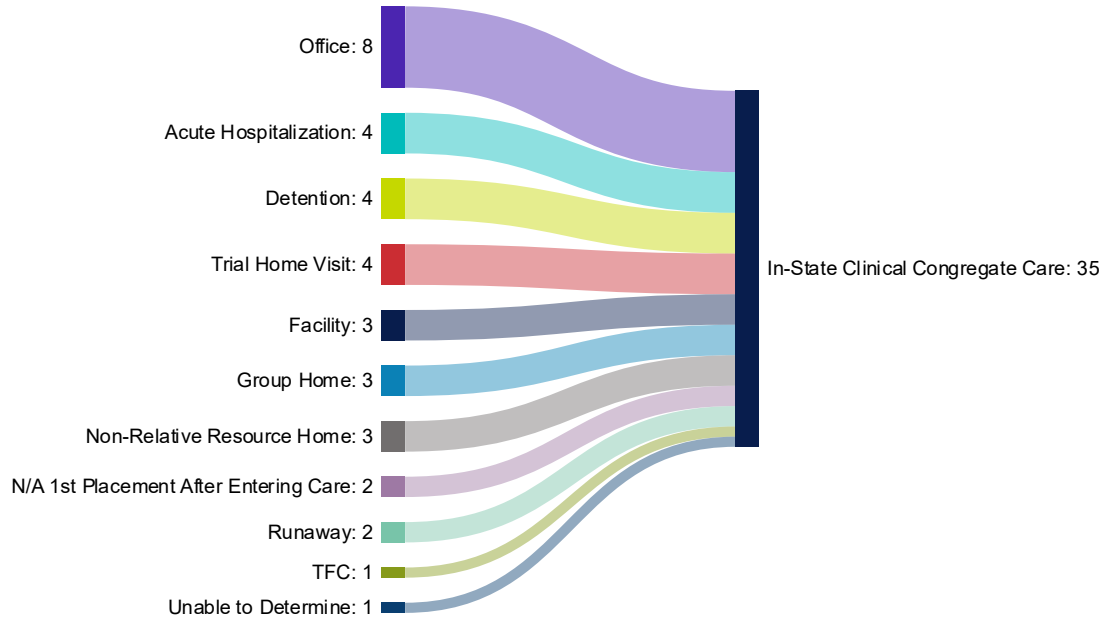
BTO3.1(ii) – qualitative metric: Qualitative review of medical necessity determinations for placements to congregate settings.

Reviewers from CYFD and the Co-Neutral team reviewed the FACTS and MCO records for a sample of placements of children who were in clinical congregate care placements in New Mexico between January and December 2024; the sample included 35 placements made in 2024 experienced by 30 unique children.¹³⁹ The most common diagnoses of the children prior to placement were Attention Deficit Disorder, Post-Traumatic Stress Disorder, and Major Depressive Disorder. Three children had a diagnosis related to intellectual and/or developmental challenges.

Nearly one-quarter of children (23%) were placed in a CYFD office immediately prior to the in-state clinical congregate placement. The other most common prior placement types were acute hospitalization (11%), detention (11%) and return from trial home visit (11%).

¹³⁹ The sample was identified from a universe of in-state residential placements pulled by the State, intending to represent a 95% confidence interval with a 9% margin of error. Following the completion of the review and in assessing the State's 2024 data submission, the Co-Neutrals identified five additional clinical congregate care placements made in 2024 that were not included in the universe identified by CYFD at the outset. Therefore, because the initial sampling universe was inaccurate, the sample of new in-state clinical congregate care placements in 2024 was not fully randomized and the review represents a 95% confidence interval with a 11% margin of error.

Figure 20: Placement Prior to In-State Clinical Congregate Placement of Placements Reviewed 2024



Source: Case record review of FACTS documentation conducted by CYFD staff and Co-Neutral team

Of the 35 clinical congregate placements reviewed, 23 had documented medical necessity determinations by the MCO for the initial placement, and reviewers assessed that nine of those took into consideration whether community-based mental health services had been or could have been provided. Overall, for the 35 applicable placements, 26 percent were made pursuant to the FSA medical necessity standard.

The FSA requires that if the clinical congregate care placement is not supported by medical necessity, there should be a determination that the placement was in the best interest of the child. Of the 26 placements that did not meet the medical necessity standard, none (0%) included documentation supporting that the placement was in the child's best interest.

Two of the 35 placements had a documented IPP or child and family team meeting held prior to the placement. Attendees in these two meetings included the child's assigned primary PC worker, the PC's supervisor, and the MCO care coordinator. The child, child's family, and GAL or YA were not present in either meeting.

Discussion

The State’s quantitative data shows a continued, years-long decline in timely completion of 30-day meetings for children placed in congregate care settings – from 60 percent in 2022, to 50 percent in 2023, and 31 percent in 2024. Of the sample of in-state clinical congregate care placements reviewed, only 26 percent had documentation that the placement was made pursuant to the medical necessity standard outlined in the FSA.

30-Day IPP Meetings for Clinical Congregate Care (App, B. TO 3.2)

FSA Requirement	Individualized Planning Meetings will be held every 30 Days for any child placed in a congregate care setting due to a medical necessity determination to support the child and identify steps necessary to promote discharge. (Due December 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Paragraph 10.1 of CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC) requires that IPP or teaming meetings occur when a child is placed in a congregate care setting due to medical necessity.¹⁴⁰ Similar to the JCR monthly meetings for children placed out of state, meetings pursuant to this commitment are expected to be held to identify the steps necessary to promote discharge and ensure that the team reviews available community-based behavioral health services and supports that have already been provided or could be provided. The PC case worker is responsible for coordinating these meetings and is required to invite specific participants to the meeting. The content of the meetings is required to be documented and entered into FACTS. Pursuant to the FSA, the finding of medical necessity must be clinically reviewed at least every 30 days, and the medical necessity finding should take into consideration whether community-based mental health services and support could be provided.

DVP Metrics and Validated Performance Data

BTO3.2(i) – primary metric: Of all IPP meetings required for placements in congregate care settings due to medical necessity, the percent that were timely (every 30 days) and reviewed steps necessary to promote discharge.

The Co-Neutrals were unable to validate data for this metric because it relies on a data collection process that the State did not use consistently in 2024. In 2022, the State embedded a survey tool into FACTS to collect information on the components of and participants in meetings (including whether a discharge plan was developed or reviewed), but the State reported that very few of these surveys had been completed in 2023 and 2024. Data from this survey tool or an alternative

¹⁴⁰ CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC) can be found [here](#).

source will be necessary to validate this metric for 2025.

BTO3.2(ii) – qualitative metric: Qualitative review of discharge planning for children in congregate placements due to medical necessity.

Reviewers from CYFD and the Co-Neutral team reviewed the FACTS and MCO records for a sample of placements of children who were in clinical congregate care facilities in New Mexico between January and December 2024, including children placed in 2023 who remained in those placements for at least 30 days in 2024. In total, there were 39 placements experienced by 33 unique children in the sample. Most (79%) placements were in facilities and hospitals, and 21 percent were in residential treatment centers.¹⁴¹ Hospital placements may have begun as acute hospitalization commitments but extended longer than 30 days, which make them applicable to this standard.

Demographics and other relevant information for the children reviewed are bulleted below:

- The largest age group of children at the time of placement was 11 to 13 years old (44%), followed by 14 to 17 years old (36%). Eight children (20%) were between the ages of seven and 10.
- The assigned permanency goal at the time of placement was reunification for two-thirds (67%) of children, and adoption for one-third (33%) of children.
- For eight (21%) of the placements reviewed, the child experienced a change in assigned PC case worker during the time they were placed and through the duration of their placement.¹⁴²

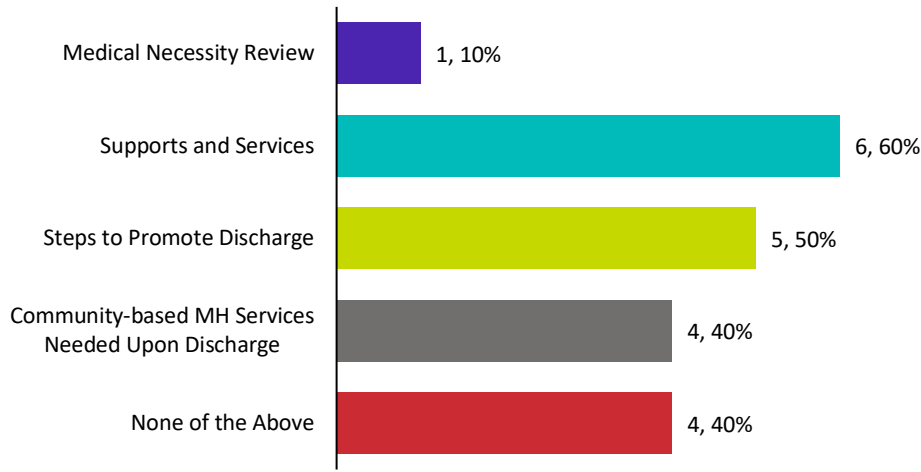
For the 39 placements reviewed, a total of 77 IPP meetings to discuss discharge planning were required between January and December 2024. Reviewers confirmed that 10 meetings (13%) were documented in FACTS as completed.¹⁴³ None of the completed meetings (0%) included all required attendees and documented discussion of all required meeting components, including review of the medical necessity finding, supports and services being provided to the child, steps necessary to promote discharge, and identification of community-based mental health services that the child needs upon discharge. The supports and services being provided to the child within the facility was the most common topic documented as discussed (6 meetings), followed by steps to promote discharge (4 meetings) (see Figure 21). A review of the child's continued medical necessity to remain in the placement was documented as reviewed in one of the 10 meetings.

¹⁴¹ Placements reviewed were in the following facilities: AMI Kids – Sandoval Inc; Peak Psychiatric Hospital; University of NM Hospital – BCMC; Children's Psychiatric Hospital; Sequoyah Treatment Center; Mesilla Valley Hospital; Navajo Regional Behavioral Health Center; and Presbyterian Hospital.

¹⁴² Four of the children's cases with change in assigned permanency worker were from Bernalillo County, three were from Chaves County, and one was from Roosevelt County.

¹⁴³ This qualitative review did not examine the timeliness component as measured in the quantitative metric discussed above. Reviewers identified whether a meeting occurred at any time during the applicable month.

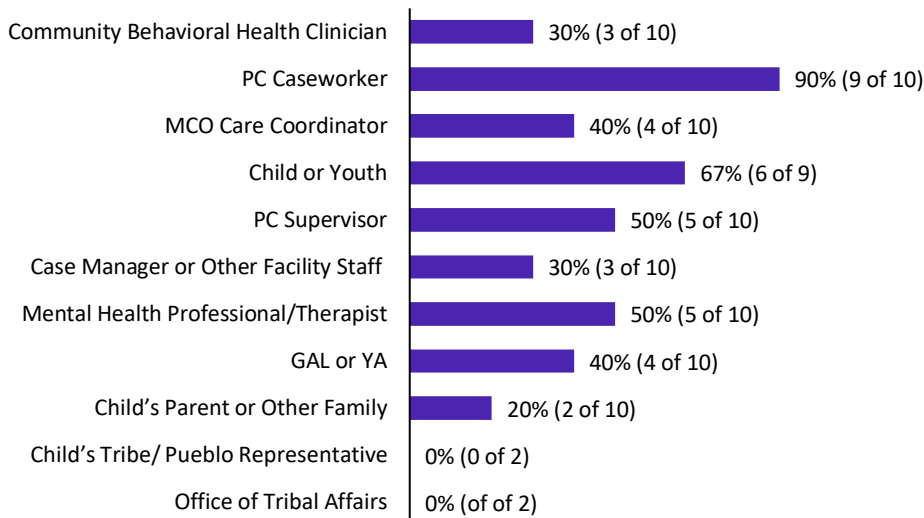
Figure 21: In-State Clinical Congregate Placement IPP Meeting Components Discussed
2024; N=10



Source: Case record review of FACTS and MCO documentation conducted by CYFD staff and Co-Neutral team

Of the 10 IPP meetings that were documented as completed between January and December 2024, the PC case worker (90%) and the child/youth (67%) were the most consistently documented attendees in the meetings (see Figure 22). The CBHC worker was present in 30 percent of meetings, and the MCO care coordinator attended 40 percent of meetings.

Figure 22: Documented Participants in Completed IPP Meetings for Children Placed In-State Clinical Congregate Care Placements
January - December 2024



Source: Case record review of FACTS and MCO documentation conducted by CYFD staff and Co-Neutral team

Discussion

The qualitative data shows that IPP meetings occurred as required only 13 percent of the time, and the CYFD staff and Co-Neutral teams' case record reviews revealed that none of the meetings included all of the required participants and discussion topics.

In 14 of the 39 placements (36%) reviewed, though medical necessity may have been determined for the initial placement decision, the placements were determined at some point during the placement to no longer be medically necessary but the children remained in the placement, primarily due to the lack of an appropriate alternative placement when the child was ready for discharge.

Similar to the review of children in out-of-state placements, reviewers identified the use of physical and chemical restraints for children in in-state clinical congregate care placements, as well as seclusion and medical neglect. Specifically, of the 39 placements reviewed (experienced by 33 unique children), one-third (13 placements) documented at least one instance of physical restraint, over half (54% or 21 placements) documented at least one instance of use of chemical restraint, six placements (15%) documented at least one instance of use of seclusion, and two placements had documentation of medical neglect.¹⁴⁴

Prohibition of Non-Clinical Congregate Care Placements Except When in a Child's Best Interest (App. B, TO 4.1)

FSA Requirement	Any placement in a congregate care setting that is not supported by a determination of medical necessity, including placement in specialized group homes such as Transitional Living Placements, Maternity Group Homes, or settings for Commercial Sexual Exploitation of Children, must be supported by a determination of the IPM team, including a mental health professional, that it is in the best interests of the child. The best interest determination will be reviewed by the IPM team, including a mental health professional, at least every 90 Days, or more frequently as needed. (Due December 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Paragraph 10.5 of CYFD's *Permanency Planning Procedures* (8.10.8 NMAC) requires that the placement of any child in a congregate care setting that is not supported by medical necessity be supported by a determination of an IPP team – which includes a mental health professional – that

¹⁴⁴ The Co-Neutral team conducted this review with CYFD and utilized the process CYFD developed for elevating allegations of medical neglect identified during the reviews.

the placement is in the child’s best interest.^{145,146} The IPP team must meet at least every 90 days and review the best interest determination for the child’s continued placement within that setting.

DVP Metrics and Validated Performance Data

BTO4.1(i) – primary metric: Of all the required IPP meetings for children in congregate care for reasons other than medical necessity during the reporting year, the percent that were held timely and reviewed the best interest determination.

IPP 90-day congregate care meetings for best interest determinations were required for children in non-clinical congregate settings 141 times in the 2024; five of these meetings (4%) were conducted on time.^{147,148,149} Performance is similar to prior years; two of 115 required meetings (2%) were conducted on time in 2022, and three of 155 required meetings (2%) were conducted on time in 2023 (see Table 12). No required reviews were completed in the first half of 2024 (79 were required); the completion rate in the second half of the year was eight percent (5 of 57 required reviews were completed timely) (see Figure 23).

Table 12: Completed and Required Reviews for Non-Clinical Congregate Placements, by Month 2022 - 2024

Year	Total Required Reviews	Completed and Timely Reviews	Percent of Required Reviews Completed Timely
2022	115	2	2%
2023	155	3	2%
2024	141	5	4%

Source: Analysis of Sandbox Placements and Meetings files

¹⁴⁵ CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC) can be found [here](#).

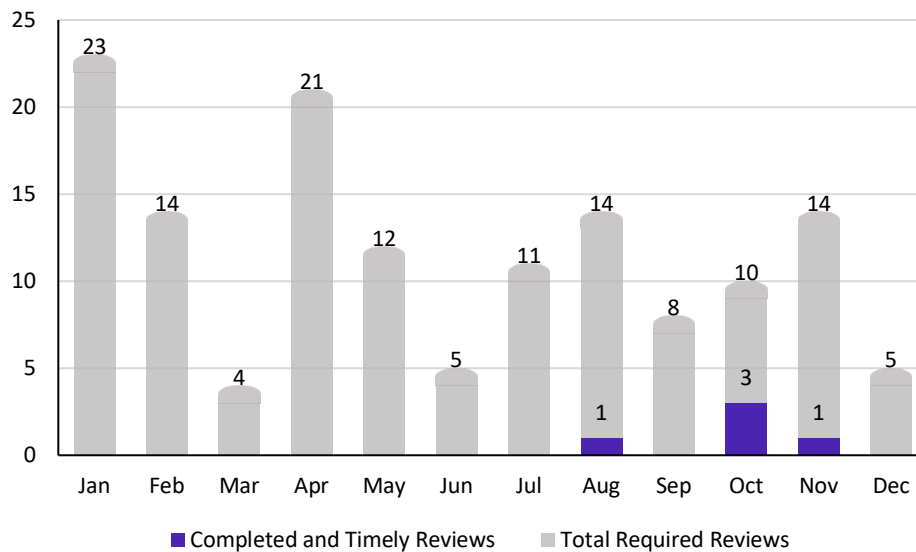
¹⁴⁶ Paragraph 10.3 of the Procedure defines best interest as “...assurance that the health, safety, and protection of the child or youth are a priority, and the child or youth will be given care, treatment, and guidance that will assist the child or youth in developing into a self-sufficient adult. Best interest also takes into consideration the importance of maintaining cultural connection, sibling connections, and other close family bonds as well as the wishes of the child or youth.”

¹⁴⁷ There were 31 children with one review due, 21 children with two reviews due, eight children with three reviews due, and 11 children with four reviews due.

¹⁴⁸ The five completed reviews were for five distinct children.

¹⁴⁹ A meeting is considered “conducted” when the State’s data indicate that it was not canceled, it occurred on or before the due date, and it was a “Best Interest Determination IPP.” Due dates were calculated as every 90 days after the start of the placement and were unaffected by a move from one non-clinical congregate setting to another.

Figure 23: Required and Completed Reviews for Non-Clinical Congregate Placements, by Month 2024



Source: Analysis of Sandbox Placements and Meetings files

*BTO4.1(ii) – qualitative metric: Qualitative review of best interest determinations for placements to congregate settings*¹⁵⁰

CYFD staff and the Co-Neutral team reviewed the FACTS records for a sample of non-clinical congregate care placements – including group homes, community homes, and supervised independent living facilities – made between January and December 2024; the sample included 61 placements experienced by 55 unique children.^{151,152} Demographic and other relevant information for the children reviewed are bulleted below:

- The average age of the children at the time of non-clinical congregate placement was 15; most children were age 15 and older (69%), 30 percent were between the ages of 11 and 14, and only one child was 10 or younger (2%).
- The assigned permanency goal at the time of placement was reunification for nearly half of children (48%, 29), adoption for 36 percent of children (22), permanent guardianship for 10 percent of children (6), and other planned permanent arrangement for eight

¹⁵⁰ In assessing best interest placement determinations, the reviewers used the FSA App. B, TO 4 requirements, specifically, that there is documentation of a best interest determination by the IPP team, which includes a mental health professional.

¹⁵¹ There were a total of 176 new non-clinical congregate care placements that began in 2024; sampling represents a 95% confidence interval with a 10% margin of error. This includes placements of any duration, including many that lasted less than 90 days and are not included in the 90-day IPP metric.

¹⁵² Per the FSA, these settings include community homes, transitional living placements, maternity group homes, and other non-clinical congregate care settings (excluding shelters). CYFD began using crisis stabilization placements in late 2022, which are also subject to this standard.

percent of children (5).

For the 61 placements made in 2024, 27 children (44%) were placed in a CYFD office immediately prior to the in-state non-clinical congregate placement. The other most common prior placement types were non-relative resource home (25%, 15 placements) and group home (11%, 7 placements).

The Co-Neutrals' review assessed whether an IPP meeting was held prior to the placement being made to determine that the placement was in the child's best interest. The team reviewed documentation in FACTS for each of the 61 placements, and none (0%) showed that the best interest standard was affirmatively determined by an IPP team. For two of the placements, an IPP meeting was documented as completed but a mental health professional was not present and there was no documented discussion of whether the placement was in the child's best interest.

BTO4.1(iii) – qualitative metric: Qualitative review of IPP meetings for children in congregate placements due to best interest determination.

For this metric, a sample of 76 non-clinical congregate care placements experienced by 70 unique children were reviewed, including placements as early as 2021 but that continued into 2024.¹⁵³ Most placements were in group homes (72%, 55), 18 percent were in community homes (14), and nine percent were in supervised independent living facilities (7).

Of the 76 placements, 25 of the placements lasted 90 days or longer, and a total of 53 IPP meetings were required in 2024.^{154,155} The team reviewed documentation in FACTS for each of the 25 placements, and none (0%) showed that the best interest standard was affirmatively determined by an IPP team, inclusive of a mental health professional, every 90 days of the placement.

Of the 25 placements reviewed, two placements included documentation of a completed and timely 90-day IPP meeting within the period under review. Documentation does not reflect that the teams determined that the placement was in the child's best interest.

Discussion

Documentation of practice in 2024 shows that placements of children in non-clinical congregate care settings in New Mexico were not made pursuant to the best interest standard. Additionally, required staffings within 90 days were rarely held, and those that were held did not meet the qualitative requirements. CYFD has continued to add new congregate care facilities to its placement array. In June 2024, in partnership with community provider AMIkids, CYFD opened a new congregate care facility for males in Albuquerque. In December 2024, a facility named HOPE

¹⁵³ There were a total of 210 non-clinical congregate care placements in 2024 that began in 2024 or prior to January 1, 2024; sampling represents a 95% confidence interval with a 9% margin of error.

¹⁵⁴ Fifteen of the placements were for 180 days or longer and required two or more IPP meetings during the period.

¹⁵⁵ Six of the placements were for 90 days or longer and the 90 days was beyond December 31, 2024; practice beyond 2024 was not assessed in this report.

House with the capacity for up to 10 females was also opened.

Prohibition of Shelter Placements Except in Extraordinary Circumstances and 48-Hour IPP Meetings (App. B, TO 4.2)

FSA Requirement	If extraordinary circumstances require placement of a child in a shelter, CYFD will conduct an Individualized Planning Team meeting within 48 hours to identify an appropriate placement to which to move the child and any medically necessary services needed by the child, and notify the child’s legal representative of the result of the review. (Due December 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Paragraph 10.6 of CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC) requires that children are only placed in a shelter when extraordinary circumstances exist. After placement, the PC must conduct an IPP within 48 hours to identify an appropriate placement to move the child and to provide any medically necessary services needed by the child. If the child remains in the shelter for 90 days, a subsequent IPP meeting should be held to identify a more appropriate placement and necessary medically necessary services.

IPP meetings are to be coordinated by the CYFD PC case worker, and the following participants must be invited to the meeting: child or youth, PC or primary assigned worker’s supervisor, CBHC staff, MCO care coordinator or other representative, and the child or youth’s GAL or YA. The PC may also include the following individuals: child or youth’s parent or other family members, case manager from the shelter, Tribal representative (as applicable), representative from the OTA (as applicable), and mental health professional assigned to the child or youth.

DVP Metrics and Validated Performance Data

BTO4.2(i) – primary metric: Of all required 48-hour meetings for children in a shelter, the percent that occurred timely.

There were 200 48-hour shelter placement reviews required in 2024 and six of them (3%) were conducted on time.¹⁵⁶ This is a substantial decrease from 2023, when 29 of 213 required reviews (14%) were conducted on time, and from 2022, when 50 of 227 required reviews (22%) were conducted on time (see Table 13). Additionally, 166 required shelter placement reviews were not conducted at all.

The Co-Neutrals also examined the average time to completion for reviews completed late. In 2024, 28 required shelter placement reviews were conducted late (after 48 hours); on average,

¹⁵⁶ A meeting is considered “conducted” when the State’s data indicates that it was not canceled, it occurred on or before the due date, and it was a “Shelter Placement/48hr” meeting. Due dates were calculated as two days after the start of each placement.

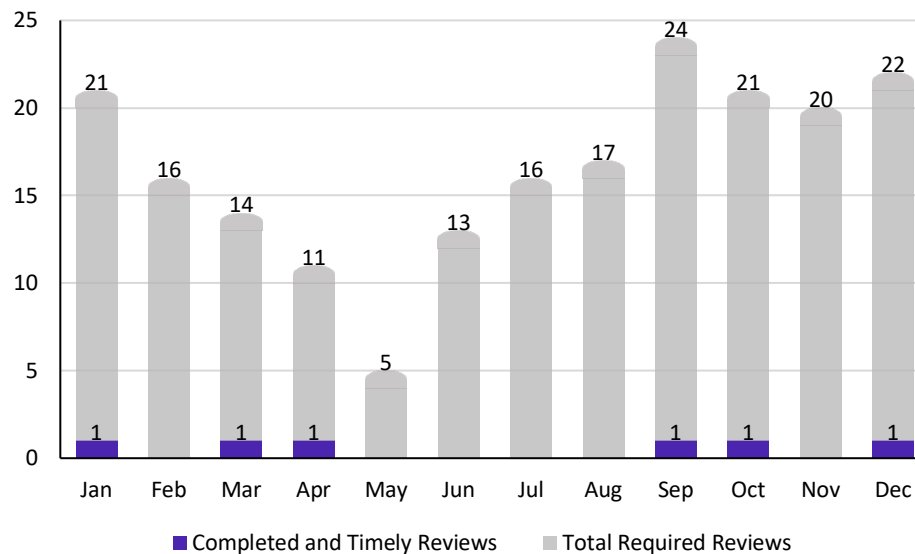
these late reviews occurred 72 days after the shelter placement (median: 52 days).¹⁵⁷

Table 13: Required and Completed 48-Hour Reviews for Shelter Placements, by Month
2022 - 2024

Year	Total Required Reviews	Completed and Timely Reviews	Percent of Required Reviews Completed Timely
2022	227	50	22%
2023	213	29	14%
2024	200	6	3%

Source: Analysis of Sandbox Placements and Meetings files

Figure 24: Required and Completed 48-Hour Reviews for Shelter Placements, by Month
2024



Source: Analysis of Sandbox Placement and Meeting files

BTO4.2(iv) – primary metric: Of all required 48-hour meetings for children in a shelter, the number for which the child’s legal representative was notified of the result of the review.

The Co-Neutrals were unable to validate data for this metric because it relies on a data collection

¹⁵⁷ For late meetings, there were often multiple shelter placements that occurred before the meeting took place. In such cases, the Co-Neutrals counted the days between the meeting and each preceding placement that required a meeting. For example, if a child experienced separate shelter placements on 3/29 and 4/8 and the earliest meeting for either placement was on 5/11, the 43 days from 3/29 to 5/11 and the 33 days from 4/8 to 5/11 would both be included in the average).

process that the State did not use consistently in 2024.¹⁵⁸ In 2022, the State embedded a survey tool into FACTS to collect information on the components of and participants in meetings (including whether the child’s legal representative attended the meeting or was notified of the result), but the State reported that very few of these surveys had been completed in 2023 and 2024. Data from this survey tool or an alternative source will be necessary to validate this metric for 2025.

BTO4.2(ii) – qualitative metric: Qualitative review of extraordinary circumstance determinations for placements to emergency shelter.¹⁵⁹

The Co-Neutral team reviewed a sample of 89 shelter placements experienced by 69 unique children to determine if extraordinary circumstances justified the placements.¹⁶⁰ The average age of the children at the time of shelter placement was 15; most children were age 15 or older (62%), 37 percent were between the ages of 11 and 14, and one child was 10 or younger (1%). For the 89 placements reviewed, 31 children (35%) were placed in a CYFD office immediately prior to the shelter placement. The other most common prior placement types were non-relative resource home (17%, 15 placements) or relative resource home (13%, 12 placements).

The Co-Neutral team reviewed documentation in FACTS for the sample of 89 placements, and none of the shelter placements (0%) identified specific safety and security threats which necessitated the shelter placement. Documentation for two placements cite the risk of homelessness and the need for shelter as the reason for the placement.

BTO4.2(iii) – qualitative metric: Qualitative review of 48-hour IPP meetings for children with emergency shelter placements.

Of the sample of 89 shelter placements reviewed by the Co-Neutral team, six of the placements lasted for less than 48 hours. Documentation in FACTS for the remaining 83 placements was reviewed; meetings were documented within 48 hours for eight placements, and none of these meetings (0%) included all applicable participants nor documented that the meeting identified an appropriate prospective placement for the child and any medically necessary services that were

¹⁵⁸ During the Co-Neutral team’s qualitative review of 89 shelter placements in 2024, the case record legal tab was reviewed to determine if notice of the placement was provided to the child’s GAL or YA. Of the eight IPP meetings held within 48 hours of a shelter placement, one included documentation that the GAL or YA was notified of the result of the review.

¹⁵⁹ In assessing extraordinary circumstances determinations, the Co-Neutral team assessed whether documentation in the child’s record demonstrated the shelter placement was necessary to protect the safety and security of the child.

¹⁶⁰ There were 220 shelter placements in 2024; sampling represents 95% confidence interval with an 8% margin of error. Four of the placements reviewed did not have an exact match for placement start date between what was included in the Sandbox universe and what was identified in the qualitative review of the child’s case record. Data for the quantitative metric discussed above references 200 shelter placement as that is the number of shelter placements that lasted two days or longer and were subject to a 48-hour IPP meeting.

needed.¹⁶¹

Discussion

Documentation of practice in 2024 does not provide evidence that placements of children in shelter settings were made pursuant to the extraordinary circumstances standard. Additionally, required staffings were not routinely held within 48 hours, with performance dropping to its lowest level since 2022. Of the meetings that were held, data from the qualitative review show that an appropriate placement to move the child was not identified.

Children in Out-of-Home Care in Licensed Foster Home Placements (App. B, TO 5.1)

FSA Requirement	Every child in out-of-home care will be in a licensed foster home placement unless a current finding of medical necessity requires otherwise or an Individualized Planning Meeting team determines that a non-clinical setting is in the child’s best interest. (Due December 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Paragraph 10 of CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC) requires that every child be placed in a licensed foster home placement unless a current finding of medical necessity requires otherwise, or an IPP team determines that a non-clinical setting is in the child’s best interest.

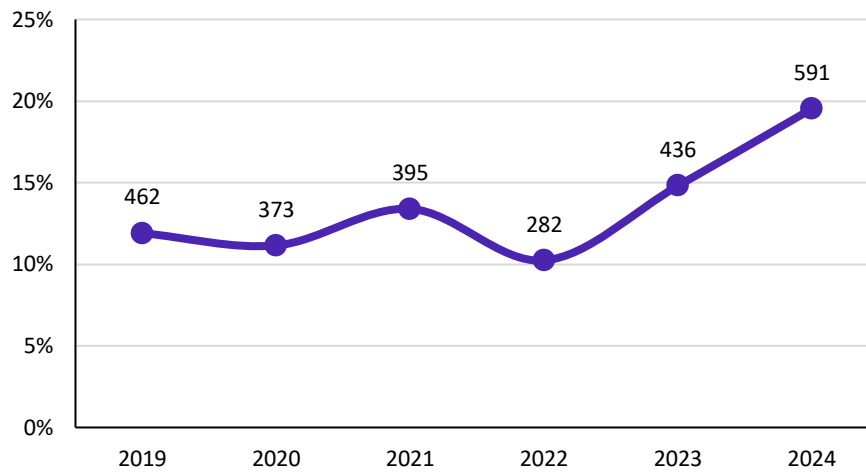
DVP Metrics and Validated Performance Data

BT05.1(i) – secondary metric: Of all children in state custody during a reporting year, the percent that had any new placement which was not a licensed foster home.*

The Co-Neutrals’ analysis of the State’s data shows that in 2024, 591 children (20%) experienced at least one placement to a setting that was not a licensed resource home.¹⁶² This is an increase of five percentage points from 2023, which was previously the highest annual percentage of children placed in settings other than licensed homes since reporting began in 2019 (see Figure 25).

¹⁶¹ The State’s data provided for the quantitative metric discussed earlier in this section noted six timely completed reviews for the universe of applicable placements. The data for the qualitative review differ as reviewers did not limit their assessment to only include meetings titled “Shelter Placement/48hr” meeting.
¹⁶² Licensed resource homes include relative, non-relative, fictive kin, pre-adoptive, or Treatment Foster Care (TFC) placements.

Figure 25: Children with Placements to Settings Other Than Licensed Foster Homes
2019 - 2024



Source: Analysis of Sandbox Placements and ProviderLicenses files, FACTS episodes files, and adjustments based on case record reviews

Of these 591 children, 108 children (18%) experienced at least one placement to a resource home that was not licensed at the time of placement, and 55 of these 108 children (51%) spent 10 or fewer days in that setting before it was licensed.¹⁶³

Table 14: Children with Placements to Resource Homes Not Licensed at Time of Placement
2019 - 2024

Placement setting	2019	2020	2021	2022	2023	2024 ¹⁶⁴	
	N=3,881	N=3,344	N=2,949	N=2,755	N=2,944	N=3,026	
Resource Family Home (Relative)	1%	1%	2%	2%	2%	76	3%
Resource Family Home (Fictive Kin)	<1%	<1%	<1%	<1%	1%	21	1%
Resource Family Home (Non-Relative)	<1%	<1%	0%	<1%	<1%	12	<1%
Pre-Adoptive Family	0%	<1%	0%	0%	0%	0	0%

Source: Analysis of Sandbox Placement and ProviderLicenses files, FACTS episodes files, and adjustments based on case record reviews

¹⁶³ Nine children spent 11 to 20 cumulative days in unlicensed resource homes, 20 children spent 21 to 60 days in unlicensed resource homes, and 24 children spent 60+ days in unlicensed resource homes.

¹⁶⁴ The sum of the rows for 2024 (109) does not match the total number of children who experienced at least one placement to a resource home not licensed at the time of placement (108) because one child experienced a placement to both an unlicensed relative resource home and a placement to unlicensed fictive kin resource home and was therefore counted in each row.

Over half of the children who experienced a new placement to a setting other than a licensed resource home only experienced one of these placements in 2024 (58%, 345 children) (see Table 15). Just over one-third had two to six of these placements in 2024 (36%, 211 children), and 35 children (6%) experienced more than six of these placements in 2024.

Table 15: Distribution of the Number of Placements to Settings Other Than Licensed Resource Homes Per Child
2024

Number of placements to settings other than licensed resource homes in 2024	Children with any placements to settings other than licensed resource homes	
	Number	Percent
1	345	58%
2	99	17%
3	51	9%
4	25	4%
5	21	4%
6	15	3%
7	15	3%
8	5	1%
9	4	1%
10 or more	11	2%
Total	591	100%

Source: Analysis of Sandbox Placements and ProviderLicenses files, FACTS episodes files, and adjustments based on case record reviews

As shown in Table 16, ICWA-eligible children were more likely than children identified with other racial or ethnic groups in the cohort to experience at least one placement to a setting other than a licensed resource home (24%, or 79 of 333).¹⁶⁵

¹⁶⁵ These 79 ICWA-eligible children experienced a total of 131 placements to a setting other than a licensed resource home. Of these 131 placements, the biggest group was the Receiving Center (44, or 34%), followed by shelters (30, 23%). Only seven children were placed in unlicensed relative resource homes (7 children had one placement each).

Table 16: Race and Ethnicity of Children with Placements to Settings Other Than Licensed Resource Homes
2024

Race/ethnicity	Children with placements to setting other than a licensed resource home	Children in state custody in 2024	Percent
Hispanic ethnicity (of any race)	351	1,745	20%
White (non-Hispanic)	110	589	19%
American Indian or Alaskan Native (non-Hispanic)	68	302	23%
Black (non-Hispanic)	30	140	21%
Multiracial/Other (non-Hispanic) ¹⁶⁶	16	68	24%
Unknown	16	182	9%
ICWA-eligible			
Yes	79	333	24%
No	512	2,693	19%
Total	591	3,026	20%

Source: Analysis of Sandbox Cohort, Placements, and ProviderLicenses files, FACTS episodes files, and adjustments based on case record reviews

BTO5.1(i) – primary metric: Of all children in state custody during a reporting year, the percent that had any new placement which was neither a licensed foster home, nor a congregate care setting with an appropriate determination (medical necessity, best interest, or extraordinary circumstance).

BTO5.1(ii) – primary metric: Of all new placements that do not have a finding of medical necessity, determination that a non-clinical setting is in the child’s best interest, or determination of extraordinary circumstance, the percent that are to licensed relative or non-relative foster homes.

As discussed, the Co-Neutrals determined that the State lacked adequate documentation to identify in FACTS those congregate placements that meet the extraordinary circumstances, medical necessity, and best interest standards; therefore, these metrics could not be calculated.

Discussion

The percentage of children who experienced at least one placement to a setting that was not a licensed resource home in 2024 has increased to its highest level since 2019 when reporting

¹⁶⁶ The “Multiracial/Other (non-Hispanic)” category for race includes children identified as Native Hawaiian or Other Pacific Islander (non-Hispanic), Asian (non-Hispanic), and Multiracial (non-Hispanic). The total number of children in each of these groups is small enough to raise confidentiality concerns and is too small for the Co-Neutrals to draw conclusions about over-or-under representation for these children.

began.

Annual Target for New Culturally Reflective Resource Homes (App. B, TO 6.1 and 6.2)

FSA Requirement	Beginning on December 1, 2020, and on an annual basis by December 31 each year thereafter, the Co-Neutrals will approve a Target Outcome for CYFD to approve a specified number of new culturally reflective foster homes during the following year. (Due December 31, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

DVP Metrics and Validated Performance Data

BTO6.2(i) – primary metric: Percent of yearly target reached statewide for newly licensed foster homes by race/ethnicity.

The DVP defines newly licensed resource homes as in-state, non-relative resource homes that became licensed and active at some point during the reporting period and did not have an active license at any point in the previous 365 days.¹⁶⁷ The Co-Neutrals approved a recruitment target for 2024 of 265 newly licensed non-relative resource homes. The establishment of the target began with the State using the Annie E. Casey Foundation’s Wildfire Foster Home Estimator tool to estimate the current overall statewide need.¹⁶⁸ CYFD recruited 212 homes in 2024, 80 percent of the target. The number of new non-relative homes licensed each month ranged between 12 and 26 (see Table 17).

¹⁶⁷ In past years, the Sandbox file omitted information on holds, so Active Provider batch reports were used to accurately capture the DVP methodology. The 2024 Sandbox file has hold information and is sufficient for this analysis.

¹⁶⁸ The Co-Neutrals and the State worked together to estimate current need in late 2022 using the Wildfire tool. However, given the State’s performance to that point, the Co-Neutrals and the State agreed that the estimate produced by the tool – 265 new non-relative resource homes – was not feasible for 2023, and thus the Co-Neutrals and the State agreed to a target of 190 for 2023. The State’s performance did not substantially improve in 2023. The Co-Neutrals agreed to a target of 265 for 2024. The Co-Neutrals also approved a target of 265 new non-relative resource homes licensed for 2025.

Table 17: New Active Non-Relative Resource Homes Recruited, by Month License was First Active and Effective¹⁶⁹
2024

Month license was first active and effective	Number of homes recruited
All months	212
January	16
February	12
March	15
April	21
May	16
June	22
July	26
August	15
September	19
October	16
November	12
December	22

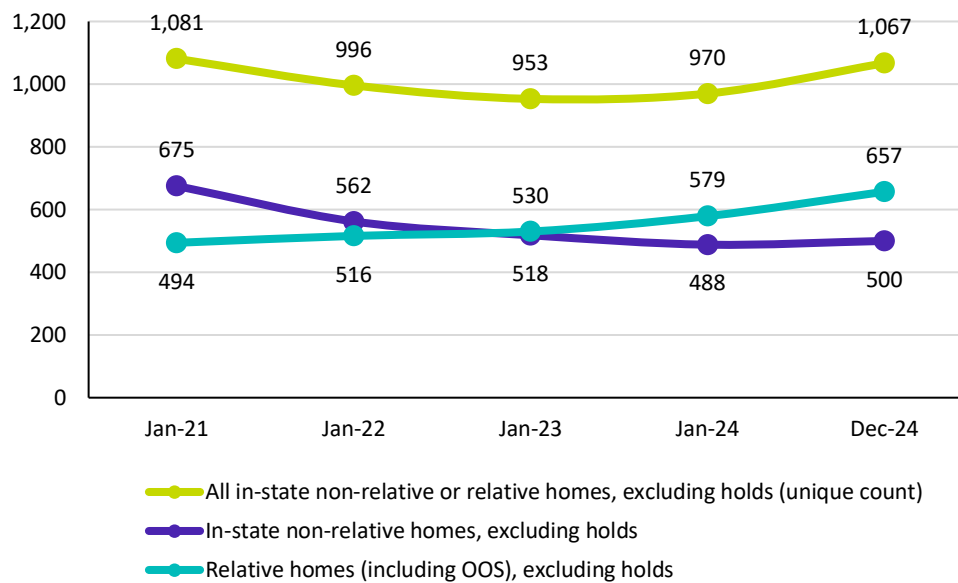
Source: Analysis of Sandbox ActiveProviders file

As additional detail to inform the Co-Neutrals’ assessment of the State’s efforts, the Co-Neutrals examined the total number of homes available in this period, including relative homes. As shown in Figure 26, the total number of homes with a foster care, specialized foster care, or relative foster care license has increased from a low in 2023 to the highest number of homes since 2021.¹⁷⁰ The number of relative homes has steadily increased since 2021, while the number of non-relative homes has declined over the same period.

¹⁶⁹ The number of active homes (i.e., no placement hold) with effective "Foster Home" or "Specialized Foster Home" licenses at any point in the calendar year that were not licensed in the prior year and did not have an active effective license at any time in the prior 12 months. TFC homes were not counted.

¹⁷⁰ The number of non-relative homes includes homes with effective "Foster Home" or "Specialized Foster Home" licenses, excluding homes not in New Mexico. The number of relative homes includes out-of-state homes. Monthly counts exclude homes with placement holds during the specified month ("NO OOHP PLACE REC"). Homes with both relative and non-relative licenses are counted only once in the total but appear separately in each count.

**Figure 26: Total Number of Resource Homes with Active Effective License by Month and Type
2021 - 2024**



Source: Analysis of Sandbox ActiveProviders files

BTO6.2(i) – secondary metric: The number of foster care resource homes newly licensed during the reporting year.*

In 2024, 212 non-relative resource homes were recruited and licensed in New Mexico (see Tables 18 and 19).¹⁷¹ Seventy-two percent (152) of the 212 new homes licensed in 2024 had at least one non-relative placement during the calendar year; 15 percent (32) were dually-licensed homes with only relative placements, and the remaining 13 percent (28) did not have any placement in 2024.¹⁷²

¹⁷¹ The number of newly licensed resource homes reported in the Co-Neutrals' Annual Report for 2023 was 129 (68% of the target). Ahead of the 2024 report, the Co-Neutral team and the State agreed to adjust the methodology to include homes licensed at any point during the calendar year, rather than only including homes still licensed and active on December 31, 2024. The number of newly licensed resource homes in 2023 according to the revised methodology was 168 (88% of the target).

¹⁷² The Co-Neutral team examined the first active month for the 28 new homes active in 2024 that did not have a placement because placements are less likely for homes licensed late in the year. Three homes (11%) were first active in the 1st quarter of the year, 11 (39%) in the 2nd quarter, four (14%) in the 3rd quarter, and 10 (36%) in the 4th quarter.

Table 18: New Active Non-Relative Resource Homes Recruited, by Placement Status¹⁷³
2024

Placement status of new active non-relative resource homes	Number of new active non-relative resource homes	Percent of new active non-relative resource homes
With at least one non-relative placement	152	72%
With only relative placements	32	15%
With no placements	28	13%
Total	212	100%

Source: Analysis of Sandbox Placements and ActiveProviders files

Table 19: New Active Non-Relative Resource Homes Recruited, by County¹⁷⁴
2024

County	New homes with non-relative placement	New dually-licensed homes with only relative placement	New homes without placement	All new homes
Statewide	152	32	28	212
Bernalillo	43	7	4	54
Dona Ana	19	7	2	28
Eddy	10	3	3	16
Otero	12	1	3	16
Valencia	9	3	2	14
Chaves	9	0	2	11
Sandoval	5	3	3	11
Santa Fe	9	0	1	10
Lea	8	0	0	8
San Juan	4	4	0	8
McKinley	4	1	1	6
Curry	4	0	0	4
Rio Arriba	2	0	2	4
San Miguel	2	1	1	4
Quay	3	0	0	3
Taos	1	2	0	3
Grant	1	0	1	2
Luna	2	0	0	2
Socorro	2	0	0	2
Torrance	1	0	1	2
Colfax	1	0	0	1
Mora	1	0	0	1
Roosevelt	0	0	1	1
Sierra	0	0	1	1

Source: Analysis of Sandbox Placements and ActiveProviders files

¹⁷³ Includes homes dually licensed as relative and non-relative homes. Relative placements include fictive kin.

¹⁷⁴ This Table includes the county at the time the provider was licensed. The table only includes counties with at least one home recruited during the period. TFC homes are not included.

As the FSA requires the State to recruit culturally reflective non-relative resource homes, the Co-Neutrals also examined data on the household demographics of non-kin resource homes recruited in 2024 with at least one non-relative placement during the year. Of the 152 new homes with a non-relative placement, 47 percent (81) had at least one parent who was identified as Hispanic; nine percent of new homes (15) had a parent who was identified as non-Hispanic American Indian or Alaskan Native; five percent of new homes (9) had at least one parent who was identified as non-Hispanic Black; and two percent of new homes (4) had a parent who was identified as non-Hispanic Asian or Pacific Islander in the data.¹⁷⁵

Table 20: New Active Non-Relative Resource Homes Recruited with at Least One Non-Relative Placement, by Race and Ethnicity¹⁷⁶

2024; N = 152 new resource homes with at least one non-relative placement

Race/ethnicity of resource parent(s)	Number of new homes	Percent of new homes
Hispanic	81	53%
White (non-Hispanic)	58	38%
American Indian or Alaskan Native (Non-Hispanic; alone or in combination)	15	10%
Black (Non-Hispanic; alone or in combination)	9	6%
Asian or Pacific Islander (Non-Hispanic; alone or in combination)	4	3%

Source: Analysis of Sandbox Placements and ActiveProviders files

The percentage of newly recruited non-relative homes with at least one Hispanic resource parent (53%) is lower than the percentage of children in state custody identified as Hispanic at the end of 2024 (60%). The percentage of newly recruited non-relative homes with at least one non-Hispanic Black parent (6%) and the percentage with at least one non-Hispanic Asian or Pacific Islander parent (3%) is close to the percentage of children in state custody in these categories. The percentage of newly recruited non-relative homes with at least one resource parent who identified as non-Hispanic American Indian or Alaskan Native (9%) is representative of the number of children in care on December 31, 2024 identified as ICWA eligible.¹⁷⁷

Discussion

In interviews with scores of CYFD stakeholders in New Mexico in January, August and September 2024, the Co-Neutrals repeatedly heard that recruitment efforts were marred by a lack of resources, planning, and reasonable workloads. The CYFD staff who met with the Co-Neutrals reported that no one was primarily assigned to recruit non-relative families, and those who included recruitment among their numerous duties, said they lacked resources and an overall

¹⁷⁵ This includes individuals for whom other races were also indicated.

¹⁷⁶ This Table does not sum to 152 or to 100 percent because categories are not mutually exclusive; resource parents who identify as multiple races are counted in each category that applies, and households with resource parents with different race-ethnicity identified appear in multiple categories.

¹⁷⁷ The number of children in state custody on December 31, 2024 who were ICWA-eligible (9%, 193 children) is similar to the number of children in state custody identified as American Indian or Alaskan Native using the race and ethnicity data in the Sandbox cohort files at the end of 2024 (9%, 202 children).

strategy to do the work effectively. Many in 2024 said the CYFD offices had become so consumed by rising caseloads and poor morale that they were forced to shift their focus to include helping their colleagues manage children’s cases. High caseloads and high attrition compromised the ability of assigned workers to respond to families. In fact, that lack of responsiveness and support was frequently cited as a source of frustration and dissatisfaction by non-relative resource parents interviewed by the Co-Neutral team in 2024.

Despite the scattered, inconsistent, and unfocused nature of the State’s efforts in 2024, CYFD recruited 212 non-relative families, 80 percent of its non-relative resource home target for 2024. The State reports a total of 274 resource parent recruitment events were held in 2024 – including tabling at various community events, presentations at churches and corporations – but that these events did not yield a significant number of inquiries that proceeded to licensure. CYFD also expressed that these kinds of events created a resource strain on agency recruitment staff and capacity without yielding a significant level of interest from participants. CYFD identified other barriers to resource parent licensure in 2024 – many of which continue to exist in 2025 – including prospective resource parents not attending the required orientation meeting and a website that was not user-friendly. CYFD acknowledged more recently the urgent need to reimagine the resource family recruitment and licensing pipeline to serve children and families more effectively, and that strategic shifts are necessary to improve process efficiency, expand capacity, and modernize outreach.

Annual Target for New Treatment Foster Care Placements (App. B, TO 6.3 and 6.4)

FSA Requirement	Beginning on December 1, 2020, and on an annual basis by December 31 each year thereafter, the Co-Neutrals will approve a Target Outcome for ... HCA to approve a specified number of new treatment foster care placements during the following year. (Due December 31, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

DVP Metrics and Validated Performance Data

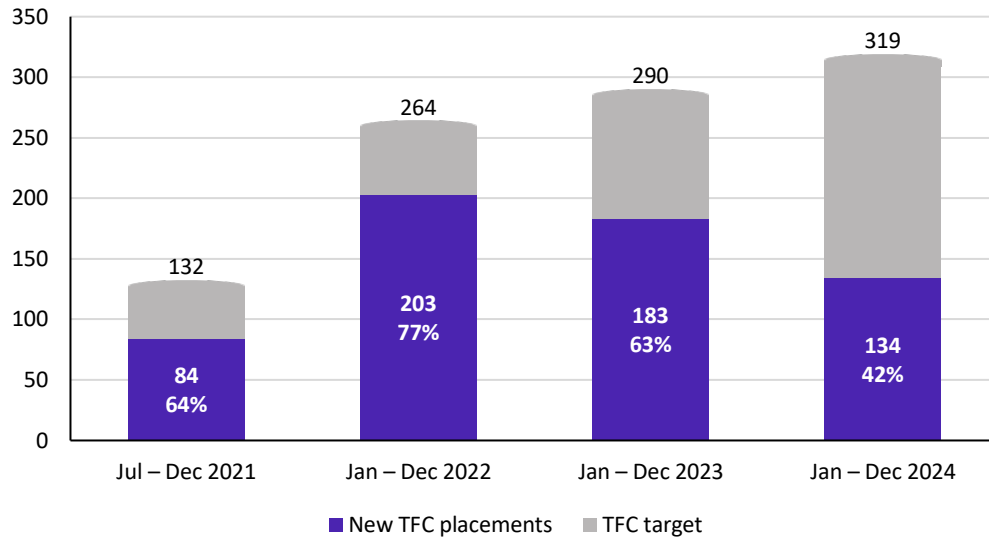
BTO6.4(i) – primary metric: Percentage of yearly target reached for new licensed treatment foster care (TFC) placements statewide.

The DVP defines a new treatment foster care (TFC) placement as the placement of a child who is eligible for treatment foster care, or their accompanying sibling, to a licensed treatment foster home that they have not resided in within the previous 365 calendar days. The Co-Neutrals approved a target of 319 new TFC placements for 2024. The State made 134 new TFC placements during the year, 42 percent of their target goal.

BTO6.4(i) – secondary metric: The number of new TFC placements during the reporting year.*

The Co-Neutrals’ analysis of the State’s data shows there were 134 new TFC placements from January 1, 2024 to December 31, 2024 that meet the definition above. The number of new TFC placements continued to decline in 2024 from the number in 2023 (183) and 2022 (203).

Figure 27: Number of New TFC Placements Made Toward Annual Target
2021 - 2024

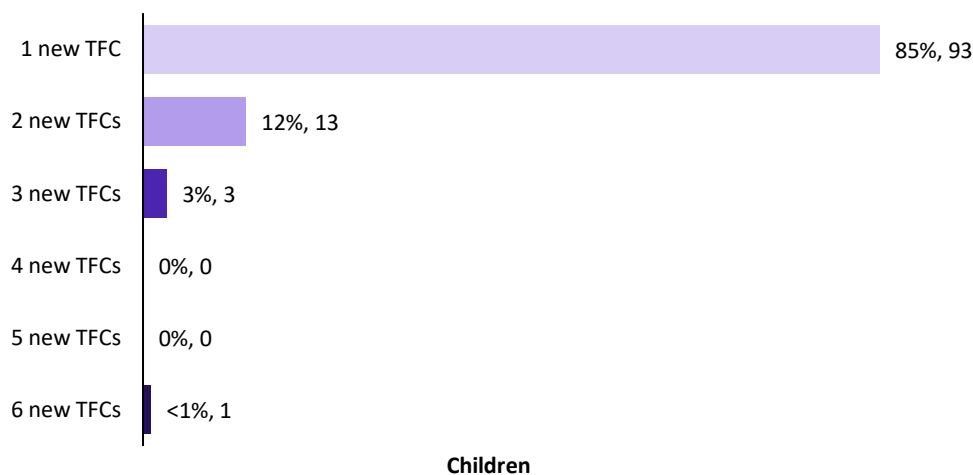


Source: Analysis of Sandbox Placements files

As additional information, the Co-Neutrals examined the number of eligible new TFC placements per child. In 2024, 110 unique children had at least one new TFC placement (including two children who were placed with siblings eligible for TFC services).¹⁷⁸ Most of these children (85%, 93 children) experienced one new TFC placement in 2024, 13 (12%) were placed in two TFC homes, and four children (4%) were placed in three or more TFC homes (see Figure 28).

¹⁷⁸ This does not include moves between homes after initial placement; as noted, new placements are defined as placements to a TFC home that the child has not resided in within the previous 365 calendar days.

Figure 28: Number of Eligible New TFC Placements Per Child
2024; N = 110 children with new TFC placements



Source: Analysis of Sandbox Placements file

The Co-Neutrals examined the length of time children spent in new TFC placements that had ended by December 31, 2024. Of the 134 new TFC placements that counted towards the target in 2024, 69 had ended by December 31, 2024 (51%), and 65 were ongoing (49%). Of the 69 placements that had ended, 28 of these placements lasted one week or less (21%), nine lasted two to four weeks (7%), and 32 lasted longer than a month (24%).

Table 21: Duration of Eligible New TFC Placements Made
2024

Duration of placement	Number of new TFC placements	Percent of new TFC placements
Ended by 12/31/2024	69	51%
A week or less	28	21%
2-4 weeks	9	7%
1-3 months	15	11%
4-6 months	14	10%
7+ months	3	2%
Ongoing as of 12/31/2024	65	49%
A week or less	1	<1%
2-4 weeks	7	5%
1-3 months	10	7%
4-6 months	19	14%
7+ months	28	21%
Total	134	100%

Source: Analysis of Sandbox Placements file

To better understand how the State is utilizing TFC, the Co-Neutrals looked closely at the 37 TFC placements that counted towards the target in 2024 but were shorter than one month in duration (examining only placements that ended in the analysis period).¹⁷⁹

Most short-term TFC placements occurred after a child’s move from either a placement in a different TFC home (38%, or 14 of 37) or a placement in a resource home (22%, or 8 of 37); more than half of those prior placements had lasted more than one month before ending (12 of 22), while more than one-quarter appeared to be unstable placements (6 of 22 ended in less than a week). Sixteen percent of short TFC placements (6 of 37) were preceded by a stay in a CYFD office; two of those prior placements lasted less than one day, while the other four had a duration of two to four weeks before ending. Short stays in TFC homes were also preceded by placements at in-state congregate facilities, and followed acute hospitalizations or runaway episodes.¹⁸⁰

Nearly half of short duration TFC placements in 2024 were followed by another placement that lasted for less than one month (46%, or 17 of 37). Many of these were to another TFC home; nine of the 25 placements to a new TFC home following a short TFC stay themselves lasted less than a month.¹⁸¹

In 2024, 29 unique children had at least one short TFC placement. The majority (25) had only one short TFC placement. Three children had two short TFC placements, and one child had six separate TFC placements less than one month in duration each.

Table 22: Type and Duration of Placement Following Short TFC Stays
2024

Type of Placements that Followed Short TFC Stays	Duration of Placements that Followed Short TFC Stays					
	Less than one week	2-4 weeks	1-3 months	More than 3 months	Ongoing (as of Dec 31)	Any duration
Other TFC home	6	3	1	2	13	25
Resource home	2	0	0	0	2	4
CYFD Office or Receiving Center	2	1	0	0	0	3
Non-placement	1	2	0	1	0	4
Unknown	0	0	1	0	0	1
Any placement type	11	6	2	3	15	37

Source: Analysis of Sandbox Placements file

¹⁷⁹ None of the new TFC placements in 2024 that were not eligible towards the target (i.e., placements in TFC homes for children that did not receive TFC services and were not siblings of a child in the same home who did receive TFC services) were short stays.

¹⁸⁰ Two placements at community homes, one that disrupted within a week, and another that lasted one to three months.

¹⁸¹ Per the DVP, returns to a TFC home occupied by the child within the last 365 days do not count as a new TFC placement eligible to count towards the target.

Discussion

The State reached less than half of the 2024 target (42%), a particularly serious shortcoming in light of the numerous children in need of therapeutic services who were housed in CYFD offices and residential facilities. CYFD reports that in 2024, staff from its Community Behavioral Health Liaison Unit were tasked with supporting submission of TFC packets to the MCOs for consideration of level of care decisions and to follow up on potential placements. While the State reports that nearly all TFC referrals were authorized as medically necessary by PHP (the MCO for most children in state custody), the lack of an appropriate clinical match and an inadequate array of providers able and willing to serve children authorized for TFC meant the needs of many children remained unmet.¹⁸² The Co-Neutral team’s case reviews of children placed in offices and in congregate care settings frequently reveal recommendations for TFC placement for children along with repeated denials from providers.

Placement Stability (App. B, TO 8.1)

FSA Requirement	For children under 18 in out-of-home care, the rate of moves from a placement setting shall not exceed three moves per 1,000 days in care. The educational consequences of a change in placement must be considered in all placement change determinations and must be discussed at Individualized Planning Process meeting and any change in placement that impacts the child's education must be accompanied by a written plan to ensure continuity in the child's education. (Due December 1, 2022)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

DVP Metrics and Validated Performance Data

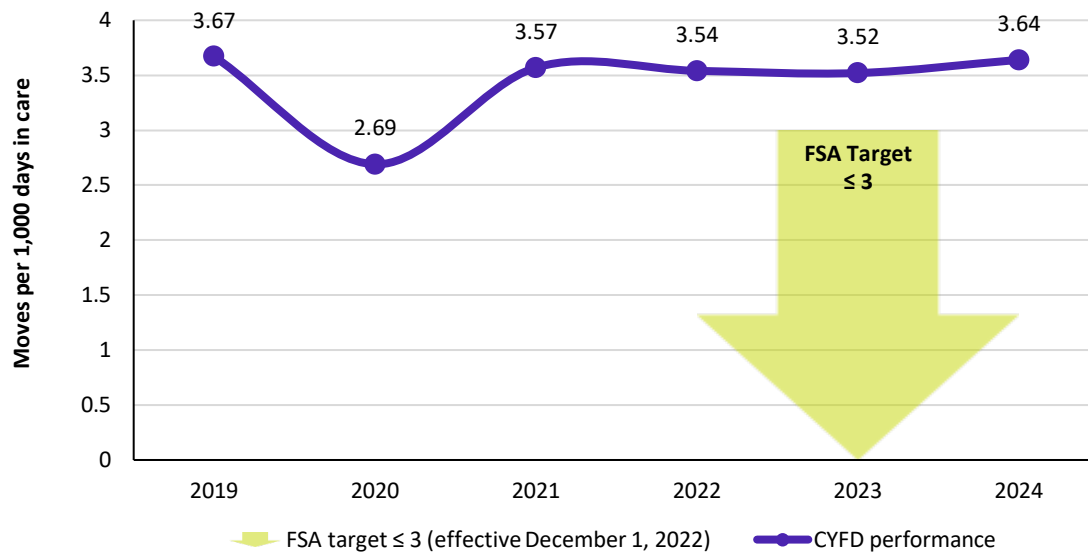
BTO8.1(i) – primary metric: Of all children in state custody during the reporting year, the rate of placement moves per 1,000 person-days in foster care within said reporting year.

During 2024, children in state custody spent a total of 730,708 days in care and experienced 2,659 total placement moves.¹⁸³ This amounts to a rate of 3.64 moves per 1,000 days which exceeds the FSA maximum of three moves per 1,000 days. The rate of placement moves in 2024 was the highest since 2019 (see Figure 29).

¹⁸² For example, data from the final three months of 2024 showed that providers denied 74 percent of TFC referrals, after medical necessity was determined by PHP, based on a “non-match” qualifier. Only 11 of the 240 referrals led to children’s alternative placements.

¹⁸³ These counts are based on analysis of data as submitted by the State; the Co-Neutral team did not validate each placement move or adjust the underlying data to account for discrepancies identified in qualitative reviews.

Figure 29: Placement Moves Rate Versus Settlement Target
2019 - 2024



Source: Analysis of Sandbox Placements files, FACTS episodes files, and separate manual data files, plus adjustments based on case record reviews

As additional information, the Co-Neutrals also compared the rate of placement moves for different racial and ethnic groups of children (see Table 23). The rate of moves per 1,000 days in care was higher for non-Hispanic Black children (4.39) than for non-Hispanic White children (3.64), non-Hispanic American Indian or Alaskan Native children (3.29), and Hispanic children of any race (3.73). The placement moves rate was lower for ICWA-eligible children (3.28) than non-ICWA-eligible children (3.68).

Table 23: Number of Placement Moves and Days, by Race/Ethnicity and ICWA Eligibility
2024

Race/ethnicity	Number of children in state custody	Total moves in 2024	Total days in care in 2024	Moves per 1,000 days in care
Hispanic (of any race)	1,745	1,620	434,500	3.73
White (non-Hispanic)	589	510	140,165	3.64
American Indian or Alaskan Native (non-Hispanic)	302	233	70,887	3.29
Black (non-Hispanic)	140	150	34,132	4.39
Multiracial/Other (non-Hispanic) ¹⁸⁴	68	58	16,090	3.60
Unknown	182	88	34,934	2.52
ICWA-eligible				
Yes	333	234	71,324	3.28
No	2,693	2,425	659,384	3.68
Total	3,026	2,659	730,708	3.64

Source: Analysis of Sandbox Placements and Cohort files, FACTS episodes files, and separate manual data files, plus adjustments based on case record reviews

BTO8.1(ii) – qualitative metric: Qualitative review of educational continuity considered at IPP reviews prior to placement changes.

BTO8.1(iii) – qualitative metric: Qualitative review of IPPs for children prior to placement moves.

The State had not developed the qualitative instrument and methodology to collect data and assess performance for these metrics. Thus, the Co-Neutrals are unable to report performance toward these metrics for 2024.

Discussion

Beset by high staff turnover, unreasonably high caseloads, and an inadequate array of safe, family-based placements, CYFD was unable in 2024 to develop and implement a set of core strategies to reduce children’s placement instability. The State’s performance in 2024 reflected the highest number of placement moves since 2019, further evidence of the consequences endured by children as a result of the crisis inside the agency.

¹⁸⁴ The “Multiracial/Other (non-Hispanic)” category for race includes children identified as Multiracial (non-Hispanic), Native Hawaiian or Other Pacific Islander (non-Hispanic), or Asian (non-Hispanic). The total number of children in each of these groups is small enough to raise confidentiality concerns and is too small for the Co-Neutrals to draw conclusions about over-or-under representation for these children.

Achieving Permanency (App. B, TO 9.1)

FSA Requirement	Of all children in care for 12-23 months at the start of a 12-month period, 40% will achieve permanency within 12 months of the start of that period. (Due December 1, 2023)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

DVP Metrics and Validated Performance Data

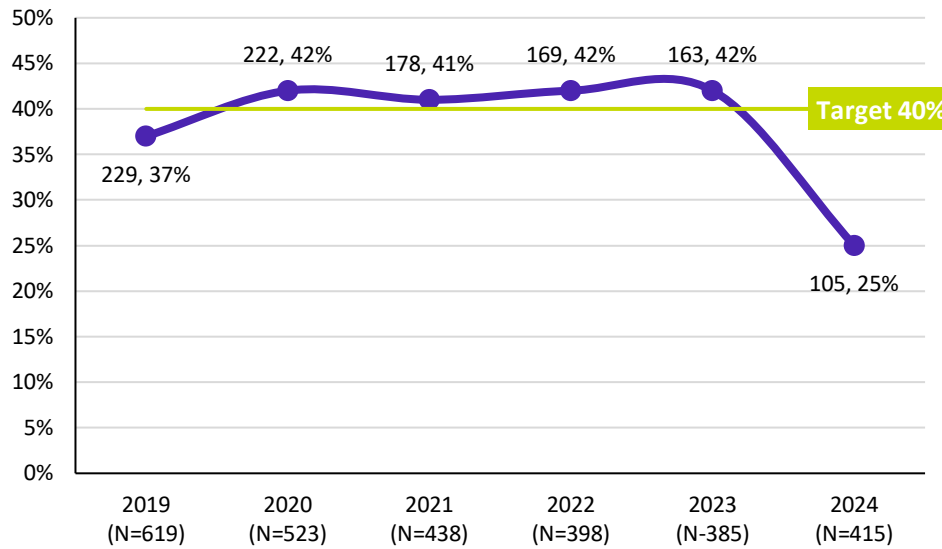
BTO9.1(i) - primary metric: Of all children in care on the first day of a 12-month period who had been in care (in that episode) between 12 and 23 months, the percentage that are discharged to permanency within 12 months of the first day.

Of the 415 children who had been in care for 12 to 23 months at the start of the reporting period (January 1, 2024), 105 (25%) reached permanency by the end of the year.^{185,186} This is the agency's worst performance in the five years since the Co-Neutrals began tracking the metric, well below the performance standard of 40 percent. In fact, this drop-off in permanency for children is the first year since 2019 that the rate fell below that standard (see Figure 30). The number of children who had been in care for 12 to 23 months at the start of the reporting period declined each year from 2019 to 2023 and then rose from 385 in 2023 to 415 in 2024.

¹⁸⁵ Per the DVP, permanency includes discharges from foster care to reunification with the child's parents or primary caregivers, living with a relative, guardianship, or adoption. Youth entering care at age 17 who turn 18 while in care or discharge at age 18 are not counted as achieving permanency.

¹⁸⁶ The Sandbox *Exits* and *EpisodeOfCustody* files submitted by the State on June 18, 2025 were missing an exit reason for one child who was in care for 12 to 23 months at the start of the reporting period. This child was not counted as having reached permanency.

Figure 30: Children Who Reached Permanency of Those Who Had Been in Care Between 12 and 23 Months
2019 - 2024



Source: Analysis of Sandbox EpisodesOfCustody and Cohort files and separate manual data files, plus adjustments based on case record reviews

As additional information, the Co-Neutrals examined rates of permanency by race and ethnicity. Of the racial and ethnic groups represented in the cohort, a comparatively low percentage of White (non-Hispanic) children reached permanency (20%, or 15 of 75), and a comparatively high percentage of ICWA-eligible children reached permanency (38%, or 18 of 47).

The Co-Neutrals also examined the ages and custody end reasons of eligible children who reached permanency in the period under review. Age was calculated as of exit date. Of the 105 children who had been in care for 12 to 23 months and who reached permanency in 2024, 52 percent were six years old or younger (55), 24 percent were seven to 11 years old (25), and 24 percent were 12 to 17 years old (25). Of the 28 children who exited to an adoption, 68 percent were six years old or younger (19).

Table 24: Age at Exit and Custody End Reason for Children Who Had Been in Care 12 to 23 Months and Reached Permanency 2024

Age at exit	Custody end reason				All reasons
	Adoption finalized	Non-subsidized guardianship	Subsidized guardianship	Reunification	
0-6 years	19	0	10	26	55
7-11 years	5	2	5	13	25
12-17 years	4	0	8	13	25
All ages	28	2	23	52	105

Source: Analysis of Sandbox EpisodesOfCustody and Cohort files

Discussion

Twenty-five percent of children who were in care for 12 to 23 months as of January 1, 2024 reached permanency by December 31, 2024. Performance has declined precipitously, by 17 percentage points since 2023, and represents the first time since 2019 that performance has fallen below the standard of 40 percent. These results were foreseeable and avoidable. Hundreds of CYFD staff, including supervisors and managers, reported to the Co-Neutrals in 2023 and 2024 that soaring caseloads, worsened by a months-long hiring pause in 2023, and unaddressed attrition among permanency workers and CYFD attorneys responsible for advancing children’s cases, had contributed to a substantial backlog of cases and a deterioration of permanency practice. These results reflect a system that lost significant ground in helping children achieve timely, safe permanency throughout 2024.

CYFD Workforce Development Plan (App. B, TO 10.2)

FSA Requirement	CYFD will create a CYFD Workforce Development Plan that will ensure CYFD's workforce has adequate qualifications, expertise, skills, and numbers of personnel. The CYFD Workforce Development Plan will describe in writing the expected nature, scope, capacity, and structure of the workforce necessary to meet the obligations described in this Agreement. The plan will include a specific hiring plan that identifies, by county, the number of staff, credentials, and training required to meet the objectives identified in the CYFD Workforce Development Plan and outlines strategies to recruit and retain staff. The Plan will require that all caseworkers and supervisors have sufficient educational credentials and/or directly relevant experience. It will require that CYFD have a sufficient number of caseworkers to ensure that no caseworker will carry a case load of greater than the current professional standard identified by the Child Welfare League of America (CWLA). It will also include sufficient numbers of staff trained and able to implement ICWA guidelines using culturally responsive practices. The Plan will describe specific strategies to attract and retain diverse, high-quality staff with appropriate qualifications and skills. Co-Neutrals must approve the CYFD Workforce Development Plan. CYFD will develop the Workforce Development Plan by December 1, 2020 and fully implement it by December 1, 2021. (Due June 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

DVP Metrics and Validated Performance Data

The State's WDP was approved by the Co-Neutrals on July 13, 2023.¹⁸⁷ The Plan includes caseload standards for case carrying staff; strategies for recruitment, hiring, training, and retention of CYFD PSD staff; development of leadership among staff with a supervisory practice framework, competencies, and mentorship program.

As reported in prior years, the Co-Neutrals conducted caseload validation interviews with CYFD staff in 2024 with a main goal of verifying primary case assignment information provided by CYFD. Between June and December 2024, Co-Neutral staff spoke with 120 case workers and supervisors within investigations, permanency, and licensing and support units. Across all staff types, self-reported caseload sizes were typically larger than caseload sizes shown in the FACTS data provided by CYFD. Specifically, of the 81 case-carrying non-supervisor staff interviewed, FACTS data showed that 29 staff (36%) had caseloads compliant with the relevant standard. Based upon the staff's self-reported caseload data, only 22 staff (27%) reported caseloads that met the compliance standard. Thus, the percentage of staff who met the caseload compliance standard according to self-reported caseloads was nine percentage points lower than the percentage based on the FACTS caseload data. Throughout 2025, the Co-Neutrals have provided caseload discrepancy data

¹⁸⁷ CYFD's Workforce Development Plan can be found [here](#).

and analysis to the State following each round of interviews, and improvements have been noted in the accuracy of primary assignments reported in FACTS data. The data below are provided with this context in mind.

The Co-Neutrals examined CYFD data on all individuals who were assigned as the primary case worker on any case in FACTS for a point-in-time during each quarter of 2024: March 31, June 11, September 6, and December 3, 2024.^{188,189} The State provided caseload data with detail on New Employee Training (NET), hire date, position title, and primary case assignments to determine the applicable caseload standard for each individual assigned as primary on a case.¹⁹⁰

As defined in the CYFD WDP:

- Investigations case workers may be assigned as primary case workers for a maximum of 12 investigations;
- Permanency Coordinators (PCs) may be assigned as a primary for a maximum of 15 children;
- In-Home Services (IHS) case workers may be assigned as primary for a maximum of eight cases; and
- Licensing and Support Specialists (LSS) may be assigned for a maximum of either 15 adoption cases, 20 licensed families, or 15 home studies.¹⁹¹

Per the methodology agreed upon in the DVP, the applicable caseload standard for individuals with mixed caseloads weights each case according to its type (e.g., an investigation case counts as one-twelfth or 8% of the standard, a child in a permanency case counts as one-fifteenth or 7% of the standard, and so on).

The WDP also prescribes graduated caseloads for case-assignable workers who have recently completed NET, such that the maximum number of investigation or permanency cases to which a case worker can be assigned as a primary case worker depends on the number of months since

¹⁸⁸ The State submitted data from three sources: (1) primary case assignments were from FACTS, (2) position titles and start dates of individuals were from CYFD's Human Resources system (SHARE), and (3) NET completion dates for individuals were from Cornerstone (an online training platform). The State completed a name match to link the SHARE and Cornerstone data to the FACTS assignment data.

¹⁸⁹ Per the DVP, the Co-Neutrals selected on point-in-time date per quarter for analysis of BTO10.2(i) and (ii). In 2024, the State submitted real-time caseload data on a biweekly cadence, with the exception of the first quarter, where only one caseload data submission was made. The Co-Neutrals selected the dates where the data submissions had the most complete data.

¹⁹⁰ The DVP defines case-assignable workers as, "staff with any of the following titles – Investigation Case Worker, Permanency Coordinator, In-Home Services Provider, or Licensing and Support Specialist – who have completed NET and are eligible for case assignments." Individuals with supervisory and managerial titles are not case-assignable, nor are staff with titles such as "Investigations Case Aide," "Kinship Specialist," and other positions that do not typically require case-carrying duties.

¹⁹¹ The data submitted by the State did not indicate whether each licensing and support case was an adoption case, a licensed family, or a home study. As a result, the Co-Neutrals could not calculate LSS case workers' compliance with the caseload standards exactly as prescribed in the WDP and instead used a maximum of 15 cases.

the case worker completed NET.¹⁹² The Co-Neutral team worked with the State to identify NET dates for all workers who carried at least one case on any one of the four point-in-time dates. Individuals in case-assignable roles are only eligible for case assignment after completing NET, and the graduated caseload period is calculated from the NET completion date.¹⁹³

BTO10.2(i) – primary metric: Of all casework staff, the share who have primary caseloads consistent with established caseload standards¹⁹⁴

The share of case workers who were eligible to carry cases and had caseloads at or below the caseload standard (taking into account graduated caseloads for case workers within six months of NET completion), ranged from a low of 35 percent in the third quarter of 2024 to a high of 42 percent in the fourth quarter. Most eligible case-assignable workers at each point in time had caseloads above the standard. A significant number of workers not eligible to carry cases were assigned as primary at each point in time (discussed further in BTO10.2[ii]).

¹⁹² The State agreed that in the first two months after completing NET, a case worker cannot be assigned as primary for any investigation case but can be assigned as primary for up to five permanency cases. In the third and fourth months after NET, a case worker can be assigned as primary for up to three investigation cases or eight permanency cases. In the fifth and sixth months after NET, a case worker can be assigned as primary for up to six investigation cases or 12 permanency cases. After the sixth month following NET completion, a case worker is eligible for full caseloads. There is no graduated caseload standard for licensing and support or in-home services cases.

¹⁹³ For this analysis, the Co-Neutrals assumed that case-assignable workers missing a NET completion date who were hired in 2021 or later and did not have a senior job title (e.g., “Investigations Senior Case Worker” or “Permanency Planning Senior Worker”) had not completed NET and were thus ineligible to carry cases. If a case-assignable worker missing a NET completion date had a senior job title, or they had a non-senior job title but were hired before 2021, they were assumed to be eligible to carry a full caseload. The year 2021 was selected as the cutoff for these assumptions because in 2021 the DVP was finalized, and the Co-Neutrals and the State reached agreement on caseload standards and the commitment that case workers needed to complete NET before being assigned any cases.

¹⁹⁴ Employees were included in this metric if they were a CYFD employee in a case-assignable role as of January 5, 2024 (the list of case-assignable job titles can be found in the DVP). Supervisors, managers, and other non-case-assignable roles were excluded.

Table 25: Summary of Worker Compliance by Quarter (All Pillars)
2024

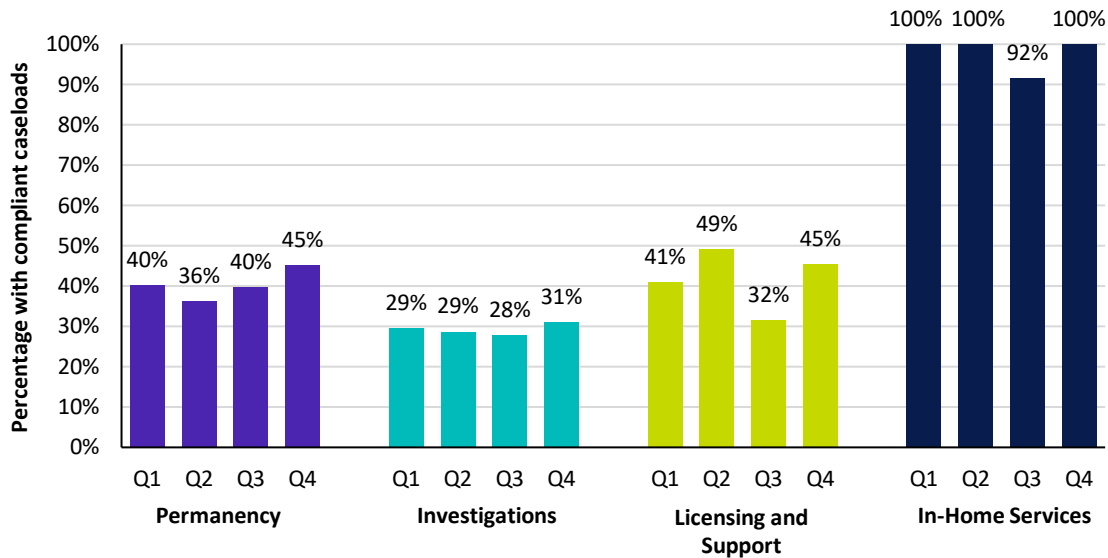
	Mar. 31 Q1	Jun. 11 Q2	Sept. 6 Q3	Dec. 3 Q4
Ineligible workers assigned as primary on at least one case	102	90	78	99
Ineligible - role	74	69	66	76
Ineligible - no NET	0	0	4	10
No longer with agency	10	3	2	9
Case-assignable workers with caseload above standard	189	190	185	176
New hire assigned as primary on at least one investigation within 2 months of NET completion ¹⁹⁵	18	18	4	13
101-150%	58	63	59	53
151-200%	51	47	47	45
201-400%	47	52	59	41
More than 400%	15	10	16	24
Case-assignable workers with compliant caseload	112	113	101	127
No cases assigned	18	3	16	35
1-50%	22	27	22	31
51-100%	72	83	63	61
Workers in case-assignable titles who completed NET	301	303	286	302
Percent of case-assignable workers who completed NET with compliant caseloads	37%	37%	35%	42%

Source: Analysis of FACTS, SHARE, and Cornerstone data submitted by the State

The share of eligible case-assignable workers with compliant caseloads was highest for IHS (100% in three of four quarters), and lowest for investigations (from 28% in the third quarter to a 31% in the fourth quarter). The share of eligible case-assignable workers with compliant caseloads remained below 50 percent at each point in time for the permanency and licensing and support pillars.

¹⁹⁵ Per the caseload standard, no case worker is eligible to be assigned as primary on any investigation in the first two months following NET completion. Therefore, any case worker (including those with mixed caseloads) assigned as primary on any investigation within two months of NET completion are categorized as having caseloads above the standard regardless of the total number of cases of any type assigned.

Figure 31: Percentage of Case-Assignable Workers Who Completed NET with Compliant Caseloads by Quarter and Pillar



Source: Analysis of FACTS, SHARE, and Cornerstone data submitted by the State

BTO10.2(ii) – primary metric: Of all children in out-of-home care, the number whose cases are assigned to any non-case-assignable casework staff, including supervisors, managers, case aides, administrators, or directors.

Significant numbers of individuals who were not case-assignable were assigned as the primary case worker for at least one case at each quarterly point in time. Most of the non-case-assignable workers assigned as primary were supervisors (51 of 74 in the first quarter, 46 of 69 in the second quarter, 41 of 66 in the third quarter, and 47 of 76 in the fourth quarter) – most often in the investigations pillar, but also frequently for permanency and licensing and support – with managers and others in non-case assignable roles assigned as primary for at least one case at each quarterly point in time. There were no individuals assigned as primary before NET completion in each of the first two quarters; however, there were individuals assigned as primary before NET completion in the second half of the year, reaching a high of 10 in the fourth quarter.

The State’s data show 1,222 cases had individuals assigned as primary who were not case-assignable at the time of assignment at the first quarterly point in time, 806 in the second quarter, 661 in the third quarter, and 910 in the fourth quarter (see Table 26). The data submitted did not specify the number of children on each case on the reference date, so the Co-Neutrals are unable to calculate the number of children assigned to non-case-assignable casework staff (i.e., the DVP metric).¹⁹⁶

¹⁹⁶ As noted above, the investigation, IHS, and licensing and support caseload standards are calculated at the case level (i.e., families), while the permanency caseload standard is at the child level.

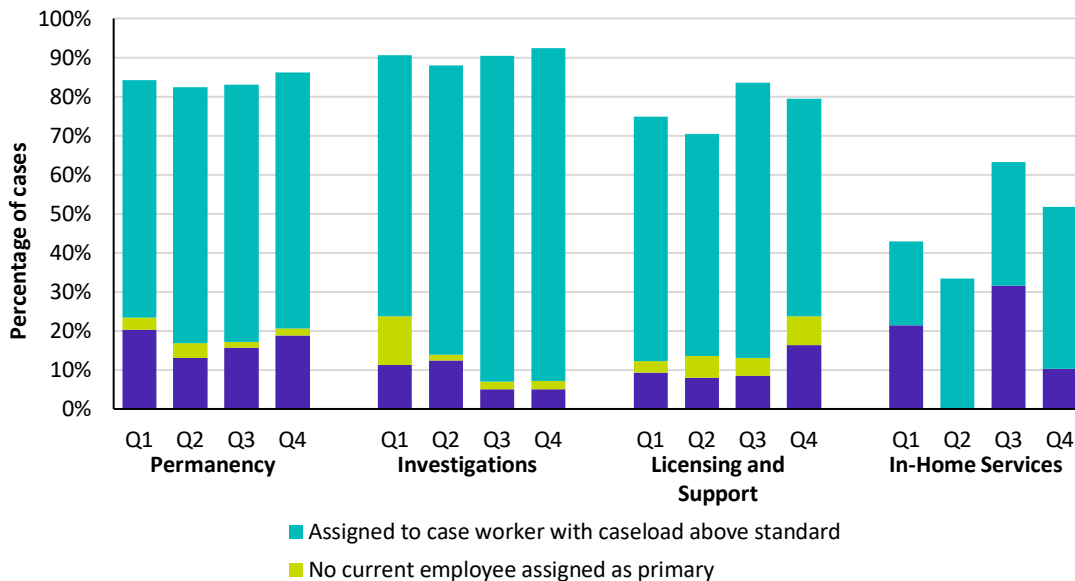
Table 26: Summary of All Case Types Assigned to Non-Case-Assignable Staff, by Quarter
2024

	Mar. 31 Q1	Jun. 11 Q2	Sept. 6 Q3	Dec. 3 Q4
Total cases:	5,648	5,413	5,445	6,221
Total cases assigned to non-case-assignable staff	1,222	806	661	910
Percent of cases assigned to non-case-assignable staff	22%	15%	12%	15%
Total unassigned or assigned to terminated worker	421	163	123	182
Total assigned to non-case-assignable worker	801	643	538	728

Source: Analysis of FACTS, SHARE, and Cornerstone data submitted by the State

For permanency and investigation cases, the percentage of cases assigned to non-case-assignable staff or to staff above the caseload standard reached a high in the fourth quarter of 2024. The highest share of licensing and support and IHS cases assigned to non-case-assignable staff or to staff above the caseload standard was in the third quarter.

Figure 32: Percentage of Cases Assigned to Ineligible Workers, with no Primary Case Worker, or to Case-Assignable Workers with Caseload Above Standard
2024



Source: Analysis of FACTS, SHARE, and Cornerstone data submitted by the State

On December 3, 2024, only eight percent of investigation cases were assigned to a case worker with a compliant caseload, and 85 percent of investigations cases were assigned to a case worker with a caseload above the standard. Fourteen percent of children in foster care (permanency cases) were assigned to a case worker with a compliant caseload, and 65 percent of children in foster care were assigned to a case worker with a caseload above the standard. Twenty-one percent of licensing and support (placement) cases were assigned to a case worker with a

compliant caseload, and 56 percent of placement cases were assigned to a case worker with a caseload above the standard. Forty-eight percent of in-home services cases were assigned to a case worker with a compliant caseload, and 45 percent were assigned to a case worker with a caseload above the standard.¹⁹⁷

BTO10.2(iii) – primary metric: In a given reporting year, the rate of voluntary separations among caseworker staff positions per 100 days worked.

There were 480 case workers with at least one day of CYFD employment, for a combined total of 83,498 workdays.^{198,199} Of the 480 staff, 84 voluntarily terminated employment in 2024, resulting in a turnover rate of 0.10 voluntary terminations per 100 days worked – roughly equivalent to one case worker leaving voluntarily for every four full-time equivalents (FTEs) each year.^{200,201}

Table 27: Voluntary Turnover Rate for PSD Case Workers
2019 - 2024

Year	Case workers	Total workdays	Number of voluntary terminations	Turnover rate
2019	492	86,884	88	0.10
2020	484	94,437	88	0.09
2021	481	94,356	116	0.12
2022	479	85,440	141	0.17
2023	486	79,429 ²⁰²	82	0.10
2024	480	83,498	84	0.10

Source: Analysis of Sandbox *StaffPosition* file, and *FACTS*, *SHARE*, and *Cornerstone* data submitted by the State

¹⁹⁷ Percentages by case type in this paragraph do not add up to 100 because only cases assigned to case-assignable staff are included.

¹⁹⁸ For this metric, the DVP defines a workday as any weekday, with no exclusions for holidays or time off.

¹⁹⁹ This analysis is based on the Sandbox *StaffPositions* file, which has one row for each position held by CYFD staff; staff may have more than one row if they held more than one position at CYFD. In the 2024 version of this file, 758 workers had two rows with different job titles but the same position start date and position number, which reflected title changes. For nine employees who appeared in the *StaffPositions* data as holding two positions at the same time, one position was case-assignable and the other was non-case-assignable. None of the nine workers were voluntarily terminated during 2024, and they collectively accounted for an additional 1,614 days worked in 2024. If these nine workers were included and they all held the case-assignable position at the time of their voluntary termination, the metric would be the same at 0.10 terminations per 100 days worked (calculated as $(84 \div 85,112) \times 100$).

²⁰⁰ No staff had a voluntary termination more than once in 2024.

²⁰¹ A rate of 0.10 terminations per 100 days worked (calculated as $(84 \div 83,498) \times 100$) roughly equates to one termination per 1,000 days worked. There were 262 DVP-defined workdays in 2024, so 1,000 days roughly equates to four full-time equivalents (FTEs) for the year.

²⁰² The number of workdays was significantly lower in 2023 than in any previous year because CYFD stopped hiring case workers and supervisors between May and September 2023. One impact of this hiring stoppage was to make a year-to-year turnover comparison difficult because 2023 not only included thousands fewer workdays, but also many fewer new case workers, and CYFD has historically experienced high turnover among that group.

As additional information, the Co-Neutrals also examined the length of tenure for the 84 staff who voluntarily terminated employment (see Table 28). Nearly half (45%, 38 staff) had been employed at CYFD for less than one year. Thirty-seven percent (31) had been employed at CYFD for one to three years, while 18 percent (15) had been employed for four years or longer. In 2023, the percentage of staff who had been employed less than one year when they voluntarily terminated employment (55%) was higher than in 2024, and the percentage who had been employed one to three years was lower (29%). The rate for case workers who had been employed four years or longer was similar for both years.

Table 28: Length of Tenure Before Termination for Eligible Employees²⁰³
2024

Length of tenure before voluntary termination	No.	%
Less than one year	38	45%
1 to 3 years	31	37%
4 to 6 years	6	7%
7 to 9 years	6	7%
10 or more years	3	4%
Total	84	100%


Source: Analysis of Sandbox StaffPosition file, and FACTS, SHARE, and Cornerstone data submitted by the State

Discussion

Unreasonably high caseloads were at the root of the organizational and case practice crisis that loomed for CYFD in 2024. Caseload compliance for CYFD at each of the four points in time selected to measure caseload compliance was below 50 percent. When examining caseloads by case worker type, investigation workers – who are responsible for responding to allegations of abuse and neglect, and assessing children’s safety and risk of harm within their homes – were the least likely to be assigned caseloads consistent with the State’s commitments.

During the Co-Neutrals’ site visits to CYFD offices in January, August, and September 2024, substantial vacancies existed across the organization. A few on-the-ground examples sharpened the Co-Neutrals’ understanding of conditions for the workforce, children, and families. Most of the investigative staff the Co-Neutrals met in 2023 in CYFD’s Santa Fe and Bernalillo offices had quit or were transferred one year later, leaving the units woefully under-resourced again. For the second year in a row, there was no permanency case worker in CYFD’s Santa Fe office in September 2024. The lone permanency worker who remained in the middle of August learned that they were going to be assigned more than 30 new permanency cases following the departure of a colleague, in addition to their own excessive caseload. This employee responded by submitting their resignation. Nearly half (45%) of the 84 staff who voluntarily terminated their employment with CYFD in 2024 had been employed at CYFD for less than one year, revealing an urgent need to better support new staff and strengthen efforts to retain them once they have

²⁰³ Percentages do not add up to 100 due to rounding.



been recruited, hired, and trained.

CYFD staff repeatedly described to the Co-Neutrals poor working conditions that negatively impacted children, including children staying/sleeping in CYFD county offices, lack of safe and appropriate family-based placements and community-based services, multiple burdensome and inefficient data systems, widespread confusions about roles and responsibilities, and poor communication from state leaders to frontline staff and horizontally within the Pillar organization structure. CYFD managers continued to report to the Co-Neutrals, as the data show, that they managed cases (even though the cases often appeared in the official data reports as assigned to other staff). This detracted significantly from their ability to lead and supervise case-carrying staff. The Co-Neutrals relayed to the CYFD and HCA Secretaries in both 2023 and 2024 that in their work across more than a dozen statewide child welfare systems, the Co-Neutrals had never seen so many children's cases managed directly by supervisors and county managers. The Co-Neutrals continuously urged the Secretaries to pay attention to staffing and caseloads as an urgent concern.

From July through December 2024, members of the Co-Neutral team spoke with 120 case workers and supervisors across all three case work pillars throughout the state about their workloads, including their general experience with children staying overnight in offices, traveling long distances to take children to placements, and their associated casework responsibilities. Below are some of the findings:

- Sixty-three percent of staff stated that they were sometimes expected to spend their regularly scheduled on-call shifts supervising children placed in offices. Permanency staff were most likely to report this (74%), followed by investigations staff (58%), and licensing and support (52%). Region 3 staff (95%) were mostly likely to report spending on-call shifts supervising children in offices.
- When staff were asked if their offices were currently experiencing overnight office stays, 71 percent stated that there were children currently staying in offices. All Region 3 staff (100%), 97 percent of Region 5 staff, and 81 percent of Region 4 staff reported overnight stays at the time of the 2024 interviews. Lower instances of current office stays were reported by Region 1 (40%) and Region 2 (32%).
- When staff were asked if they had to volunteer or had been assigned to stay overnight with children in the office, 84 percent reported that they had. And when asked if training had been provided to staff on what to do during overnight office stays, 93 percent of staff said that no training was provided. Some staff mentioned that they had reviewed guidelines on what to do during office stays, but those instances were rare, and staff considered that training inadequate.
- Among staff who were asked about providing daytime supervision to children housed in CYFD offices, 84 percent stated that there currently were or recently had been children staying in the office during the day that required staff supervision. Staff described a number of strategies for providing daytime supervision, including creating schedules among staff, mostly with child services agents (CSAs), case aides, or temporary workers. Staff who had experienced daytime supervision unanimously agreed that supervising

children during the day distracted from staff’s ability to focus on their casework responsibilities to other children and families.

iii. Appendix C: Indian Child Welfare Act

The commitments in Appendix C of the FSA require CYFD and HCA to “serve Native American families, build a relationship with each of the New Mexico Tribes and Pueblos, and comply with the Indian Child Welfare Act (ICWA) in its letter and intent.” The State must “comply with ICWA and shall make every effort to ensure that all Native Children and families receive appropriate support and services.”^{204, 205}

CYFD’s Office of Tribal Affairs (OTA) has incrementally developed and implemented processes and procedures to improve communication and relationships with New Mexico’s Nations, Pueblos, and Tribes. With increased staffing in 2024, including a Quality Assurance Manager, OTA has been able to collect and report data related to submission of required notices to Tribes during investigations, permanency goals for Native children in care, and completion of monthly staffings for Native children not placed with their relatives, among other process measures and outcomes. In respect of data sovereignty, Nations, Pueblos, and Tribes are able to request data related to Native children from their communities in the state’s custody at their discretion.

During 2024, there was an increase in CYFD staff completing required Indian Child Welfare Act (ICWA) and Indian Family Protection Act (IFPA) training;²⁰⁶ specifically 73 percent of staff completed the Tier One: Novice certification by the end of the year, compared to 55 percent of required staff in 2023.²⁰⁷ Between July and December 2024, the Co-Neutral team spoke with 118 case workers and supervisors who completed the ICWA/IFPA training, and 91 percent of staff reflected positively on the training and its impact on their direct work with children, parents, and families. In general, those who reported favorably on the training found it helpful and generally acknowledged the importance of gaining a better understanding of the unique history and background of Native families.

The ICWA/IFPA Training Plan has three Tiers of required training. Tier One: Novice, described above, was the only formal training offered throughout 2024. Tier Two: Advanced Certificate and Tier Three: Leadership Certificate of the ICWA/IFPA training – which are mandated for supervisors, managing attorneys, County Office Managers, Regional Managers, and Deputy Directors – were not finalized and available throughout 2024, and therefore not provided to staff.²⁰⁸


²⁰⁴ FSA, pg. 8a.

²⁰⁵ Indian Child Welfare Act (ICWA) is a federal law enacted in response to a history of disproportionately removing Native children from their families, and mandates active efforts to preserve families and prioritizes placement with Native relatives and families, among other requirements. 25 U.S.C. §§ 1901-63.

²⁰⁶ The Indian Family Protection Act (IFPA) codifies into NM state law provisions of the federal ICWA, among other requirements. N.M. Stat. Ann. §§ 32A-28.

²⁰⁷ The State’s approved Indian Child Welfare Act and Indian Family Protection Act Training and Coaching Plan can be found [here](#).

²⁰⁸ The first training cohort for Tier Two: Advanced Certificate was held on December 10 and 11, 2024, and included 18 participants.



In October 2024, the Centers for Medicaid and Medicare Services (CMS) approved HCA's Medicaid 1115 Waiver proposal to provide Medicaid funding for traditional healing. This is a significant development, and is the first time that reimbursement for these services has been permitted through Medicaid. The benefit is voluntary to those Nations, Pueblos, and Tribes who choose to participate, and the Navajo Nation expressed an interest in participating in the traditional healing reimbursement. HCA reports having launched the reimbursement benefit in October 2025.

Payment or reimbursements for cultural activities or Traditional Medicine Benefits (TMBs) for Native children decreased in 2024 compared to 2023; nine percent of children were documented as having received payments or reimbursements in 2024, compared to 12 percent in 2023. In 2024, CYFD through its OTA, piloted a procedure to offer supports in promoting traditional interventions and services to Native children in state custody, including instructions for requesting and providing payments for cultural activities that connect children to their heritage and recognize Tribal sovereignty. Policy to expand this beyond a few selected cases was developed during 2024 but not finalized and published until September 2025. Payments for such activities are first sought from the MCO as a TMB, and if that is not approved or not approved timely, reimbursement is potentially available from CYFD under this new policy.

A requirement of state and federal law, and CYFD policy is that Native children be placed in accordance with IFPA placement preferences, with the first order preference placement with a relative. In 2024, of the 333 Native children in state custody at some point during the year, 51 percent experienced at least one placement with a relative. If a child is not placed in a home that meets the tribal placement preference, monthly meetings are required to plan for and make active efforts to identify a relative placement or placement that meets tribal preferences. Of the monthly meetings required for Native children who were not placed in accordance with IFPA, 38 percent were conducted on time. A qualitative review of a sample of completed meetings found that documentation from these meetings show that not all necessary participants had been invited, nor that all required discussion topics and issues were addressed. Follow-up on plans between monthly meetings was reported to be insufficient. In many instances, lack of engagement by the PC and other team members with the child's Nation, Pueblo, or Tribe, as well as family members negatively impacted the team's ability to identify and engage and support a relative placement for the child.

a. *Implementation Targets*²⁰⁹

Development of Processes and Procedures to Promote Traditional Interventions (App. C, IT 2.1)

FSA Requirement	With the input of New Mexico’s Tribes and Pueblos, CYFD and HCA will develop processes and procedures to promote traditional interventions as first-line interventions and services, using an assessment tool for Native Children in State Custody, modifications of existing assessment tools, or other means recommended by Native experts. The form of the assessment tool or other means shall be approved by the Co-Neutrals, but the Co-Neutrals shall not withhold approval of the assessment tool if it is reasonably calculated to achieve the Goals of this Agreement. (Due June 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this IT in 2024.

Discussion

Beginning in 2021, CYFD collaborated with New Mexico’s Nations, Pueblos, and Tribes to develop processes and procedures to promote traditional interventions as first-line interventions and services for Native children and families. This work was controversial as tribal leaders expressed sovereignty concerns about the Department’s role in assessing the needs of their children. The intent of the processes was to determine what CYFD needed to do to support Native children in state custody’s access to traditional interventions and services, and to effectively respond to requests for assistance; these processes were not intended to assess children and families with respect to cultural ties and needs nor to reduce culture or tradition to “tools.” Corresponding guidelines and procedures were to include how often the process would take place; who participates in the process; and the roles and responsibilities of the State to support a Native child in state custody in having regular and consistent access to interventions which promote cultural connectedness.

In response to the feedback received, the State organized and facilitated two listening sessions with New Mexico Nations, Pueblos, and Tribes in 2023 – one in May and one in November – to hear directly from Tribal leadership on how to address the needs of Native children in state custody. Although not fully resolving the questions raised about an “assessment process,” CYFD continued developing processes to offer support in promoting traditional interventions and services to Native children in state custody, including how to provide payments for cultural connectedness activities that recognize Tribal sovereignty. CYFD developed a process with input from Tribal representatives, which was piloted beginning in June and July 2023 and continued throughout 2024. As discussed below, CYFD finalized and published a policy related to this practice in September 2025.

²⁰⁹ A list of all ITs where the State previously met the Performance Standard can be found in Appendix ii. *Implementation Targets and Target Outcomes Met in Prior Reporting Periods.*

Pursue Federal Funding through Medicaid and Title IV-E (App. C, IT 3.1)

FSA Requirement	HCA and CYFD will pursue federal funding to the maximum extent allowable through Medicaid and IV-E funding for traditional and culturally responsive treatments, interventions, and supports, including non-medicalized interventions, for Native Children in State Custody. (Due June 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this IT in 2024 although foundational work occurred.

Discussion

CYFD reports that through its OTA, Office of General Counsel, and the Title IV-E/Medicaid unit, meetings were held weekly – as requested by respective Nations, Pueblos, and Tribes – to discuss and provide information on Title IV-E pass through agreements for foster care, guardianship, and adoption assistance. CYFD reports approximately 18 meetings were held with six different Nations, Pueblos, and Tribes in 2024.²¹⁰

The State is also working with MCO staff to leverage Medicaid where possible for Native children. On July 1, 2024, New Mexico transitioned to Turquoise Care which provided for one MCO, PHP, to serve most children in state custody. Native children in state custody can choose which MCO they want to enroll in, or they can remain Fee For Service.²¹¹ Turquoise Care covers value added services which include Native American Traditional Healing Benefits (TMB), providing reimbursement for traditional health practices for treatment of diagnosed conditions.²¹²

In October 2024, the Centers for Medicaid and Medicare Services (CMS) approved HCA's Medicaid 1115 Waiver proposal to provide Medicaid funding for traditional healing. CMS approval for traditional healing was provided to three additional states – Arizona, California, and Oregon – and is the first time that reimbursement for these services has been permitted through Medicaid. The State reports that a kickoff meeting was held with Tribal leadership in December 2024 to review the list of Special Terms and Conditions required by CMS, and to begin work on a 2025 implementation plan. The benefit is voluntary to those Nations, Pueblos, and Tribes who choose to participate, and the Navajo Nation expressed an interest in participating in the traditional healing reimbursement. HCA reports that it launched the reimbursement benefit in October 2025.

²¹⁰ Additional efforts by CYFD to pursue Tribal access to Title IV-E funding are discussed below within App. C, IT 6.1 – *New Mexico Tribes and Pueblos Access to IV-E Funding*.

²¹¹ Fee For Service is a payment model where NM pays providers directly for each individual service they deliver, as opposed to a managed care plan.

²¹² Data on utilization of TMBs in 2024 are discussed within below within App. C, TO 2.1 – *Identification, Access, and Expansion of Culturally Responsive Services*.

Native Resource Family Recruitment and Retention Plan (App. C, IT 5.1)

FSA Requirement	CYFD will develop a plan to increase recruitment and retention of Native Resource Families. The plan will include identifying relatives of Native Children, as required by ICWA or the New Mexico Tribe or Pueblo's preferred placement priorities, as well as identifying other potential Native Resource Families. The plan will include identification of additional supports needed for Native Resource Families, including supports and services that are culturally responsive and are not the same as those provided to non-Native parents, as well as providing assistance for families to navigate Resource Family licensing requirements. One methodology for identifying additional needed supports will be surveying former Native Resource Families to determine why they have stopped serving as a Resource Family and surveying potential Native Resource Families that did not complete the process to determine why they chose not to become a Resource Family. (Due June 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this IT in 2024.

Discussion

Although some efforts were underway in 2024, CYFD did not provide the Co-Neutrals with a Native Resource Family Recruitment and Retention Plan. Of the 333 Native children in state custody at some point during 2024, 51 percent experienced at least one placement with a relative, but nearly half of Native children did not. Substantial additional efforts are needed to ensure Native children have placements that meet IFPA preferences.

Following years of meetings between CYFD's OTA and NM's Nations, Pueblos, and Tribes to review and solicit input and feedback on resource family licensing procedures, new resource home licensing procedures were adopted, effective January 1, 2024.²¹³ In early 2024, OTA hired a Native American Resource Parent Consultant who is responsible for improving communication between CYFD PSD staff and Tribal ICWA social workers and community-based providers and stakeholders.

CYFD has consistently reported feedback they received from the Nations, Pueblos, and Tribes that they support CYFD's efforts toward placement of children with relatives, but do not want CYFD to launch recruitment efforts that establish a pool of non-relative Native resource homes. OTA reports engaging in conversations with several Nations, Pueblos, and Tribes during 2024 about their interest in hiring their own staff to recruit homes and complete home studies for families within their communities, but those conversations did not lead to a resourced plan with implementation milestones.

²¹³ CYFD's licensing procedures can be found [here](#).

New Mexico Tribes and Pueblos Access to IV-E Funding (App. C, IT 6.1)

FSA Requirement	CYFD will work with New Mexico Tribes and Pueblos to engage in dialogue, develop agreements, and take any other steps necessary to help New Mexico Tribes and Pueblos better access IV-E funding to improve services for Native Children, including additional funding for legal representation for New Mexico Tribes and Pueblos and Respondents. (Due June 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this IT in 2024. Some foundational work occurred in 2024 and continued in 2025.

Discussion

CYFD has committed to creating additional opportunities for New Mexico Nations, Pueblos, and Tribes to leverage Title IV-E federal funding for children in foster care or who are at risk of entering foster care.²¹⁴ CYFD's primary strategy for this action has been through development of Joint Power Agreements (JPAs) between the State and New Mexico Nations, Pueblos, and Tribes. Such Agreements would allow the State to pass through Title IV-E federal funds to Tribal Nations for reimbursable costs. Decisions about whether to enter into a JPA rests with the Nations, Pueblos, and Tribes.²¹⁵

As discussed above, OTA and the Title IV-E/Medicaid unit offered regular meetings and trainings to Nations, Pueblos, and Tribes to provide information on JPAs, how funding is provided, and that Title IV-E reimbursement is available for monthly foster care payments and adoption and guardianship subsidies for children in care who are determined eligible for Title IV-E; administrative costs to manage the program; training for staff and resource/adoptive parents, including recruitment of resource parents and providing tuition and book stipends for social work students preparing to work for CYFD or Tribal social services agencies; and costs related to the design, implementation, and operation of a state-wide data collection system. No new JPAs were signed in 2024, though conversations, collaboration, and training has resulted in several new JPAs being executed in 2025. The Co-Neutrals have recently learned that administrative costs are not available through the JPA template currently being utilized by the State, and that separate negotiations, agreements, and administrative processes are required for Nations, Pueblos, and Tribes to receive funding for those costs.

²¹⁴ CYFD is the designated Title IV-E agency for New Mexico, and can pass Title IV-E funds to Nations, Pueblos, or Tribes for the care of Native children who meet the eligibility criteria, and who are in the custody of the Nation, Pueblo, or Tribe as a result of caregiver abuse or neglect.

²¹⁵ The Navajo Nation is the only New Mexico Tribe with a Title IV-E direct plan, which allows them to draw down funds directly from the federal government for approved activities and costs. Although the Navajo Nation is its own Title IV-E agency, the Ramah Navajo (Pine Hill) is not.

Collection and Analysis of Data to Understand Needs of Native Children, and State’s Capabilities to Meet those Needs (App. C, IT 7.1)

FSA Requirement	CYFD and HCA will collect and analyze data sufficient to understand the characteristics and needs of Native Children in State Custody and the capabilities of the State to meet those needs. The data to be collected will include (1) data about Native Children in State Custody, including Tribal membership status, confirmation and correction of birth certificates, removal rates, and placements (including whether children are placed with relative, non-relative Native, or non-relative non-Native Resource Families, Treatment Foster Care, congregate care, residential placement, or other out of home placement); (2) data on the demographics and characteristics of placements available to Native children (including Resource Families); and (3) data on the demographics, characteristics and services provided by treatment providers available to Native Children in State Custody. (Due June 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this IT in 2024. Some foundational work continued in 2024.

Discussion

Beginning in 2023 and throughout 2024, CYFD has made efforts to improve its data tracking and analysis to understand and anticipate the needs of Native children in care, while also being cognizant of data sovereignty concerns raised by Tribal leaders and partners. The data OTA has begun collecting include, for example: timeliness of notice to Tribes that CYFD is initiating an investigation and an invitation for the Tribe to collaborate; timely notice to Tribes of CYFD’s intent to file a petition; outcomes of investigations involving Native children; permanency goals for Native children in care; and number of Native children in ICWA/IFPA-preferred placements. OTA has a Quality Assurance (QA) Manager who maintains quarterly reporting to Nations, Pueblos, and Tribes, and OTA has established a process for Nations, Pueblos, and Tribes to request data from CYFD respective to their communities.

Though OTA has recently developed a monthly dashboard with some outcomes for Native children in care, data specific to all components of this IT were not collected and reported to the Co-Neutrals in 2024. Specifically, data and information on treatment providers available to provide services to Native children – separate from cultural activities and traditional healing services, the details of which may be considered private and sacred to Tribal members – continued to be characterized by key partners, including community members, as difficult to obtain in 2024. Additionally, in case record reviews the Co-Neutral team jointly conducted with CYFD staff, discrepancies continued to be identified for some Native children related to whether their placement provider is a relative or non-relative, and whether the resource home has at least one parent who identifies as Native.

b. Target Outcomes

Screenings and Referrals for Native Children within 30 Days of Entering Care (App. C, TO 1.1)

FSA Requirement	By December 1, 2021, assessments using the tool developed for Native Children in State Custody or other process developed per Implementation Target 2 above will be conducted within 30 Days of CYFD filing a petition for custody of a Native Child in State Custody. (Due December 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

DVP Metrics and Validated Performance Data

CTO1.1(i): qualitative metric: Qualitative review of practice for screening and referrals to traditional and culturally-responsive services.²¹⁶

The State had not finalized the qualitative instrument and methodology to assess performance for this metric. Thus, the Co-Neutrals are unable to report performance toward this metric for 2024.

CTO1.1(ii): primary metric: assessments for Native children within 30 days.

Tribal leaders have expressed significant concerns to the State and Co-Neutrals about the development and use of assessments or tools regarding their children, and the State's role in identifying or promoting cultural interventions or services, which the State has heeded. As a result, this practice has not been fully implemented by the State, and data pursuant to the DVP was not provided to the Co-Neutrals. Thus, the Co-Neutrals are unable to report performance toward this metric for 2024.

²¹⁶ This qualitative metric will be used to validate multiple related commitments, specifically App. C, TO 1.1, App. C, TO 2.1, App. C, TO 2.2, App. C, TO 2.3, and App. C, TO 3.1.

Identification, Access, and Expansion of Culturally Responsive Services (App. C, TO 2.1)

FSA Requirement	CYFD will work with New Mexico Tribes and Pueblos, families, and Native Children to identify culturally responsive services. HCA will develop and expand access to traditional and culturally responsive treatments, interventions, and supports. CYFD will develop and arrange for traditional and culturally competent interventions, which may include interventions that are not medicalized and/or have not been evaluated as evidence-based, well-supported, or promising. CYFD and HCA will expand culturally relevant services that can be used as an active effort to keep families intact and to avoid taking children into custody. (Due June 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

DVP Metrics and Validated Performance Data

CTO2.1(i) – primary metric: Number of Native American children in CYFD custody receiving Traditional Medicine Benefits (TMB) during the reporting year.

There were 236 ICWA-eligible children in state custody for at least eight days who were affiliated with a MCO in 2024, and 23 of those children (10%) were documented as having received Traditional Medicine Benefits (TMB) during the year.^{217,218} This is a decrease from 2023, when 33 of 232 eligible children (14%) received a TMB (see Table 29).

²¹⁷ A child is considered ICWA-eligible if: (a) the Court has affirmatively determined that they are ICWA-eligible, or (b) the Court had not yet made an ICWA-eligibility determination but either their race is identified as “American Indian or Alaskan Native” or they are documented in FACTS as having a Tribal affiliation.

²¹⁸ Source: Analysis of Sandbox *Cohort* and *Episodes of Custody* files and MCO data submitted June 11 and June 18, 2025. In the MCO data submitted, TMBs are referred to as Traditional Healing Value Added Services.

Table 29: ICWA-Eligible Children Who Received At Least One TMB, by MCO²¹⁹
2024

Affiliated MCO	Eligible children	Total children who received at least one TMB	Share who received TMB
Presbyterian Health Plan	187	19	10%
Blue Cross Blue Shield of New Mexico	41	4	10%
Molina Healthcare	4	0	0%
Western Sky Community Care	4	0	0%
Total MCO-affiliated children	236	23	10%

Source: Analysis of MCO data and Sandbox Cohort and EpisodesOfCustody files

CTO2.1(ii) – primary metric: Percentage of Native American children in CYFD custody receiving payments and/or reimbursements for cultural activities during the reporting year (including Traditional Medicine Benefits, TMBs).

There were 276 ICWA-eligible children in state custody for at least eight days in 2024, and 26 of those children (9%) were documented as having received payments and/or reimbursements for cultural activities (including TMBs) during the reporting year (see Table 30). This is a decrease from 2023, when 35 of 298 eligible children (12%) were documented as having received payments and/or reimbursements for cultural activities (including TMBs) during the year.

Table 30: Number of Native American Children Who Received at Least One Payment and/or Reimbursement for Cultural Activities (including TMBs)²²⁰
2024

	N	%
Total eligible children	276	100%
Children who received benefits	26	9%
Traditional Medicine Benefits (TMBs) only	20	7%
Payments and/or reimbursements for cultural activities only	3	1%
Both TMB and payment/reimbursement for cultural activities	3	1%

Source: Analysis of MCO data and Sandbox Cohort, EpisodesOfCustody, and MCO Affiliation files

Discussion

Nine percent of applicable ICWA-eligible children received at least one payment for a cultural activity in 2024, a decrease from 2023. The new policy finalized by the State in September 2025,

²¹⁹ The universe for this table is limited to ICWA-eligible children who were in care for at least eight days and affiliated with an MCO.

²²⁰ The universe for this Table is limited to ICWA-eligible children who were in care for at least eight days.

and CMS’s approval of the traditional health benefit effective October 2025 provides opportunities going forward.

IPPs for Native Children to Address Need for Traditional or Culturally Responsive Services, Supports, or Interventions (App. C, TO 2.2)

FSA Requirement	By December 1, 2022, Individualized Planning Meetings for every Native Child in State Custody will address the need for traditional or culturally responsive services, supports, or interventions, including non-medicalized interventions, to meet his or her individualized needs as indicated by his or her assessments. (Due December 1, 2022)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

DVP Metrics and Validated Performance Data

CTO1.1(i): qualitative metric: Qualitative review of practice for screening and referrals to traditional and culturally-responsive services²²¹

The State had not finalized the qualitative instrument and methodology to assess performance for this metric. Thus, the Co-Neutrals are unable to report performance toward this metric for 2024.

CTO1.1(ii): primary metric: assessments for Native children within 30 days

The State has not finalized the process and procedures for this metric, thus, data have not been collected to assess performance.

²²¹ This qualitative metric will be used to validate multiple related commitments, specifically App. C, TO 1.1, App. C, TO 2.1, App. C, TO 2.2, App. C, TO 2.3, and App. C, TO 3.1.

Policies to Support Native Children to receive Traditional or Culturally Responsive Services (App. C, TO 2.3)

FSA Requirement	CYFD will make every effort to ensure that services are provided as quickly as possible with consideration of the traditions and culture of the Native child's Tribe or Pueblo, as well as child and family preferences. CYFD will develop policies to ensure that Native Children in State Custody receive traditional or culturally responsive services, supports, or interventions, including interventions which are non-medicalized and/or have not been evaluated as evidence-based, well-supported, or promising, including collecting data on implementation of the protocols. The Co-Neutrals will approve the policies and evaluate the Department's compliance with the policy. The Co-Neutrals shall not withhold approval of the policy if it is reasonably calculated to achieve the goals of this Agreement. (Due June 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Discussion

As discussed earlier for App. C, IT 2.1 – *Development of Processes and Procedures to Promote Traditional Interventions*, the State continued its work to develop and implement the processes and policies that will be utilized to support Native children in their access to traditional or culturally responsive services, supports, or interventions.

Policy to Provide Direct Assistance for Traditional Ceremonies (App. C, TO 3.1)

FSA Requirement	CYFD will develop a policy to provide or ensure provision of direct assistance for traditional ceremonies, including arranging for all preparation and providing payment if needed, if Native Children want to participate. The policy will 1) provide for Native Children in State Custody to be presented with information about traditional ceremonies with sufficient time to decide whether they want to participate, 2) affirmatively encourage participation, and 3) facilitate all necessary preparation activities. The Co-Neutrals will approve the policy and evaluate the Department's compliance with the policy. The Co-Neutrals shall not withhold approval of the policy if it is reasonably calculated to achieve the Goals of this Agreement. (Due June 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Discussion

The State included the requirements of this TO into the policy that was developed for App. C, IT 2.1 – *Development of Processes and Procedures to Promote Traditional Interventions*, and App. C, TO 2.3 – *Policies to Support Native Children to Receive Traditional or Culturally Responsive Services*. CYFD developed a process with input from Tribal representatives, which was piloted beginning in June and July 2023 and continued throughout 2024. CYFD did not finalize and publish this policy titled, *Cultural Activities and Traditional Healing Services for Indian Children/Youth*, until September 2025.

Development of Protocols for 30-Day Review Process (App. C, TO 4.2) ²²²

FSA Requirement	CYFD will establish protocols governing the 30-Day review process to include families, Tribal representatives, legal representatives, and Resource Families. The protocols will require that the aim of the placement review will be to determine what actions, services and supports will enable the child to be moved to an ICWA-approved placement. If State ICWA legislation is passed and is more protective than the federal ICWA, a placement may meet this standard by being preferred by or consistent with the State ICWA legislation. The Co-Neutrals shall approve the protocols, but the Co-Neutrals shall not withhold approval of the protocols if they are reasonably calculated to achieve the Goals of this Agreement. The Co-Neutrals will evaluate compliance with the protocols. (Due December 1, 2020)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024. Protocols have been developed, however, consistent compliance with the protocols, as required by this TO, did not occur in 2024.

Discussion

On January 16, 2021, the Co-Neutrals approved the State's process and procedure for this TO as outlined in a Guidance Memorandum titled, *ICWA – Foster and Adoptive Placement of American Indian/Alaskan Native Children*, and later in PIG 03-2021-#7, dated March 24, 2021. These materials described the legal requirements pursuant to the federal ICWA on the placement of Native children in foster care, and established a process by which CYFD will conduct regular reviews of Native children who are not placed according to ICWA placement preferences in order to identify and secure preferred placements for the Native child.

In response to the State's inadequate performance toward placement of Native children in IFPA/ICWA preferred placements as discussed in the Co-Neutrals' 2022 Annual Report, the parties' June 2023 CAP describes CYFD's commitments to improve its processes and procedures to ensure

²²² Although out of sequence, this report discusses App. C, TO 4.2 prior to discussion of App. C, TO 4.1 in order to provide an explanation of the process and procedure established by CYFD prior to presentation of the data in App. C, TO 4.1.

Native children are in ICWA/IFPA-preferred placements.²²³ In late 2023, the State developed and issued a policy titled, *Out-of-Preferred Placements (OOPP) for Indian Children* which rescinded the prior Guidance Memorandum and PIG.²²⁴ This policy articulates the placement preferences pursuant to IFPA and provides a framework for monthly meetings and “OOPP up-staffings” (described below) for Native children not in IFPA-preferred placements. This policy was effective December 1, 2023.²²⁵

IFPA provides for the following order of placement preference:

- (a) an extended family member of the Indian child;
- (b) a foster home licensed, approved or specified by the Indian child’s tribe; or
- (c) a foster home licensed or approved by a licensing authority in New Mexico in which one or more of the licensed or approved foster parents is Indian.

Prior to placing a Native child in any placement, the primary PSD case worker should consult with all Nations, Pueblos, or Tribes involved to determine their placement preferences.

Pursuant to the policy, OTA must notify the following required invitees to the scheduled OOPP meeting two weeks in advance: Native youth age 14 and older (unless there is a documented reason for exclusion, e.g., a youth with developmental disability); parents, if parental rights have not been terminated; Tribal representative(s); PSD managers; primary PSD case workers; Children’s Court Attorney (CCA); respondent attorneys; guardian ad litem (GAL); youth attorney (YA), if assigned; extended family members/supports identified by the family; and resource parents. OTA facilitates the OOPP meeting, and the primary PSD case worker and their supervisor are responsible for ensuring the recommendations made during the OOPP meeting are completed prior to the next meeting.

An OOPP *up-staffing* is a high-level internal review to ensure accountability and follow-through for expeditiously moving Native children into IFPA-preferred placements. After two consecutive OOPP meetings, if a Native child remains in an out-of-preferred placement that is not the first order of preference, up-staffings will be scheduled within two weeks of the last OOPP meeting with the following required participants: PSD Director or their designee; PSD investigations, permanency, and placement Deputy Directors or their designees; and OTA Director or their designee. The goal of these meetings is to increase accountability and follow-up on the recommendations from the OOPP staffings and ensure active efforts to place Native children in accordance with IFPA.

²²³ CAP Section II.3.

²²⁴ This policy can be found [here](#).

²²⁵ The CAP required the State to revise and finalize this policy no later than November 1, 2023, and that any revisions to the OOPP procedure previously approved by the Co-Neutrals in January 2021 would be subject to review and approval by the Co-Neutrals. On November 8, 2023, the State provided the Co-Neutrals with the policy for review and comment but omitted to include the referenced attachments which the Co-Neutrals requested. On December 5, 2023, the State provided the Co-Neutrals with the requested information, however, failed to notify the Co-Neutrals that the policy was signed by Secretary Casados on November 16, 2023, and became effective December 1, 2023.

While CYFD has developed a policy for 30-day review processes and OTA staff have been scheduling and facilitating reviews, performance data discussed below show that practice in 2024 was not compliant with established protocols and procedures as required by this TO.

30-Day Review of Native Children in Non-ICWA/IFPA-Preferred Placements (App. C, TO 4.1)

FSA Requirement	By December 1, 2020, when a Native Child is in a non-ICWA-preferred placement, the placement will be reviewed every 30 Days. (Due December 1, 2020)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

DVP Metrics and Validated Performance Data

CTO4.1(i) – primary metric: Length of time Native American children spent in non-ICWA preferred placements.²²⁶

Of the 3,026 children in care at any point during 2024, 333 were ICWA-eligible.²²⁷ Of these 333 children, 184 (55%) were placed only in IFPA-preferred placements and 49 (15%) spent more than 180 days in a non-IFPA-preferred placement.^{228,229} Table 31 shows the number of days spent in non-IFPA-preferred placements for all 333 children. The data show a slight improvement from 2023.

CTO4.1(i*) – secondary metric: Length of time Native American children spent in non-ICWA-preferred placements made after December 1, 2020.

To assess changes in the placement process since the adoption of the FSA, the secondary metric limits the analysis to ICWA-eligible children in non-IFPA-preferred placements that began on or

²²⁶ Per the DVP, these calculations (for both primary and secondary metrics) included temporary absences that occurred within or between non-IFPA-preferred placements. For example, if a child was in a non-IFPA-preferred placement, then was in an acute hospitalization, and then either returned to that same placement or moved to a new non-IFPA-preferred placement, the length of that entire spell would count toward the total.

²²⁷ A child is considered ICWA-eligible if: (a) the Court has affirmatively determined that they are ICWA-eligible, or (b) the Court had not yet made an ICWA-eligibility determination but either their race is identified as “American Indian or Alaskan Native” or they are documented in FACTS as having a Tribal affiliation.

²²⁸ The 184 children may include some children who were not in a placement in 2024 including, for example, those on runaway or trial home visits.

²²⁹ A placement was considered non-IFPA-preferred if a court hearing deemed the placement non-IFPA-preferred. If there was no court determination, CYFD’s determination was used. If there were no court or CYFD determinations, the placement was considered non-IFPA-preferred if it was not a relative resource home.

after December 1, 2020. There were no non-IFPA-preferred placements that began before December 1, 2020 and lasted into 2024. As a result, the secondary metric is no different from the primary metric.

Table 31: Number of Children in Non-IFPA-Preferred Placements, by Total Days Spent²³⁰ 2024

Number of days in non-IFPA-preferred placements	All placements that overlapped with 2024	
	N	%
0	189 ²³¹	57%
1-30	61	18%
31-90	14	4%
91-120	8	2%
121-150	11	3%
151-180	1	<1%
180+	49	15%
Total	333	100%

Source: Analysis of Sandbox Placements, Cohort, and CourtDisposition files and FACTS episodes file

CTO4.1(ii) – primary metric: Percent of 30-day reviews for non-ICWA-preferred placements conducted on time

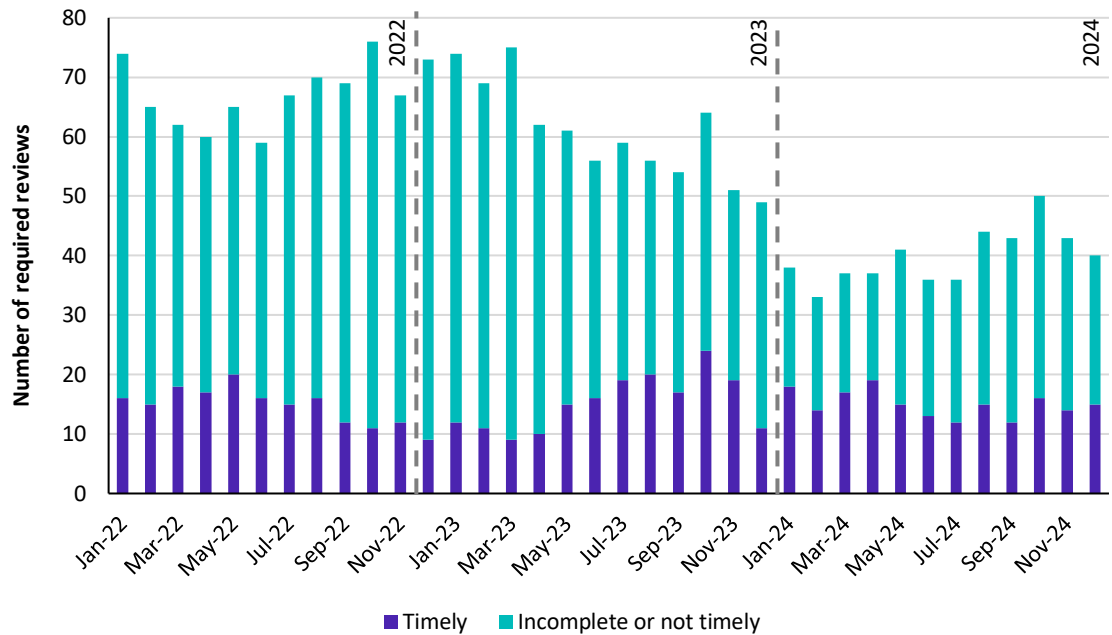
There were 478 required 30-day reviews for children in non-IFPA-preferred placements in 2024, and 180 of them (38%) were conducted on time.²³² This is an improvement from 2022, when 177 of 807 required reviews (22%) were conducted on time, and from 2023, when 183 of 730 required reviews (25%) were completed on time. The Co-Neutrals also examined the data by month and found that the percentage of completed and timely reviews decreased over the course of the year (from 43% in the first half of the year to 33% in the second; see Figure 33).

²³⁰ Percentages do not add up to 100 due to rounding.

²³¹ This includes 184 children who experienced no non-IFPA-preferred placements and five who experienced non-IFPA-preferred placements that began and ended on the same day.

²³² A meeting was considered “conducted” when the State’s data indicated that it was not canceled, it occurred on or before the due date, and it was an “ICWA Non-Preferred 30-Day Review.” Due dates were calculated as every 30 days after the start of the placement and were unaffected by a move from one non-IFPA-preferred placement to another.

Figure 33: Number of Required and Completed Reviews for Non-IFPA-Preferred Placements, by Month
2022 - 2024



Source: Analysis of Sandbox Placements, Meetings, Cohort, and CourtDisposition files, FACTS episodes file, and adjustments based on case record reviews

CTO4.1(iii): qualitative metric: Qualitative review of IFPA-preferred placements for Native children.

CTO4.1(iv): qualitative metric: Qualitative review of meetings for Native children in non-ICWA/IFPA-preferred placements.

To collect data for these qualitative metrics, CYFD staff and the Co-Neutral team collaborated in developing protocols and instruments for reviews of children’s FACTS records to assess if Native children who were placed in non-IFPA-preferred placements received monthly reviews inclusive of the required participants and discussion topics as outlined in CYFD’s procedures.²³³

CYFD staff and the Co-Neutral team reviewed records for a random sample of 49 Native children who were placed in a non-IFPA-preferred placement for at least 30 days between January and

²³³ Reviewers participated in an orientation and training on the FSA standards and the review instrument. CYFD and Co-Neutral staff implemented a quality control process during the reviews, including completing second level reviews of identified surveys.

September 2024.^{234,235} These 49 Native children experienced a total of 121 placements, of which 102 placements (84%) were not in accordance with IFPA placement preferences.²³⁶ A total of 283 OOPP meetings were required between January and September 2024 for this sample of children. Documentation in FACTS showed that of the 283 required OOPP meetings, 182 OOPP meetings (64%) were held.²³⁷

CYFD staff and the Co-Neutral team reviewed documentation for all 182 OOPP meetings completed between January and September 2024, and none (0%) documented that invitations to attend had been extended to all necessary participants, and that all required discussion topics and issues were addressed within the meeting.^{238,239} OTA staff were present in nearly all completed meetings, and the PC's supervisor attended 87 percent of meetings (see Figure 34). A Tribal representative was present in slightly over one-third of meetings (36%), and the child's parents were present in four percent of meetings.

²³⁴ Data are based on random sampling and do not include the full universe of applicable Native children and placements during the period under review.

²³⁵ Six children who were originally identified by CYFD as applicable for the review were removed when reviewers determined that they were placed in relative homes during the period under review but their placements were miscategorized in FACTS.

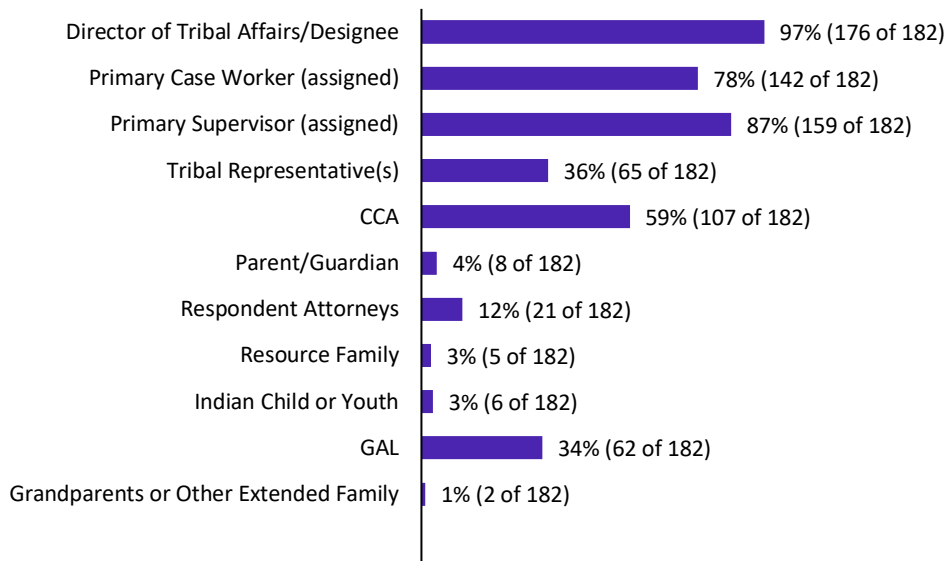
²³⁶ Non-IFPA-preferred placements include non-relative foster homes, fictive kin foster homes, congregate care facilities, and office or hotel placements. Children placed with relatives are considered to be in IFPA-preferred placements. Children placed in second or third order IFPA placement preferences (i.e., a foster home licensed, approved or specified by the Indian child's tribe; or a foster home licensed or approved by a licensing authority in New Mexico in which one or more of the licensed or approved foster parents is Indian) were not considered to be in IFPA-preferred placements unless there was written documentation from the Nation, Pueblo, or Tribe that provided an alternative order of placement preferences. One of the 102 non-IFPA-preferred placements was a second order IFPA placement, and 24 were a third order IFPA-preferred placements.

²³⁷ Data are based on random sampling, and findings differ from the quantitative metric discussed earlier in this section because in addition to only including a sample of children, the methodology of the qualitative review differed in two main ways. First, the qualitative review counted meetings if they were documented as having been conducted for the required purpose regardless of how they were categorized in FACTS (for the quantitative metric, meetings were excluded if they were categorized as anything other than an "ICWA Non-Preferred 30-Day Review"). Second, the qualitative review counted OOPPs as due or completed based on the calendar month, not 30-day periods.

²³⁸ CYFD's procedure requires OTA facilities the meeting and invite the following individuals to OOPP meetings two weeks in advance: PC, PC supervisor/manager, resource family, GAL and/or Youth Attorney, CCA, Tribal representative, Native child's parents if parental rights have not been terminated, parents' attorneys, extended family members, and the child, as appropriate.

²³⁹ Discussion topics include, but are not limited to: if a preferred placement has been identified since the last OOPP meeting; the reason the child has been placed in an out-of-preferred placement; the barriers to identifying a preferred placement; diligent efforts regarding family identification and next steps; Tribe's position and recommendations for placement; and next steps to move a child to a preferred placement.

Figure 34: Documented Participants in Completed OOPP Meetings
January - September 2024



Source: Case record review of FACTS documentation conducted by CYFD staff and Co-Neutral team

Other available preferred placements were documented as discussed in 20 percent of completed meetings (37), and of those meetings in which a placement was identified, only six meetings had a documented transition calendar which identified specific supports to make the child's placement transition successful. Outcome data shows that 17 of the children reviewed moved from a non-IFPA-preferred placement into an IFPA-preferred placement within the period under review, and 12 of these placements continued through the end of the period.

For other discussion topics, documentation showed discussion of culturally responsive services, supports, services, and community resources as being requested or provided in 30 percent of completed meetings (55), and diligent efforts to identify family as possible placement resources in 29 percent of meetings (52).

Discussion

Quantitative and qualitative data for this TO show that placement meetings to review non-IFPA-preferred placements did not consistently occur when required. Of those that did occur, of the random sample reviewed, none documented inclusion of all necessary team members and discussion topics.

Procedures to Enhance Accountability for ICWA Placement Preferences
(App. C, TO 4.3)

FSA Requirement	CYFD will work with New Mexico Tribes and Pueblos to identify any Tribal placement preferences that deviate from ICWA. CYFD will create procedures that enhance accountability for ICWA placement preferences, including allowing the child’s tribe or pueblo and extended family members to participate in ICWA-preferred placement reviews, Individualized Planning Meetings and case decision making meetings. (Due December 1, 2020)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024. Procedures to enhance accountability for ICWA placement preferences have been developed, but good faith efforts are needed to ensure Tribal and family member participation in non-ICWA/IFPA-preferred placement meetings and to follow-up on meeting recommendations.

Discussion

CYFD established processes to review non-IFPA-preferred placements for Native children, which requires that OTA schedule and conduct the OOPP meeting and ensure that a representative of the child’s Nation, Pueblo, or Tribe and family members are invited to attend. Other attendees in the meeting should also include, but are not limited to, the child’s parents, grandparents and other extended family members, and the child, as appropriate.

The case record review described above found that based upon documentation in the child’s record, a Native child’s family or Nation, Pueblo, or Tribe were not consistently invited to participate in OOPP meetings. Tribal representatives have reported to the Co-Neutrals that timely invitations and scheduling to enable their and family member’s participation remains an issue. Specifically, a Tribal representative or case worker was present in 36 percent of the meetings held, four percent of the meetings included the child or youth, six percent of applicable meetings included the child’s parent, and only two meetings included the child or youth’s grandparents or other extended family members. The highest priority ICWA placement preferences are with family and Native resource parents, making these participants essential in developing a plan to move a Native child into an IFPA preferred placement.

Implementation of ICWA Training Plan (App. C, TO 5.2)

FSA Requirement	CYFD will develop an ICWA training plan by December 1, 2020, and implement it by December 1, 2021. The Co-Neutrals will evaluate implementation of the training plan. ICWA trainings will be developed collaboratively with the CYFD's Academy for Training and Professional Development Team, Protective Services Tribal Liaison, CYFD Tribal Liaison, Tribal Advisors, and culturally responsive experts. The ICWA training will include specific information on the history of ICWA, historic relations between Native American people and state and national government, and the history of culturally insensitive social work practices. It will also include skills development in working with Native families and communities, historical trauma, engagement, cultural humility and culturally responsive intervention techniques for Native American parents and youth and community engagement with New Mexico Tribes and Pueblos, as well as best practices for ICWA. The training will include information on New Mexico Tribes and Pueblos, sovereignty, and jurisdictional issues. The Co-Neutrals shall approve the ICWA training plan, but the Co-Neutrals shall not withhold approval of the training plan if it is reasonably calculated to achieve the Goals of this Agreement. The Co-Neutrals will evaluate implementation of the training plan. (Due December 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

On January 12, 2023, the Co-Neutrals approved the State's Indian Child Welfare Act and Indian Family Protection Act Training and Coaching Plan, dated December 30, 2022.²⁴⁰ The Plan was developed by CYFD's WDB, OTA staff, and two workgroups – the Tribal Advisory Group (TAG) and the Native American Training Curriculum Advisory Group (NATCAG). As the curriculum is rolled out, CYFD reports that the workgroups will continue to meet to modify content, as needed, and to evaluate the training's effectiveness.

The Plan includes three tiered levels of training certificates. These levels are described below:

Tier 1: Novice ICWA/IFPA Certification is required for all CYFD PSD employees, including CCAs and OTA staff, and includes four courses, totaling 22 hours.²⁴¹ CYFD reports all courses were available beginning in January 2023. Existing staff were required to complete the Novice Certification by December 31, 2023, and new staff must complete the training within one year of hire.

²⁴⁰ The State's approved Indian Child Welfare Act and Indian Family Protection Act Training and Coaching Plan can be found [here](#).

²⁴¹ *Novice* courses include: Cultural Humility in Social Services; Populations of New Mexico; Indian Child Welfare Act Overview – Best Practice for Best Outcomes (e-learning); and ICWA and IFPA In-Depth Training – Applying Best Practices.

Tier 2: Advanced Certification is required for all CYFD PSD supervisors, managing attorneys, and ICWA unit staff. It consists of five courses, totaling 12 hours.²⁴² CYFD's goal for completion of the curriculum for all Advanced courses was March 31, 2023.²⁴³ Existing staff are required to complete the training within one year of its availability, new staff are required to complete the training within 18 months of hire, and staff who are promoted into supervisor and managing attorney positions must complete the training within six months of promotion.

Tier 3: Leadership Certification is required for County Office Managers, Regional Managers, and Field Deputy Directors. It includes six courses, for a total of 26 hours.²⁴⁴ CYFD's goal for completion of the curriculum for all Leadership courses was December 31, 2023.²⁴⁵ Existing staff are required to complete the training within one year of its availability, new staff are required to complete the training within 24 months of hire, and staff who are promoted into the applicable positions must complete the training within 18 months of promotion.

The Plan also includes additional trainings required for CCAs and resource parents, and has strategies to provide coaching to staff – including hiring an ICWA/IFPA Coach in OTA – and for evaluation of the training.

DVP Metrics and Validated Performance Data

CTO5.2(i) – primary metric: Of the staff required to complete ICWA training during a year ending December 31, the percent that completed all levels of training required for their position.

On December 31, 2024, there were 1,661 staff employed at CYFD. According to the ICWA/IFPA Training and Coaching Plan, 146 of these 1,661 staff were required to complete ICWA training in

²⁴² *Advanced* courses include: Supervising Indian Child Welfare Act/IFPA Cases; Community Cultural Wealth; Importance of Cultural Connections; Implications of Historical Trauma – Proficient; and Government-to-Government Relations – Proficient.

²⁴³ Training completion data provided to the Co-Neutrals indicates that this training was not yet available to staff in 2024.

²⁴⁴ *Leadership* courses include: Accountability and ICWA: Assuring Cultural Responsiveness; Accountability and ICWA: Assuring ICWA Compliance; Collaborative Decision-Making; Values-Based Leadership; Creating an Environment of Cultural Humility; and Community Engagement.

²⁴⁵ Training completion data provided to the Co-Neutrals indicates that this training was not yet available to staff in 2024.

2024.^{246,247} Of these 146 staff, 73 percent completed all modules of training for Tier One: Novice ICWA/IFPA Certification by the due date (106).^{248,249} This is an increase from 2023, when 392 of 717 required staff (55%) completed all modules of Tier One training.

CTO5.2(ii) – qualitative metric: qualitative review of ICWA training for case worker staff

The State had not finalized the qualitative instrument and methodology to collect data and assess performance for this metric. Thus, the Co-Neutrals are unable to report performance toward this metric for 2024.

Discussion

The quantitative data show that 73 percent of CYFD staff received the required ICWA/IFPA Tier 1: *Novice* training by December 31, 2024. Although the ICWA/IFPA Training and Coaching Plan anticipated that the content and curriculum for Tier 2: *Advanced* and Tier 3: *Leadership* would be completed by 2023, data provided to the Co-Neutrals related to training completion shows that these trainings were not yet available to staff in 2024.


From July through December 2024, members of the Co-Neutral team spoke with case workers and supervisors across all three case work pillars throughout the state about their workload, including their general experience with the ICWA/IFPA training. Of the 120 staff who were interviewed, 118 reported taking ICWA/IFPA training and 91 percent (107 staff) reflected positively on the training and its impact on their direct work with children, parents, and families. In general, those who reported favorably on the training found the training helpful and generally acknowledged the importance of gaining a better understanding of the history and background of Native families. Many staff commented that they were not aware of the history and that the training was “eye

²⁴⁶ In 2024, the State carried out trainings for Tier One: *Novice* ICWA/IFPA Certification, but the two higher tiers of training were not yet available to staff. Thus, for this metric, the Co-Neutrals counted all staff who were required to complete Tier One. Rates of training completion for Tiers Two and Three trainings could not be calculated.

²⁴⁷ The ICWA/IFPA Training and Coaching Plan states staff hired prior to January 1, 2023, must complete the Tier One trainings by December 31, 2023, and new staff must complete required Tier One trainings within one year of their hire date. The DVP states that only staff required to complete ICWA training during a reporting year are included in the metric, so only employees hired between January 1, 2023, and December 31, 2023, were required to complete ICWA training during 2024 and are thus included in this metric.

²⁴⁸ As additional information, the Co-Neutrals calculated the number of staff who were employed on December 31, 2024, and were required to complete the Tier One trainings in 2023 or 2024. Of the 704 staff required to complete the trainings, 438 (62%) completed all four required Tier One trainings by their assigned due date, and 629 (89%) completed at least one of the four required trainings by the due date. There were 456 additional staff who completed at least one Tier One training as of December 31, 2024. Of these, 384 were required to complete the training while in their PSD position, but were not employed in that position on December 31, 2024, 35 staff were contract or temporary staff and not within the required staff in the DVP, 19 staff were not in the State’s *Staff Positions* file, and 18 staff were not in PSD.

²⁴⁹ Completion of all four training modules within the *Novice* Tier are required. Completion data for each individual module is as follows: Cultural Humility – 85 percent of all required staff completed; ICWA/IFPA Best Practices – 82 percent of all required staff completed; Indian Child Welfare Act Overview – 91 percent of all required staff completed; and Populations of New Mexico – 93 percent of all required staff completed.



opening” for them. Other staff stated how the training helped them understand the expectations for how to handle ICWA/IFPA cases, including asking children and families about any Native heritage; using active efforts to notify Nations, Pueblos, and Tribes; and working with OTA. Staff talked about the value in learning about Native cultural distinctions and traditions. Many staff commented on the value of the training, despite the fact that they have very few Native families in their county and had not experienced working on an ICWA/IFPA case.

iv. Appendix D: Behavioral Health Services

The commitments in Appendix D of the FSA require HCA and CYFD to “structure and build a statewide, community-based mental health system that all children and families will be able to access.”²⁵⁰ The FSA envisions a statewide system that provides:

- Prompt access to necessary services regardless of where children and families live;
- Access to services that are critical to keeping children with their families or in the most family-like setting possible; and
- A diverse and full spectrum of community-based services that will decrease reliance on congregate care, keep families together in their community to the maximum extent possible, and greatly reduce reliance on out-of-state residential placement.

The State made limited progress on some of its commitments in Appendix D in 2024, however performance was generally stagnant from 2023. Throughout 2024, HCA worked with the Co-Neutrals to develop and revise its Behavioral Health Workforce Development Review, which was provisionally approved on March 12, 2025 and formally approved on November 13, 2025 upon the finalization of specific metrics to track implementation as required in Appendix D. Those metrics are incorporated into the final Behavioral Health Workforce Development Review and the DVP.

HCA’s Turquoise Care MCO contracts went into effect on July 1, 2024 with PHP as the sole MCO serving most children in state custody.²⁵¹ HCA administers and manages PHP’s contract for serving children in state custody, and added a Population Health Unit to its staff to increase management and oversight of outcomes for children in state custody, including monitoring the provision of care coordination services.

As was the case in 2023, by the end of 2024, the State had still not developed a joint process for offering services and supports to children in custody, with no discernable efforts to move this process forward. The FSA required this to be completed in 2021. Absent this process, the Co-Neutrals have observed confusion and inconsistencies in agency and staff roles and responsibilities in identifying and monitoring services and supports to children.

While the EBP-specific billing codes and increased reimbursement rates for evidence based behavioral health services (the State’s primary incentive for providers to become trained in and deliver EBPs) were in effect for all of 2024, the data did not show improvement in access to

²⁵⁰ FSA, pg. 12a

²⁵¹ Most children in state custody eligible for Medicaid are served by PHP. Native children in state custody can choose which MCO they want to enroll in, or they can remain Fee For Service.

services for children in state custody.

Slightly more than half (53%) of children who entered state custody in 2024 received a well-child checkup within 30 days of entry, which is an increase in performance from 2023 (46%) and 2022 (44%), and equal to the State’s performance in 2021. Less than one-quarter of children (23%) had well-child checkups completed more than 30 days after entering custody in 2024. However, there was also an increase in 2024 in the percentage of children who did not receive a well-child checkup at any point after their entry into care, with 24 percent of children not receiving a checkup compared to 19 percent in 2023.

a. *Implementation Targets*²⁵²

Behavioral Health Care Workforce Development Review (App. D, IT 1)

FSA Requirement	HCA and CYFD will create a Behavioral Health Care Workforce Development Review with the objective of supporting and expanding provider capacity to provide community-based mental and behavioral health services with reasonable promptness that are accessible throughout the State, and particularly in rural areas. The Behavioral Health Care Workforce Development Review will describe in writing the expected nature, scope, capacity, and structure of the workforce necessary to meet the obligations described in this Agreement, including how HCA works with MCOs on increasing capacity to make available screening/assessment, High Fidelity Wraparound services, evidence-based, well-supported, or promising therapeutic treatment for children with complex trauma, intensive case management, mobile crisis response services and intensive home-based services to every Child in State Custody for whom they are medically necessary. HCA will either create or require MCOs to create a specific hiring/contracting plan that identifies, by county, the number of staff and credentials required to meet the objectives identified in the Behavioral Health Care Workforce Development Review. The Co-Neutrals must approve the Behavioral Health Care Workforce Development Review. (Due June 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State met the Performance Standard for this IT in 2024.

Discussion

After extensive gaps of inactivity in 2023, the State submitted its Behavioral Health Workforce Development Review (“Review”) on December 20, 2024, which the Co-Neutrals reviewed, and provisionally approved on March 12, 2025. The Co-Neutrals specified that approval was contingent in part on eliminating discrepancies contained in the draft between HCA-authored and PHP-authored information and on the development of metrics and iterative performance targets to be used to assess implementation under App. D, TO 1 – *Workforce Development*.²⁵³ The metrics

²⁵² A list of all ITs where the State previously met the Performance Standard can be found in Appendix ii. *FSA Implementation Targets and Target Outcomes Met in Prior Reporting Periods*.

²⁵³ The approved Behavioral Health Workforce Development Review can be found [here](#).

were finalized on November 13, 2025 and the Review is considered formally approved. The metrics and iterative performance targets are incorporated into the final Review.

HCA developed and revised the Review based on the Co-Neutrals’ feedback in the latter half of 2024, clarifying the document contained elements required by the FSA. The approved Review utilizes the State’s service utilization methodology approved by the Co-Neutrals in 2021 to identify an estimated number of behavioral health providers necessary to meet the needs of children in state custody specific to the EBPs identified in the FSA. As the sole MCO serving children in state custody, PHP also provided a behavioral health gap analysis and workforce development plan as part of the Review that identifies, by county, the number of providers needed to meet estimated behavioral health needs across the state.

Monitor Implementation of Care Coordination in Contracts (App. D, IT 5.1)

FSA Requirement	HCA will monitor implementation of a term in all contracts with its designees to require that care coordination include identification of physical, behavioral health, and long-term care needs, and providing services to address said needs, in compliance with Section 4.4 of Centennial Care 2.0 Managed Care Organization contracts with HCA. (June 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this IT in 2024.

Discussion

Section 4.4 of the PHP Turquoise Care contract for children in state custody requires care coordination to be provided in collaboration with a child’s treatment team and through direct contract with the child and family.²⁵⁴ Children in state custody are designated as a special population under Turquoise Care and should be automatically connected with a care coordinator upon their entry into custody. Care coordinators can assist with advocacy, navigating complex systems, and communicating with others as needed to meet the child’s needs, such as CYFD case workers and other staff, family members, physicians, specialists, and other health care professionals.

HCA administers and manages PHP’s contract for serving children in state custody. In July 2024, HCA added a Population Health Unit to increase management and oversight of outcomes for children in state custody. As part of their contract, PHP is required to submit regular reports to HCA demonstrating outcomes, including a report specifically focused on member engagement and care coordination. The creation of this unit is a positive step to provide increased oversight of the healthcare needs of children in state custody.

Consistent with the requirements in place under HCA’s MCO contracts, HCA requires training for

²⁵⁴ The PHP Turquoise Care contract for serving children in state custody can be found [here](#). Additional information about PHP can be found [here](#).

those providing care coordination for children in state custody who receive Medicaid. HCA requires the submission of quarterly reports from all MCOs on compliance with required training, including a Care Coordination 101 training.

Care coordination services should support timely access to, and provision of, services necessary to maintain or improve the physical and behavioral health status or functional abilities of children in the least restrictive settings. As part of the qualitative reviews completed to assess outcomes for children placed in congregate care settings in 2024, documentation was reviewed from all MCOs who served children in state custody in 2024. The reviews showed overall limited involvement from the child’s care coordinator, which in some cases impacted children’s discharge plans to the extent that some children were discharged without connection to services, or remained in a congregate facility despite the facility stating they were ready for discharge.²⁵⁵

Developing a Joint Process for Offering Services and Supports (App. D, IT 8.1)

FSA Requirement	HCA and CYFD will review and identify the responsibilities shared by both Departments and create a joint process for offering services and supports to include screening, assessing, referring, treating and providing transition services to Children in State Custody of the department, including Children in State Custody who were never removed from Respondents’ homes or children who have returned to Respondents’ homes but who remain Children in State Custody. The goal of this joint process shall be to maximize each child’s access to services and to create a unified process for offering services and supports. (June 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this IT in 2024.

Discussion

The FSA requires the State to review and identify the responsibilities of HCA and CYFD to offer services and supports such as screening, assessing, referring, treating, and providing transition services, and to create a unified process to maximize access to these services for children in state custody. As of December 31, 2024, the State did not develop a joint process for offering services and supports to be approved by the Co-Neutrals. The State has not produced a draft joint process proposal to the Co-Neutrals since September 2022.

The lack of a joint process inhibits the working relationships and information sharing between CYFD and HCA, and impacts children’s ability to receive timely assessments, services, and

²⁵⁵ Specific findings of these reviews are discussed earlier in this report in App. B, TO 1 – *Prohibition of Placements in Hotels/Motels, Out-of-State, and in Offices Except in Extraordinary Circumstances*, App. B, TO 2.1 – *Joint Clinical Reviews*, and App. B, TO 3.2 – *30-Day IPP Meetings for Clinical Congregate Care*.

treatments. These effects are evidenced in the data discussed in other sections of this report, for example, EBP service utilization, discharge planning from higher levels of care, and receipt of well-child checkups.

b. Target Outcomes

Workforce Development (App. D, TO 1)

FSA Requirement	HCA will work with MCOs to implement the Behavioral Health Care Workforce Development Review, with the objective of expanding and developing the statewide workforce sufficient to implement the system for delivery of community-based mental and behavioral health services described in this Agreement. (Due December 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Discussion

The work required in this TO is to be guided by App. D, IT 1.1 – *Behavioral Health Workforce Development Review*. As discussed above, the Co-Neutrals provisionally approved the State's Behavioral Health Workforce Development Review on March 12, 2025, and formally approved the Review on November 13, 2025, upon finalization of metrics and iterative performance targets embedded in the document, which form the scaffolding for implementation under this TO. Implementation consistent with an approved plan did not occur in 2024.

Employing Sufficient Staff (App. D, TO 1a)

FSA Requirement	By December 1, 2021, HCA will employ sufficient staff such that it has the internal capacity to effectively oversee, monitor, and manage the MCOs and to oversee and develop policy and procedures related to EPSDT. (Due December 1, 2021)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Discussion

Implementation consistent with an approved plan did not occur in 2024. However, in July 2024, HCA added a Population Health Unit to increase management and oversight of outcomes for children in state custody, including contract management of PHP as the sole MCO for children in state custody. The work of this unit should be instrumental given the important role of PHP as the single-MCO responsible to expand access to services including those required under the federal

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) legislation.²⁵⁶

Sufficient Provider Network (App. D, TO 1b)

FSA Requirement	By December 1, 2021, HCA will require that MCOs have a provider network sufficient to meet the needs identified in the Behavioral Health Care Workforce Development Review and hiring plans. (Due December 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Discussion

Implementation consistent with an approved plan did not occur in 2024.


Incentives for Provider Training (App. D, TO 2)

FSA Requirement	By December 1, 2021, HCA or its designees will provide incentives for providers to be trained in evidence-based, well-supported, and promising trauma-responsive services, which include intensive case management, High Fidelity Wraparound services, intensive home-based services, and trauma-based therapies including Dialectical Behavior Therapy (DBT), Multi-Systemic Therapy (MST), trauma-informed Cognitive Behavioral Therapy (CBT), Functional Family Training (FFT), and Eye Movement Desensitization and Reprocessing therapy (EMDR). Training will comply with professional standards and best practices in adult education, including by incorporating experiential and interactive components and using evaluations to measure effectiveness. (Due December 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Discussion

Dating back to 2023, HCA has consistently cited increases in approved Medicaid billable rates as the primary incentive for providers to be trained in evidence-based, well-supported, and

²⁵⁶ EPSDT is a Medicaid benefit providing comprehensive and preventative health services for children under age 21 to ensure necessary medical, dental, behavioral, and developmental care. More information about EPSDT can be found [here](#).



promising trauma-responsive services. HCA issued LOD #10 on July 1, 2024, which provides guidance to clinicians regarding enhanced rates for billing for MST, FFT, TF-CBT, EMDR, and DBT.²⁵⁷

The enhanced rates are connected to specific modifier codes to be used by providers when billing Medicaid. Historically, New Mexico providers utilizing clinical interventions such as DBT, TF-CBT, and EMDR would bill Medicaid or insurance for non-specific psychotherapy sessions, which is typical practice. With the addition of the modifiers, HCA is offering increased reimbursement rates to clinicians using any of the specific EBP interventions and can track specific trauma-responsive interventions that are provided to children in state custody. CMS approved the addition of the modifiers in late 2023, and eligible providers could begin billing using the modifiers for services provided after July 1, 2023. HCA reports that additional work remains to ensure the modifier rates are competitive compared to the general increases in Medicaid reimbursement rates that occurred as of January 1, 2025.

HCA reported that the enhanced billing rates were intended to cover the startup costs for providers who want to provide EBPs, such as the costs of required training, supervision, and certification. To receive an enhanced EBP billing rate, a provider must be certified in the modality through the national certifying organization and enrolled with the NMSU COI, which tracks and maintains the list of all providers certified to access the rates. Since 2023, the State has also partnered with NMSU COI to facilitate free training for providers by hosting trainings with the certifying EBP organizations.²⁵⁸

Despite the increased rates and training for some EBP interventions, the State's data show that no services were billed using the modifiers in 2024, and as discussed earlier in this report in App. A, TO 2 – *Expansion and Availability of Services* and App. D, TO 3 – *Community-Based Mental and Behavioral Health Services*, only three percent of children in state custody at any point in 2024 received at least one session of HFW, FFT, MCR, or MST. Those results speak directly to the ineffectiveness of the State's approach to incentives and capacity building. Rebuilding New Mexico's behavioral health system, which was reportedly substantially diminished during the 2013 Medicaid payment freeze, will require more provider-informed efforts consistent with the workforce needs identified in the Review discussed above.²⁵⁹

²⁵⁷ LOD #10 can be found [here](#), and the State reports this was incorporated into the MCO contracts.

²⁵⁸ For example, NMSU COI offers training and certification in EMDR by hosting staff from the EMDR International Association (EMDRIA).

²⁵⁹ Additional information about the 2013 Medicaid freeze (commonly referred to as “The Shake-Up”) can be found [here](#).

Community-Based Mental and Behavioral Health Services (App. D, TO 3)

FSA Requirement	By December 1, 2022, the following services will be available to every Child in State Custody for whom they are medically necessary, as indicated by the CANS and functional trauma assessments and any follow up. ²⁶⁰ Services will be available immediately where possible and not to exceed 10 Days otherwise. (Due December 1, 2022)
Co-Neutrals' Finding	Based upon the Co-Neutrals' review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

Procedure 17 of CYFD's *Permanency Planning Procedures* (8.10.8 NMAC) outlines processes case workers are required to follow regarding CANS screenings to meet children's behavioral health needs. Both HCA and CYFD are responsible for ensuring that children have access to medically necessary services as quickly as possible after the need is identified.

DVP Metrics and Validated Performance Data

This commitment is measured using the same metrics as App. A, TO 3.

ATO2.2(i) – primary metric: The sum number of children in cohort who received either High Fidelity Wraparound services, Mobile Crisis Response (MCR), DBT, MST, Trauma Informed-CBT, FFT, or EMDR during the reporting year.

The State's data show that no services were provided using the billing codes and modifiers for DBT, TF-CBT, and EMDR in 2024.

ATO2.2(i) – secondary metric: The sum number of children in the cohort who received either High Fidelity Wraparound services, MST, MCR or FFT during the reporting year.*

Of the 3,026 children in state custody at any point in 2024, 79 unique children (3%) received at least one session of HFW, MST, MCR, or FFT in 2024. The number of children in state custody who received any indicated modality decreased for the second consecutive year and was lower in 2024 than in any other year since reporting began in 2019.²⁶¹ A comparison of the State's performance over the years can be found earlier in this report in Table 8 within App. A, TO 2 – *Expansion and Availability of Services*.

²⁶⁰ App. D, TO 3 defines these services as: HFW services; intensive case management; and intensive home-based services, which include mobile crisis response services and evidence-based, well-supported, or promising trauma-responsive therapies such as DBT, MST, TF-CBT, FFT, and EMDR.

²⁶¹ Counts are based on analysis of data as submitted by the State; the Co-Neutral team has not validated each reported service.

ATO2.3(i) – primary metric: Of all children in state custody who received screenings or assessments that indicated a need for High Fidelity Wraparound services (HFW), Mobile Crisis Response (MCR), DBT, MST, Trauma-informed CBT, FFT, or EMDR during the reporting year, the percent that initiated or received all services for which they were indicated within 10 days of that screening or assessment.

The Co-Neutrals were unable to validate data for this metric because this metric relies on a data collection process that the State did not use consistently in 2024. In 2022, the State embedded a survey tool into FACTS to collect information on referrals for services, but the State reported that very few of these surveys had been completed in 2023 and 2024. Data from this survey tool or an alternative source will be necessary to validate this metric for 2025.

Discussion

As discussed in App. A, TO 2 – Expansion and Availability of Services earlier in this report, the State’s 2024 data show the lowest service utilization for children in state custody among the last five years, and the State has not yet consistently implemented the data collection process necessary to track information on referrals for services. Qualitative reviews of a sample of completed CANS screenings and corresponding case records in FACTS showed a lack of information in children’s FACTS records to determine whether CANS screening service recommendations are resulting in actual services provided to children.

Well-Child Checkups (App. D, TO 4)

FSA Requirement	By December 1, 2021, every Child in State Custody will receive a comprehensive well-child checkup within 30 Days of entering state custody. (December 1, 2021)
Co-Neutrals’ Finding	Based upon the Co-Neutrals’ review and consideration of all available information, the State did not meet the Performance Standard for this TO in 2024.

The FSA requires all children in state custody to have a comprehensive well-child checkup within 30 days of entering care. The requirements for well-child checkups for children in state custody are outlined in Procedure 17 of CYFD’s *Permanency Planning Procedures* (8.10.8 NMAC). The procedure states that children in state custody should have a comprehensive well-child check-up including a physical examination within 30 days of entering custody, as well as annual well-child checks, dental exams, and eye exams. For children who are Medicaid-eligible (which includes almost all children in state custody), they should receive all services indicated in accordance with EPSDT requirements.

HCA issued LOD #21 on October 8, 2024, which outlines the responsibilities and reporting requirements of MCOs to ensure all children in state custody have a well-child checkup within 30

days of entering care.²⁶² LOD #21 requires,

“The MCO shall utilize all available internal resources such as [the child’s] care coordinator, a community health worker, care worker or tribal liaison to contact [the child’s] caregiver to ensure that the well child visit is scheduled within the 30 days. These efforts must be in collaboration with the child and the child’s legal custodian ([CYFD PC]), caregiver/resource parent, and parent/guardian (where appropriate) to avoid scheduling conflicts and to ensure that barriers such as transportation and language access have been addressed. The care coordination efforts must be documented.”

MCOs are also required to provide education and assistance to the child’s PC, the child, and their resource parent or caregiver on the importance of the well-child visit, and are also required provide communication, education, and training to providers to ensure that these visits take place within the 30 days after the child enters custody.

In terms of the services that should be provided as part of a child’s well-child visit, HCA’s Keeping Kids Healthy website defines well-child check-ups as follows:²⁶³

Well Child Checkups

Children may go to a doctor, a nurse practitioner or a physician’s assistant for a well-child exam. Children do not need to have a specific complaint to be seen. New Mexico has adopted the examination periodicity schedule and screening guidelines recommended by the American Academy of Pediatrics (AAP) and Bright Futures.

Federal regulations require that providers review a child’s development at every well-child visit to include the following:

- Medical history;
- Measurements of height, weight, and BMI;
- Unclothed physical examination;
- Nutrition screening;
- Vision and hearing screenings;
- Developmental/behavioral assessment;
- Hematocrit/hemoglobin at 9 months and 13 years;
- Lead screening at 12 months and 24 months;
- Immunizations;

²⁶² LOD #21 was initially issued as LOD #96 under the Centennial Care MCO contracts on June 30, 2023, and was re-issued as LOD #21 under Turquoise Care. LOD #21 can be found [here](#).

²⁶³ HCA’s Keeping Kids Healthy webpage can be found [here](#).

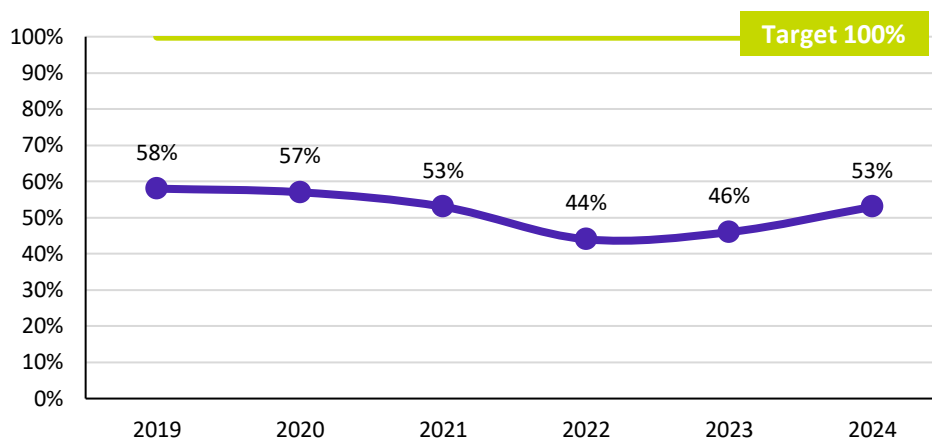
- Selective screenings necessary according to risk factors;²⁶⁴ and
- Anticipatory Guidance.²⁶⁵

DVP Metrics and Validated Performance Data

DTO4.1(i) – primary metric: Of all episodes of custody longer than 30 days that began during the reporting year, the percent that included a well-child checkup within 30 days of the child entering State custody, as recorded by casework staff or reflected in Medicaid billing data.

Of the 762 episodes of children’s custody that began in 2024 and lasted longer than 30 days, 407 (53%) included a well-child checkup within 30 days of the child entering custody. This is higher performance than in 2023 (46%) and 2022 (44%), but lower than performance in 2020 and 2019 (see Figure 35) and significantly below the targets in the FSA.

Figure 35: Percent of Children in State Custody Who Received a Well-Child Checkup Within 30 Days of Entry^{266,267}
2019 - 2024



Source: Analysis of Sandbox Encounters and Entries files

As shown in Figure 36, the percentage of children who received timely well-child checkups remained generally steady throughout the year, with monthly performance ranging between 46

²⁶⁴ This may include a Tobacco, Alcohol, or Drug Use Assessment, or STI testing due to sexual behavior. Additional information on screening for risk factors can be found [here](#) and [here](#).

²⁶⁵ Anticipatory guidance is given by the health care provider to assist parents and caregivers in understanding the expected growth and development of children. Anticipatory guidance, specific to the age of the patient, includes information about the benefits of healthy lifestyles and practices that promote injury and disease prevention. This guidance may be given in the form of a handout or verbally. Additional information on anticipatory guidance can be found [here](#).

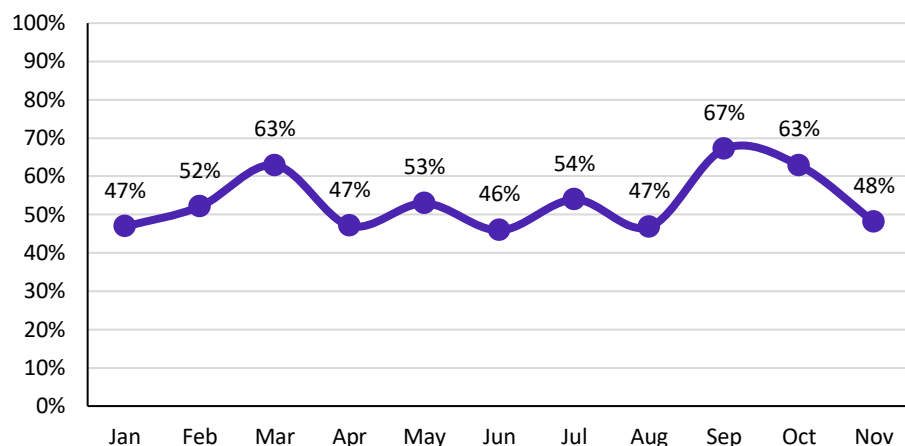
²⁶⁶ Children may enter custody more than once during the year, and each entry that lasted longer than 30 days is counted as an episode.

²⁶⁷ The methodology was updated in 2024 to include only children with episodes lasting *longer than 30* days. In prior years, children were included if they remained in state custody for *at least 30* days.

and 54 percent, with increases in March, September, and October 2024.

Figure 36: Percent of Children Who Received a Well-Child Checkup Within 30 Days of Entry, by Month

2024; N = 407 episodes of children's custody

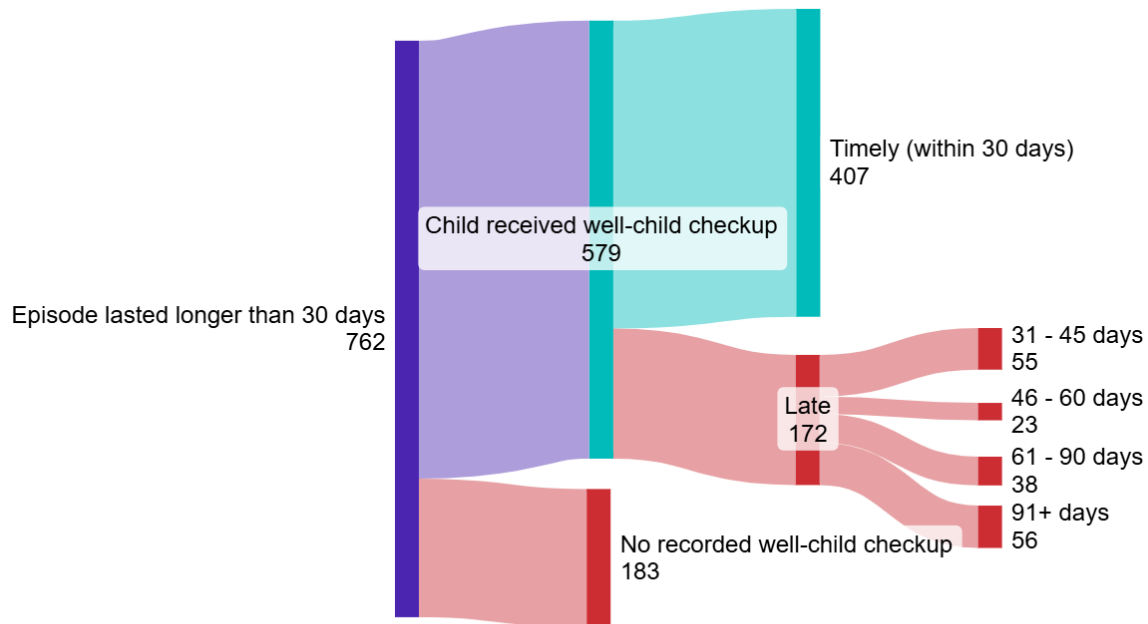


Source: Analysis of Sandbox Encounters and Entries files

The Co-Neutrals examined all episodes of children's custody beginning in 2024 when children did not receive a well-child checkup within 30 days of entering custody (see Figure 37). For 172 episodes of children's custody, a checkup was completed late (more than 30 days after the child entered custody): specifically, 55 were completed 31 to 45 days after entry, 23 were completed 46 to 60 days after entry, 38 were completed 61 to 90 days after entry, and 56 were completed more than 90 days after entry. For the remaining 183 episodes of children's custody (24%), there was no recorded well-child checkup. For comparison, in 2023, 19 percent of episodes of children's custody recorded no well-child checkup and in 2022, 29 percent of episodes of children's custody recorded no well-child checkup.

Figure 37: Time to Well-Child Checkups

N = 762 episodes of children's custody that began in 2024 and lasted longer than 30 days



Source: Analysis of Sandbox Encounters and Entries files

As additional information, the Co-Neutrals examined rates of timely well-child checkups by race, ethnicity, and ICWA-eligibility. American Indian or Alaskan Native (non-Hispanic) children received a disproportionately low rate of timely well-child checkups (see Table 32); of these 65 children who required well-child checkups, 25 (38%) received a timely checkup. Well-child checkups for Black (non-Hispanic) children occurred timely for 66 percent of children, well-child checkups for Multiracial (non-Hispanic) children occurred timely for 62 percent of children, well-child checkups for White (non-Hispanic) children occurred timely for 56 percent of children, while well-child checkups for Hispanic children (of any race) occurred timely for 51 percent of children. Of the 74 children identified as ICWA-eligible, 34 children (46%) received a timely well-child checkup.

Table 32: Percent of Completed Timely Well-Child Checkups, by Race/Ethnicity and ICWA-Eligibility
2024

Race/ethnicity	Total	Not timely	Timely	Percent timely
Black (non-Hispanic)	38	13	25	66%
Multiracial (non-Hispanic)	21	8	13	62%
White (non-Hispanic)	137	60	77	56%
Hispanic (of any race)	446	219	227	51%
American Indian or Alaskan Native (non-Hispanic)	65	40	25	38%
Unknown	55	15	40	73%
Total	762	355	407	53%
ICWA-eligible				
No	688	315	373	54%
Yes	74	40	34	46%
Total	762	355	407	53%

Source: Analysis of Sandbox Encounters, Cohort, and Entries files

DTO4.1 – validation strategies.


In 2022 and 2023, the Co-Neutral team conducted qualitative reviews of children’s medical records and the child’s FACTS case record to determine whether all required elements were being addressed during well-child checkups for children in state custody. In August 2024, HCA requested the opportunity to create a new process to review this information as HCA and CYFD identified barriers to efficiently and effectively producing the information necessary for these qualitative reviews. In December 2024, HCA shared a proposed process with the Co-Neutrals where they committed to working with New Mexico providers to create a uniform list of elements to help providers ensure the results of the well-child checkup were being recorded and communicated back to the child’s CYFD PC, resource parent or caregiver, and others who are part of their case planning team.²⁶⁸ This work stalled, and as of the writing of this report, has not been completed.

Discussion

Timely well-child checkups are essential to identifying children’s physical, developmental, and behavioral needs at the time they enter state custody. Just as important is the ability for the results and recommendations of the well-child checkup to be communicated and available to the child’s case worker, resource parent, biological parent (if applicable), the child’s GAL or YA, and any additional providers who are working with the child. The lack of a timely, comprehensive well-child checkup can cause delays in identifying and treating children’s needs.

In 2024, slightly more than half (53%) of children who entered custody received a well-child

²⁶⁸ In 2025, the State reported that healthcare providers advocated against a new assessment checklist for well-child visits for children in state custody.



checkup within 30 days of entry and one-quarter of children (24%) did not receive a well-child checkup.

Throughout 2024, both CYFD and HCA made efforts to increase the number of children receiving timely well-child checkups. After the Turquoise Care contracts went into effect on July 1, 2024, HCA began discussions with PHP to better track and understand the barriers for children in state custody receiving timely well-child checkups. One major barrier identified is a gap in time between when a child enters CYFD custody and when HCA and PHP were notified that a child is eligible for Medicaid and thus would begin to receive care coordination services through PHP. In late 2024, PHP and CYFD developed a pilot program in Dona Ana County where care coordinators attend portions of case transfer meetings that occur for children transitioning from assignment to an investigator to a PC, allowing the care coordinator to become familiar with relevant case information as early as possible to reduce the time between a child entering care and their introduction to the PHP care coordinator. The results of this pilot are unclear, and the State has continued its work to find a manageable solution. The difficulty that the state agencies and PCP have had in resolving this issue are a reflection of broader communication and coordination problems between the agencies.

HCA hired a Deputy Chief Medical Officer and created the Population Health Unit with one contract manager to monitor PHP's contract as the single-MCO for children in state custody. As part of this new oversight, HCA revised one of the quarterly reports required by PHP to include additional data to track and monitor barriers to completion of well-child visits. This new quarterly report went into effect in 2025.

V. Appendices

i. List of Acronyms

- ADR – Alternative Dispute Resolution
- CYFD BHS – Behavioral Health Services
- CANS – Child and Adolescent Needs and Strengths
- CAP – Corrective Action Plan
- CAT – Crisis Assessment Tool
- CBHC – Community Behavioral Health Clinician
- CCA – Children’s Court Attorney
- CCP – Comprehensive Care Plan
- CDTRC – Cross-Departmental Training Review Committee
- CFT – Child and Family Team
- CIR – Critical Incident Reports
- CMS – Centers for Medicare and Medicaid Services
- CWG – Child Welfare Policy and Practice Group
- CWLA – Child Welfare League of America
- CYFD – Children, Youth, and Families Department
- DBT – Dialectical Behavior Therapy
- DRNM – Disability Rights New Mexico
- DVP – Data Validation Plan
- EBP – Evidence-Based Practice
- EMDR – Eye Movement Desensitization and Reprocessing
- EPSDT – Early and Periodic Screening, Diagnosis and Treatment
- FCM – Family-Centered Meeting
- FFT – Functional Family Therapy
- FSA – Final Settlement Agreement
- FTE – Full-Time Equivalent
- GAL – Guardian ad Litem
- HCA – Health Care Authority (previously the Human Services Department [HSD])
- HCA BHSD – Behavioral Health Services Division
- HFW – High-Fidelity Wraparound
- ICWA – Indian Child Welfare Act
- IFPA – Indian Family Protection Act
- IPP – Individualized Planning Process (previously IPM – Individualized Meeting Plan)
- IT – Implementation Target
- JCR – Joint Clinical Review
- JJS – Juvenile Justice Services
- JPA – Joint Power Agreement
- LFC – Legislative Finance Committee
- LOD – Letter of Direction
- MCO – Managed Care Organizations
- MCR – Mobile Crisis Response

- MFD – Memorandum for Decision
- MOU – Memorandum of Understanding
- MST – Multi-systemic Therapy
- NATCAG – Native American Training Curriculum Advisory Group
- NET – New Employee Training
- NMBHPA – New Mexico Behavior Health Providers Association
- NMSU COI – New Mexico State University Center of Innovation
- OCR – Office Children’s Rights
- OGC – Office of General Counsel
- OOPP – Out-of-Preferred Placements
- OTA – Office of Tribal Affairs
- OTS – Office of the Secretary
- PC – Permanency Coordinator
- PHP – Presbyterian Health Plan
- PIG – Program Instruction Guideline
- PSD – Protective Services Division
- QA – Quality Assurance
- QAIEP – Quality Assurance, Improvement, and Evaluation Plan
- RO – Remedial Order
- RTC – Residential Treatment Center
- SCI – Statewide Central Intake
- TAG – Tribal Advisory Group
- TCOM – Transformational Collaborative Outcomes Management
- TFC – Treatment Foster Care
- TF-CBT – Trauma-Focused Cognitive Behavioral Therapy
- TMB – Traditional Medicine Benefits
- TO – Target Outcome
- WDB – Workforce Development Bureau
- WDP – Workforce Development Plan
- YA – Youth Attorney

ii. Implementation Targets and Target Outcomes Met in Prior Reporting Periods

Commitment		Co-Neutral Report in Which Performance Standard was Met
Appendix A		
IT 1.1	Establish Child and Adolescent Needs and Strengths and Functional Trauma Assessment Criteria	Report Assessing 2020
IT 1.2	Revised Serious Emotional Disturbance (SED) Criteria	Report Assessing 2020
IT 2.1	Development of a Trauma-Responsive Training and Coaching Plan	Report Assessing 2022
TO 4.1	Development of an Individualized Planning Meeting (IPM)	Report Assessing 2022
TO 5.1	Development of a Quality Assurance, Implementation, and Evaluation Plan (QAIEP)	Report Assessing 2022
Appendix B		
IT 1.1	Development of Recruitment and Retention Plan	Report Assessing 2021
IT 2.1	Publish Guidance Prohibiting Retaliation	Report Assessing 2021
IT 3.1	Development and Promotion of Warm Line for Resource Parents	Report Assessing 2021
IT 3.2	Promotion of Internal Grievance Procedure for Youth	Report Assessing 2022
IT 3.3	Development of a Grievance Procedure for Resource Families	Report Assessing 2021
TO 7.1	Children Placed with Kin	Report Assessing 2022 Report Assessing 2023
TO 10.1	Development of a CYFD Workforce Development Plan	Report Assessing 2022
Appendix C		
IT 1.1	Draft and Promote Passage of State ICWA law	Report Assessing 2021
IT 4.1	Maintain a Full-time Employee Responsible for Developing, Maximizing, Coordinating, and Overseeing Provision of Culturally Responsive Services	Report Assessing 2020
IT 8.1	Create and Maintain a Dedicated ICWA unit in the 2nd Judicial District	Report Assessing 2020
TO 5.1	Development of an ICWA Training Plan	Report Assessing 2022
Appendix D²⁶⁹		
IT 2.1	Initial Expected Service Utilization Methodology	Report Assessing 2022
IT 3.1a	Detailed Progress Report on Reimbursement Methodology, Billing Rate Information, and Guidance for Providers	Report Assessing 2020
IT 3.1	Develop and Publish Reimbursement Methodology, Billing Rates, and Provider Guidance	Report Assessing 2022
IT 4.1a	Publishing Medication Protocols for Public Comment	Report Assessing 2020
IT 4.1	Adopt Regulations Governing Medication Protocols	Report Assessing 2020
IT 6.1	Reinstating “No Reject, No Eject” Language in Medicaid Contracts	Report Assessing 2021
IT 7.1	Notice of Action and Grievance Protocols	Report Assessing 2021
IT 9.1	Contractually Require Training for Care Coordination Providers	Report Assessing 2022

²⁶⁹ Appendix D commitments 3.1a and 4.1a were created and agreed upon by the parties in the August 8, 2020 Parties’ Extension Agreement and do not appear in the original FSA.



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