Center *for the* Study *of* Social Policy
Ideas into Action

PUBLIC CATALYST

Co-Neutrals' Annual Report

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

January - December 2025

Co-Neutrals

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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 (DRNM); they were represented by DRNM, 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). Following months of negotiations among the *Kevin S.* parties, on March 17, 2020, the parties executed a Final Settlement Agreement (FSA), 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.

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 and support of a trauma-responsive system of care for all children in 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 sixth annual report produced by the Co-Neutrals. The IT and TO Performance Standard determinations in this report assess CYFD and HCA's performance in 2025. The FSA dictates the period of assessment for each annual report; specifically, this report – due by November 16, 2026 – assesses the State's performance from January 1 to December 31, 2025.

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 2025 performance.

On January 6, 2023, following the release of the Co-Neutrals' November 15, 2022 Report assessing the State's progress in 2021, the Plaintiffs invoked the FSA Dispute Resolution process. The Co-Neutrals mediated discussions between the parties and a 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, resource home development and retention, well-child visits (WCVs), and data submission. The Arbitrator, Charles Peifer, held an initial hearing in November 2024, and

issued Remedial Order No. 1 on January 21, 2025.[1] The Arbitrator has continued to maintain jurisdiction over this action, has held periodic hearings in 2025 and 2026, and issued three additional Remedial Orders. Pursuant to these Remedial Orders, the Co-Neutrals have issued reports with associated appendices describing performance and outcomes toward select commitments set forth in Remedial Orders No. 1, No. 2, and No. 3 (RO#1, RO#2, RO#3). Remedial Order No. 4 (RO#4) was approved and adopted by the Arbitrator on September 23, 2026. This report, where possible, validates the 2025 data and information produced by the State, and documents the Co-Neutrals' determinations whether the State met the Performance Standard for FSA ITs and TOs in 2025. While there may be references to activities, strategies, or reporting from the Remedial Orders, as appropriate, this report is limited to FSA commitments and standards.

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 2025.
- Section III provides an overview of the demographics of children in custody in New Mexico during 2025.
- Section IV discusses the State's performance on each of the FSA commitments due by December 2025, 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 September and October 2025, the Co-Neutrals met in New Mexico with CYFD case workers, supervisors, managers, and children's court attorneys (CCAs) in six county offices across the state; met with staff from CYFD's Office of Tribal Affairs (OTA); met with representatives from New Mexico's Nations, Pueblos, and Tribes; and visited four congregate care facilities to inform the Co-Neutrals' understanding of the State's performance and their efforts in 2025. Additionally, throughout 2025 and 2026, the Co-Neutrals met with the Plaintiffs' team, community advocates, private providers, and resource parents to collect information on the quality and impact of the State's efforts.

Between January and December 2025, the Co-Neutral team conducted 227 virtual interviews with CYFD staff (case workers, supervisors and non-supervisors) representing investigations, permanency, and licensing and support work from all regions/counties. In February 2025,

[1] The CAP and Remedial Orders can be found here.

members of the Co-Neutral team participated in CYFD's introductory trauma training for employees – *Trauma: A Journey to Self-Discovery*.

In January and July 2026, the Co-Neutrals conducted visits to eight CYFD county offices and met with case workers, supervisors, managers, case aides, Community Behavioral Health Clinicians (CBHC), and Care and Behavioral Support Specialists (CBSS); met with staff from CYFD's OTA; met with representatives from NM's Nations, Pueblos, and Tribes; met with youth; and visited three congregate care facilities and two Certified Community Behavioral Health Clinics (CCBHCs) to further inform the Co-Neutrals' understanding of the State's performance and efforts in 2025 and 2026.

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).[2] 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 2025 performance data for several TOs.

The Performance Standard determinations are focused on the State's efforts to achieve substantial and sustained progress in 2025, even though comments regarding some commitments completed in 2026 are included in this report. The Co-Neutrals' next annual report – due by November 15, 2027 – will discuss and assess the State's performance in 2026.

[2] The DVP is discussed in more detail in Section IV.A.i. of this report.

II. Overview

This is the sixth report produced by the Co-Neutrals on the State's efforts to achieve the *Kevin S.* FSA commitments, covering January 1 through December 31, 2025. The FSA was structured with initial Implementation Targets (ITs) as the foundation for improved outcomes (Target Outcomes, TOs) to be achieved in subsequent years for New Mexico's children, youth, and families. On the whole, the State's performance in 2025 is disappointing, leaving many of New Mexico's children and families facing the same conditions that prompted the lawsuit and led to the agreements in the FSA by both CYFD and HCA to create a better resourced and more effective trauma-informed system of care. The State previously met the Performance Standard for all the ITs in Appendices A and B of the FSA. By December 31, 2025, the State met the Performance Standard for two of the five overdue and remaining ITs in Appendix C. The State did not meet the Performance Standard for the two remaining ITs in Appendix D by December 31, 2025, though these ITs were due several years ago.

Overall, the State met the Performance Standard for only two of the 42 TOs due in 2025, both within Appendix C.[3] For the 40 TOs and five ITs where the State did not meet the Performance Standard in 2025, with few exceptions, the State's performance was either unchanged from 2024 or declined. These TOs were significantly overdue at the end of 2025. The discussion that follows provides a brief summary of performance within each FSA Appendix.

Trauma-Responsive System of Care (Appendix A)

The State has committed to use the Child and Adolescent Needs (CANS) and Crisis Assessment Tool (CAT) as screenings to identify children's strengths and needs, and to guide case and service planning. The parties decided these screenings should be completed within set timeframes after a child's entry into custody, and should be shared with the child's MCO and the court to inform treatment and case planning. But many years into this effort, these screenings are rarely completed as required; State data show that 12 percent of children's episodes of custody that began in 2025 had a completed CAT within 10 days, and only 36 percent of children's episodes of custody had a CANS screening completed.[4] Very few of these completed screenings were documented as shared with the MCOs or courts. Children's strengths and needs continue to go unidentified by these screening tools in most instances, despite the FSA promising a very different outcome to support children and families long ago.

A requirement of Appendix A that is integral to the success of outcomes in all FSA Appendices is the State's obligation to ensure children in custody receive trauma-responsive services, supports, and treatments to meet their needs. Consistent with prior years, in 2025, only four percent of

[3] 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.*
[4] Since some children experience more than one episode in custody each year, the data analysis for this and other commitments focuses not just on children but on all their episodes of custody.

children in custody at any point during the year received one of the evidence-based services identified in the FSA (126 of 3,083).[5]

The State developed a comprehensive Trauma-Responsive Training and Coaching Plan in 2022 with a goal of building and sustaining trauma awareness, knowledge, and skills in CYFD and HCA staff, providers, and contractors who work with children and families. Despite the State's focus on developing these trainings and making them available to staff, training completion data show that less than one-third of CYFD staff (32%) were up-to-date on trauma-responsive training, and 23 percent of HCA staff had completed required training by the end of 2025.

Appendix A required the State to develop and implement a plan to conduct Individualized Planning Meetings to make decisions with and deliver services to children and their families; and a plan for Quality Assurance, Improvement, and Monitoring to continually assess quality of care, collaboration across agencies, and provide transparency and accountability. Both of these plans were developed and finalized in 2022, however, these plans have not been fully implemented and performance remains poor and unchanged in 2025. The failure to move forward to implement the Appendix A commitments with quality have diminished the chances for successful experiences and outcomes for many children in custody.

Least-Restrictive and Appropriate Placements (Appendix B)

Of all children in recognized placements on December 31, 2025, 49 percent were in relative resource homes, 35 percent were in non-relative resource homes, and eight percent were in treatment foster care (TFC) homes. The State recruited 51 percent of its 2025 annual target for new non-relative resource homes by December 31, 2025 (134 of 265). Similarly, the State met 55 percent of the annual target for new child placements to TFC homes in 2025 (134 of 244).

Fewer children experienced placements in CYFD offices in 2025 compared to 2024, and as discussed later in this report, this practice has nearly stopped in 2026. The FSA requires that children only be placed in non-family-based settings if they meet certain standards – extraordinary circumstances for offices, shelters, and out-of-state (OOS) facilities; medical necessity for clinical congregate placements; and best interest for non-clinical congregate placements. The Co-Neutrals assessed that none of the office, OOS facility, or shelter placements were made due to extraordinary circumstances as necessary to protect the safety and security of the child. Thirty-one percent of OOS facility placements and 12 percent of in-state clinical congregate care placements were made pursuant to the medical necessity standard outlined in the FSA; performance for both declined since 2024.

A foundational and necessary component to positive outcomes in all FSA Appendices is that case workers have caseloads within required limits that allow them to engage, support, and plan for the children and families they serve. Of all workers assigned as primary on at least one case on

[5] The evidence-based services identified in the FSA include: High-Fidelity Wraparound (HFW), Multi-Systemic Therapy (MST), Mobile Crisis Response (MCR), Functional Family Therapy (FFT), Dialectical Behavior Therapy (DBT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and Eye-Movement Desensitization and Reprocessing (EMDR).

December 15, 2025, 20 percent had caseloads within the caseload standards (74 of 376), making progress on many of the FSA commitments nearly impossible.

Indian Child Welfare Act (Appendix C)

In 2025, CYFD's Office of Tribal Affairs (OTA) finalized a policy to provide reimbursement for cultural activities and traditional healing services to Native children in care. The State also launched a 1115 Waiver benefit that provides Medicaid funding for traditional healing services; this benefit is in addition to the Traditional Healing Benefits (THBs) that are available as value added services to Native children affiliated with a Managed Care Organizations (MCO). Both of these developments, if promoted and implemented appropriately, can provide Native children with increased access to traditional and culturally responsive services. As a result of this work, the Co-Neutrals assessed that the following Appendix C commitments were met in 2025: App. C, IT 2.1 – *Development of Processes and Procedures to Promote Traditional Interventions*; App. C, TO 2.3 – *Policies to Support Native Children to Receive Traditional or Culturally Responsive Services;* App. C, TO 3.1 – *Policy to Provide Direct Assistance for Traditional Ceremonies*; and App. C, IT 3.1 – *Pursue Federal Funding through Medicaid and Title IV-E*. Utilization of these benefits remains low. In 2025, 14 percent of applicable children's cases documented a payment and/or reimbursement for cultural activities, including THBs, during the year.

There was limited progress toward other Appendix C commitments. Twenty-three percent of required monthly meetings for Native children not placed with relatives and/or in Indian Child Welfare Act/Indian Family Protection Act (ICWA/IFPA) preferred placements were conducted on time, a decline from 38 percent in 2024. And 38 percent of required CYFD staff received the ICWA/IFPA Tier 1: *Novice* training by December 31, 2025, also a decline from 2024 when 73 percent of required staff completed the training.

Behavioral Health Services (Appendix D)

The State's performance on completing well-child visits (WCVs) for children within 30 days of entering care improved in the final months of 2025, and data for 2026 show that positive outcomes have continued. Annual performance on timely WCVs reached the highest level (66%) since 2020, and by November 2025, monthly performance was at 93 percent. These improvements are the result of diligent and consistent efforts by CYFD, HCA, and Presbyterian Health Plan (PHP).

Work continued in 2025 to build out New Mexico's children's behavioral health service array and workforce. The State reports a total of 183 providers completed training in one of the evidence-based modalities identified in the FSA, and 386 providers were in training during the year. This is progress, however, the State only met the target for certifying providers in two evidence-based services in 2025 – Multi-systemic Therapy (MST) and Eye Movement and Desensitization and Reprocessing (EMDR). The State's Behavioral Health Workforce Development Review – approved by the Co-Neutrals on March 12, 2025 – outlined the number of children in custody who were expected to receive specific evidence-based services and included annual targets for service delivery. Between January 1 and December 31, 2025, utilization data show no payment claims submitted at all for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), intensive case management, Mobile Crisis Response (MCR), Functional Family Therapy (FFT), and Dialectical

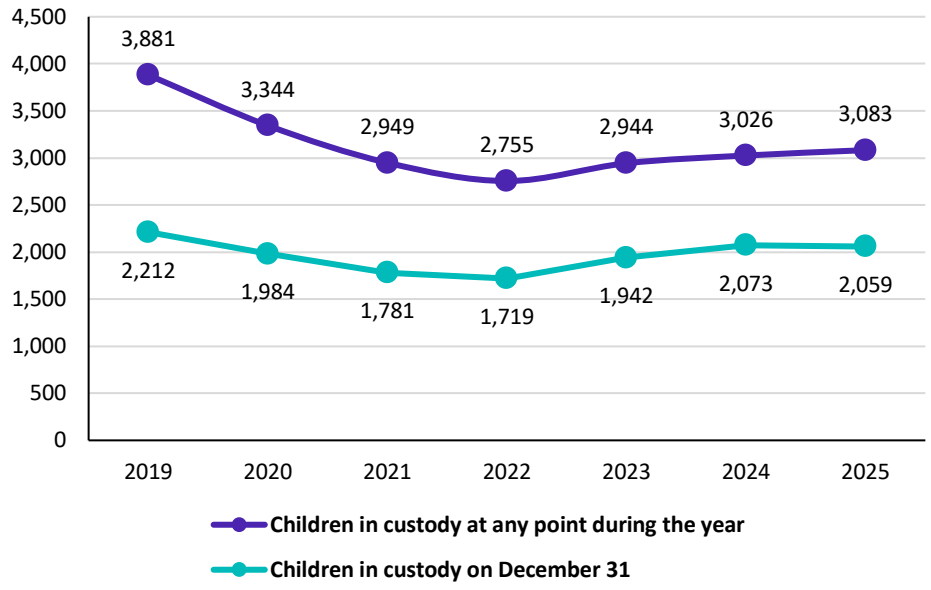
Behavior Therapy (DBT). In fact, the State's data showed some payment claims for only three service modalities – High-Fidelity Wraparound (HFW), MST, and EMDR.

Two long overdue FSA Appendix D ITs remained unmet in 2025 pertaining to monitoring care coordination by MCOs and developing a joint process for CYFD and HCA to deliver services and supports to children in custody.

III. Contextual Summary of Children in Custody

Data provided by CYFD show that 3,083 children were in CYFD's Protective Services Division (PSD) custody at any point between January 1 and December 31, 2025. The total number of children in custody during the reporting year decreased each year between 2019 and 2022, and then increased each year from 2022 to 2025. The total number of children in custody on the last day of the reporting year decreased each year from 2019 to 2022, increased each year from 2022 to 2024, and then declined slightly from 2024 to 2025 (see Figure 1).

Figure 1: Children in Custody at Any Point and on December 31[6]
2019 – 2025



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

There were 2,047 children in custody on January 1, 2025. During the year, there were 1,105 entries into custody and 1,103 exits, leading to a total of 2,059 children in custody on December 31, 2025 (see Table 1).

[6] The 2025 data include 10 children who exited custody on December 31, 2025.

Table 1: Children Entering and Exiting Custody[7]
2025

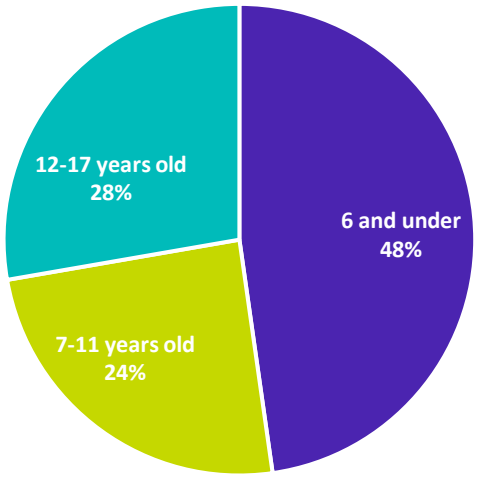
	Count
Children in custody on Jan. 1, 2025	2,047
Entries during the year	1,105
Exits during the year	1,103
Children in custody on Dec. 31, 2025	2,059[8]

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 custody on December 31, 2025, with children age six or younger comprising almost half (48%) (see Figure 2). The age distribution was similar for each year from 2019 to 2025, though there was a slight increase in the percentage of children who were under one year old from 2024 to 2025 (from 6% on December 31, 2024 to 8% on December 31, 2025).

Figure 2: Age of Children in Custody on December 31, 2025
N = 2,059 children



Source: Analysis of Sandbox Dec31 files

In 2025, there were slightly more male (51%) than female children (49%) in custody. The majority of children in custody on December 31, 2025 were of Hispanic ethnicity (63%, 1,301 children). Nineteen percent were White (non-Hispanic) (389), eight percent were American Indian/Alaskan Native (non-Hispanic) (163), four percent were Black (non-Hispanic) (90), three percent were

[7] The data include all entries and exits for children with multiple episodes of custody.
[8] This includes 10 children who exited custody on December 31, 2025.

either Multiracial (non-Hispanic) or Other (non-Hispanic) (57), and three percent were categorized as "Unknown" (59).[9] Of all 2,059 children in custody, 10 percent of children were indicated as ICWA eligible in FACTS (202) and 90 percent (1,857) were not, as shown in Table 2.[10]

Table 2: Race, Ethnicity, and ICWA-eligibility Status of on December 31, 2025
N = 2,059 children

Race and ethnicity	Dec. 31, 2025	
	N	%
Hispanic (of any race)	1,301	63%
White (non-Hispanic)	389	19%
American Indian or Alaskan Native (non-Hispanic)	163	8%
Black (non-Hispanic)	90	4%
Multiracial/Other (non-Hispanic)[11]	57	3%
Unknown	59	3%
ICWA-eligible[12]		
ICWA-eligible (No)	1,857	90%
ICWA-eligible (Yes)	202	10%

Source: Analysis of Sandbox Dec31 and Cohort files

B. Living Arrangements

On December 31, 2025, 84 percent of children in custody (1,738) lived in family settings, including 44 percent of children (912) in relative and fictive kin resource families, 32 percent of children (666) in non-relative resource families, seven percent of children (142) in treatment foster care (TFC) homes (relative and non-relative), and one percent of children (18) in pre-adoptive homes. Six percent of children (118) were placed in in-state congregate settings, and one percent of children (25) lived in out-of-state (OOS) facilities, as shown in Table 3 and Figure 3.[13]

[9] According to 2024 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 22 percent are White. US Census Bureau, American Community Survey 1-Year Estimates for children under 18 years in New Mexico; categories are not exclusive.
[10] FACTS is CYFD's State Automated Child Welfare Information System (SACWIS).
[11] 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.
[12] 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.
[13] In 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 in a non-congregate setting.

Table 3: Placement Type for Children in Custody on December 31

2023 - 2025

Setting	Dec. 31, 2025		Dec. 31, 2024		Dec. 31, 2023	
	N	%	N	%	N	%
Children in placements	**1,881**	**91%**	**1,868**	**91%**	**1,761**	**91%**
Family-Based Settings						
Resource family home (non-relative)	666	32%	627	31%	611	31%
Resource family home (relative & fictive kin)	912	44%	912	44%	863	44%
TFC (non-relative)	134	7%	143	8%	147	8%
TFC (relative)	8	<1%	10	<1%	14	<1%
TFC (unspecified)	0	0%	1	<1%	0	0%
Pre-adoptive family	18	1%	32	<1%	16	<1%
In-State Congregate Settings						
Emergency shelter	40	2%	36	<1%	13	<1%
Group Home	19	1%	15	<1%	16	<1%
Hotel/motel, office, Receiving Center	18	1%	27	<1%	8	<1%
Community home	14	1%	16	1%	28	1%
Supervised Independent Living	15	1%	11	<1%	10	<1%
Facility	12	1%	17	<1%	17	<1%
Out-of-state (OOS) congregate settings	25	1%	21	<1%	18	<1%
Other[14]	**178**	**9%**	**205**	**9%**	**181**	**9%**
Trial home visit	116	6%	122	4%	84	4%
Runaway	37	2%	51	3%	57	3%
Unknown[15]	11	1%	11[16]	1%	27	1%
Detention	9	<1%	10	<1%	4	<1%
Acute hospitalization[17]	5	<1%	7	<1%	5	<1%
Temporary absence	0	0%	0	0%	0	0%
Protective supervision	0	0%	4	<1%	4	<1%
Total for all children in custody[18]	**2,059**	**100%**	**2,073**	**100%**	**1,942**	**100%**

Source: Analysis of Sandbox Dec31 and Placements files

[14] "Other" settings are those that are not counted as placements in the DVP. See DVP Technical Appendix, available here, for further explanation.

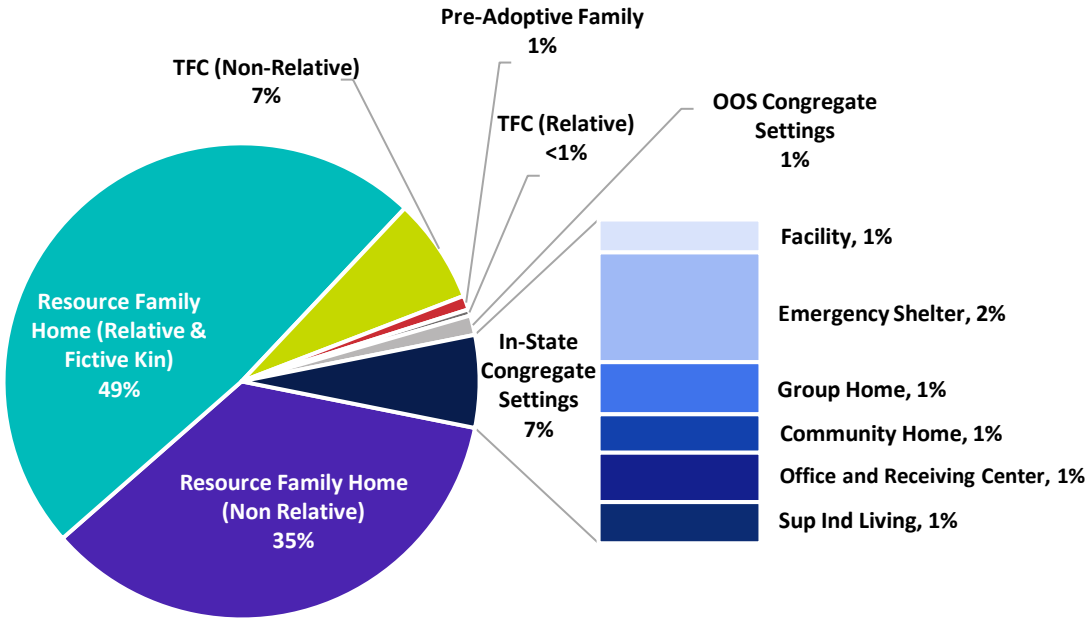
[15] The "Unknown" category includes one child with a missing placement type and 10 children with a placement type of "Historical Placement."

[16] 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.

[17] Though FACTS captures information on hospital stays for children in custody, acute hospitalizations are defined as temporary absences in the DVP and 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.

[18] Percentages may not sum to 100 due to rounding.

Figure 3: Placement Settings for Children in Placements on December 31, 2025
2025; N = 1,881 placements



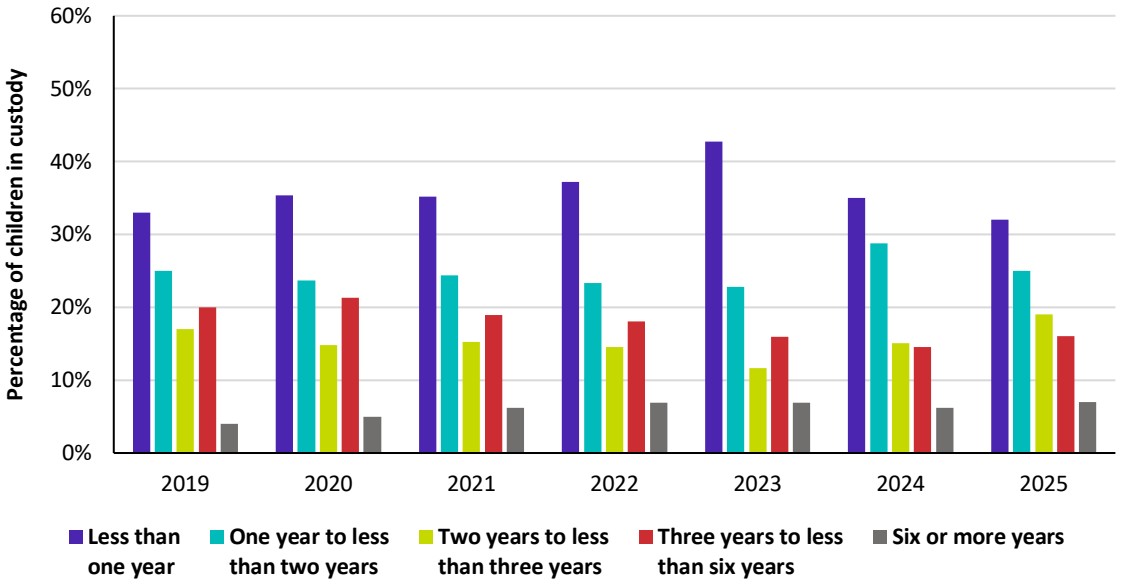
Source: Analysis of Sandbox Dec31 and Placements files

C. Duration of Current Episode in State Custody

Of the 2,059 children in custody on December 31, 2025, 32 percent had been in custody for less than one year (666), 25 percent had been in custody for one to less than two years (516), 19 percent had been in custody for two to less than three years (394), and 23 percent had been in custody for three years or longer (483) (see Figure 4).

Between 2019 and 2025, the length of time children spent in custody remained relatively consistent. As of December 31st of each reporting year, most children in custody had been in custody for two years or fewer. In 2025, the proportion of children who had been in custody for fewer than two years as of the end of 2025 (57%) was the lowest proportion observed since 2020 and the proportion of children who had been in custody for two years or more (43%) was the highest proportion observed since 2020.

Figure 4: Duration of Current Episode in Custody for Children in Custody as of December 31
N = 2,212 children in 2019; 1,984 in 2020; 1,781 in 2021; 1,719 in 2022; 1,942 in 2023; 2,073 in 2024; and 2,059 in 2025



Source: Analysis of Sandbox Dec31 files

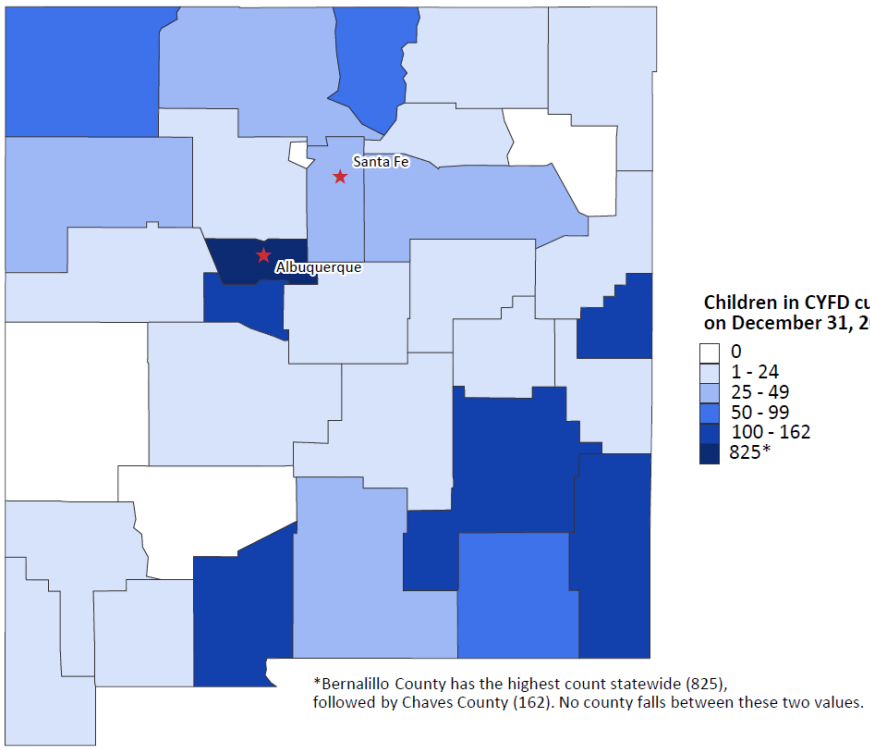
D. Geography

As of December 31, 2025, more than one-third of children in custody (40%) were from Region 3 (Bernalillo County). Thirteen percent of children were from Region 1 (Northwest), nine 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 (1,455) were placed in their home region on December 31, 2025. A total of 99 children were placed out of state (5%), including 25 children in congregate settings and 74 children in family-based settings.

Figure 5 shows the number of children in custody on December 31, 2025 by the county where the child entered custody. There were nine counties in which 10 or fewer children had entered CYFD custody, and six counties in which 100 or more children had entered custody. [19]

[19] Harding, Catron, Los Alamos, and Sierra counties had no children in CYFD custody on December 31, 2025.

Figure 5: Children in Custody on December 31, 2025, by County the Child Entered Custody
N = 2,059 children



Source: Analysis of Sandbox Dec31 files

E. Federal Permanency Goals and Legal Status[20]

Of the children in custody on December 31, 2025, 461 children (22%) had a federal permanency goal of reunification. The percentage of children with a goal of reunification had steadily increased from 2019 to 2024 (40% in 2019, 43% in 2020, 45% in 2021, 49% in 2022, 56% in 2023, and 57% in 2024), before decreasing sharply in 2025. This decrease coincided with a substantial increase in the share of children whose federal permanency goals were recorded as "unknown" in FACTS, from one percent in 2024 to 37 percent in 2025. The percentage of children in custody with a federal permanency goal of adoption has decreased since 2019 (51% in 2019 and 30% in 2025).[21]

[20] In previous reports, the Co-Neutrals reviewed data from the State showing the legal status of children in custody on December 31st 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 2019-2025 *Cohort December* 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), June 18, 2025 (2024), and May 1, 2026 (2025).

Table 4: Federal Permanency Goals for Children in Custody on December 31
2023 - 2025

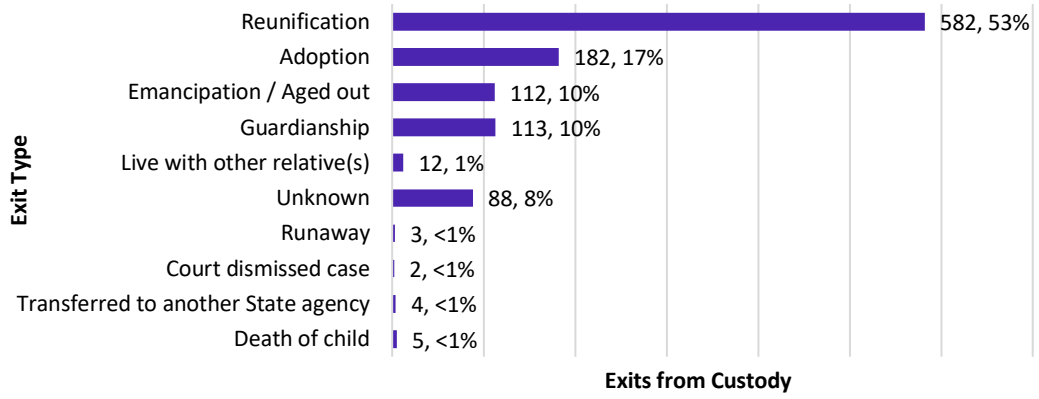
Federal permanency goal	2025		2024		2023	
	N	%	N	%	N	%
Reunification	461	22%	1,179	57%	1,089	56%
Adoption	621	30%	642	31%	582	30%
Guardianship	178	9%	168	8%	133	7%
Planned permanent living arrangements[22]	39	2%	64	3%	45	2%
Unknown	760	37%	19	1%	90	5%
Live with other relative(s)	0	0%	1	<1%	3	<1%
Total	**2,059**	**100%**	**2,073**	**100%**	**1,942**	**100%**

Source: Analysis of Sandbox Dec31 files

F. Exits from State Custody

Figure 6 shows the rate of exits from care by exit type for 2025. Most children (53%, 582) who exited custody in 2025 exited to reunification with family, followed by adoption (17%, 182). In 2019, reunification and adoption accounted for 90 percent of all exits, while in 2025, reunification and adoption accounted for 69 percent of all exits. The share of children who exited to emancipation or guardianship has ranged from 15 to 20 percent from 2020 to 2025.

Figure 6: Exits from State Custody, by Exit Type[23,24]
2025, N = 1,103



Source: Analysis of Sandbox Exits files

[22] In previous years, the data submitted by the State referred to this permanency goal as "long term foster care." Starting with the data submitted by the State on June 18, 2024, it was referred to as "planned permanent living arrangements."
[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 May 1, 2026, was missing exit reasons for 11 discharges. There were 77 discharges from care with exit reasons listed as "Discharge/No Further Agncy Spvrsn/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. As specified in 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." [25] 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."[26]

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, and detail about core data systems and processes (including planned system changes to strengthen data collection). It also presents specified quantitative and/or qualitative metrics for each IT and TO 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 ITs and TOs, both quantitative metrics and qualitative methodologies are necessary for a complete assessment and validation.

The State has not developed or proposed many of the required qualitative instruments to be reviewed and approved by the Co-Neutrals.[27] As a result, there was no performance data available for numerous qualitative metrics in 2022, 2023, 2024, and now again in 2025. It is also very likely these delays will impact the availability of 2026 performance data for some if not all of the outstanding qualitative metrics, making it once again impossible to assess the State's progress in meeting the Performance Standards.

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 2026 to modify the DVP to create clearer guidelines for calculating certain performance metrics.[28] The State and the Co-Neutrals will continue to identify proposed modifications each year, and the Co-Neutrals will assess whether to approve changes

[25] FSA, pg. 6.
[26] Ibid.
[27] 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.
[28] The approved DVP, as revised and agreed upon in May 2026, can be viewed here.

after consultation with each party.

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.[29,30] In February 2026, the State and the Co-Neutral team agreed that the State would submit cohort files, which show information on all children who were in custody at any point in 2025, by March 1 instead of May 1, 2026, to allow the Co-Neutral team to review the data early and avoid delays to the production of the Annual Report.[31] The State submitted cohort files by March 1, 2026, and the Co-Neutral team sent the State a detailed review of the cohort data quality on March 23, 2026.

As in previous years, the Co-Neutral team identified data quality issues in the cohort files, including missing and inconsistent information about children's placements and episodes. The State submitted revised cohort files on May 1, 2026, which resolved many, but not all the issues identified. On that date, the State also submitted the remainder of its annual data, consisting of non-cohort files such as all licensed and active foster care providers, all State staff, and all behavioral health services delivered to children in custody. The State resubmitted data several times after May 1, 2026, based on feedback from the Co-Neutral team. By June 22, 2026, the State had submitted its final versions of all required files. Several quality issues remained in these data files, but to avoid further delays to the validation process, the Co-Neutrals utilized these files for their performance calculations and note any discrepancies in footnotes to this report.

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 2025. There were some areas in which the State was able to correct discrepancies in its data submissions, and some areas in which the data discrepancies were limited enough that validation was still possible.

The State has informed the Co-Neutrals that many of the issues described above will be corrected or mitigated by the transition to CYFD's new child welfare information system, NM IMPACT, which remains under development as of October 15, 2026; FACTS will represent an archival record that will no longer be updated or current.

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[29] 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 custody. Throughout 2025, the State continued to develop the capacity to do this work, aided by an 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 in this section.

[30] The structured reports produced by RS21 and submitted for validation are referred to as "Sandbox" files.

[31] The State agreed that the Co-Neutral team's early review of 2025 cohort data would be a stopgap measure (not a permanent change to the data production process) to support the State as it builds capacity to produce high-quality data.

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. The State released its report, titled 2025 Annual Report *Kevin S*. Settlement, on August 3, 2026. The State's report describes their performance on commitments due in 2025.[32]

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."[33] The parties have the ability to provide comments on the Co-Neutrals' Annual Report prior to the second meeting.

The Co-Neutrals presided over two meetings between the parties in 2025 – one on January 7 and another on October 2, 2025. The parties were engaged in the dispute resolution process pursuant to Section IX of the FSA throughout 2025, which impacted the timing of the meetings.

[32] The State's 2025 Annual Report on *Kevin S.* is available here.
[33] FSA IV, C.

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."[34] The FSA 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 ensure children's needs and strengths are identified as early as possible, and to offer trauma-responsive services such that children can receive the supports they need without unreasonable delay. The FSA also identifies the need for a trauma-responsive system to have "accurate, complete, and relevant evidence-based quality management tools."[35]

In prior reports, the Co-Neutrals assessed that the State met the Performance Standard for all the FSA Appendix A ITs.[36] This section discusses the State's performance for nine Appendix A TOs that remained unmet at the close of 2025. These include timely and appropriate use of the State's Crisis and Assessment Tool (CAT) and Child and Adolescent Needs and Strengths (CANS) screening tools; children's timely access to medically necessary services; implementation of the State's Trauma Responsive Training and Coaching Plan; implementation of the State's plan for Individualized Planning Meetings (IPMs); and implementation of the State's Quality Assurance, Improvement, and Evaluation Plan (QAIEP).

In 2025, the State made inadequate progress in building out a trauma-responsive system of care. Despite the State's reported efforts in 2025 to improve the application of the CAT and CANS screening tools, the State made little progress in 2025 in all aspects of CAT and CANS practice:

- 47 percent of children's episodes of custody during 2025 that lasted 45 days or longer did not have a CAT or CANS screening completed.
- Six percent of children's episodes of custody that began in 2025 and required a CANS screening had a screening completed within 45 days as required, and only 12 percent of

[34] FSA, pg. 1a.
[35] Ibid.
[36] 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.*

children's episodes of custody that began in 2025 and required a CAT screening had a screening completed.

- For the CAT and CANS screenings that were completed, a qualitative review conducted by CYFD's Office of Performance and Accountability (OPA) and the Co-Neutral team found that screening scores were inconsistent with guidance provided in the CAT and CANS Reference Guides in nearly one-quarter (23%) of all scored items based on documentation available in the FACTS case record. A focus on improving these screenings – both in practice and in data collection – is an integral part to meeting the commitments in all Appendices of the FSA.

Regarding behavioral health service delivery to children in custody, as in prior years, the State has not yet been able to effectively track the follow-up assessments or service recommendations that are made for children based on CAT and CANS screenings. Therefore, it is not possible to identify whether children are timely receiving the services they need, if at all. Four percent of children in custody received an evidence-based practice (EBP) service specified in the FSA in 2025 according to the Medicaid billing data.[37] The number of children who received an EBP service increased from 2024, primarily due to more children receiving HFW, but is still less than the number of children who received EBP services each year from 2019 to 2022. While the Medicaid EBP billing modifiers have been in effect since July 1, 2023, they did not appear to be in use by providers based on the 2025 billing data.

Appendix A envisions a trauma-responsive system of care in which child welfare and behavioral health staff and providers are adequately equipped not only with the appropriate knowledge to identify and understand trauma, but also with the necessary skills and workforce supports to provide trauma-responsive case practice in their work with children and families. Since the approval of the Trauma-Responsive Training and Coaching Plan in 2022, CYFD and HCA have focused on training staff on the initial training modules identified in the Plan. In 2025, the State reported efforts to expand trauma-responsive training offered to staff. Despite these efforts, the data indicate only 35 percent of CYFD staff and 23 percent of required HCA staff completed the trainings as required in 2025. Additionally, both CYFD and HCA struggled with data collection issues in 2025 that prevented the State from identifying all contractors, resource parents, and respondent families who completed or who were required to complete training.[38]

During 2025, many required Individualized Planning Meetings (IPMs) meetings were not documented as completed, both for children who were missing or who had run away from their placements, and for children placed in congregate facilities such as out-of-state (OOS) facilities, in-state clinical and non-clinical congregate settings, and shelters.[39] State leaders report they intend to develop a revised IPM Plan to streamline the purpose of IPMs and to simplify the meeting types

[37] The EBP services provided to children in 2025 include HFW, MST, and EMDR.
[38] The FSA defines respondents as defendant(s) in an abuse and neglect case under the New Mexico Children's Code.
[39] Specific findings for these meetings can be found in App. B, TO 2.1 – *Joint Clinical Reviews of Out-of-State Placements*, App. B, TO 2.3 – *Out-of-State IPP Meeting and Development of Discharge Plans*, and App. B, TO 3.2 – *30-Day IPP Meetings for Clinical Congregate Care*.

and objectives while still meeting the requirements set forth in the FSA. As of the writing of this report, the State has not submitted a revised IPM Plan to the Co-Neutrals for review and approval.

Lastly, unchanged from prior years, the State struggled to gain traction on implementing "Phase 1" of the approved Quality Assurance, Improvement, and Evaluation Plan (QAIEP). 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 tiered committees integral to building a system with an accurate, complete, and relevant evidence-based quality management approach. As with prior years, significant staff turnover at both agencies inhibited progress toward implementation of the QAIEP. The State reported that QAIEP meetings resumed during the last quarter of 2025.

a. 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).[40] 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 2025.

The Co-Neutrals approved the State's CAT and 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 domains, including the child's individual strengths, life functioning, behavioral and emotional needs, risk behaviors, cultural needs, potentially traumatic/adverse childhood experiences, and traumatic stress. The results of the CAT screenings are intended to identify strengths, supports, and services necessary to maintain the child in the most appropriate placement immediately after entering custody. The results of the CANS screenings are intended to guide the child's case or treatment plan while in custody, and can identify appropriate referrals to services and supports based on the child's CANS screening scores.

[40] 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.

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).[41] All children are to have a CAT screening completed after an abuse or neglect petition has been filed, and the CAT screening must be completed and filed with the Court before the child's 10-day hearing. CANS screenings are required to be completed within 45 days of the child entering custody, and are to be readministered 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 – such as a placement change – 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).[42] Staff are required to be trained and subsequently certified to administer CAT and CANS screenings, and are required to take ongoing training to maintain certification each year.[43]

PHP is the sole MCO serving most children in custody.[44] PHP is required in its HCA contract to maintain two CANS-certified trainers responsible for training care coordination staff as well as others in the organization on the CAT and CANS screenings. The PHP 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.

Performance for the CAT and CANS screenings is measured within four commitments: App. A, TO 1 – *Completing Indicated Screenings*; App. A, TO 1a – *Filing Results of CAT Screenings with the Court*; App. A, TO 1b *Comprehensive CANS Screenings*; and App. A, TO 1c – *Completing Follow Up Screenings*. An analysis of the State's overall performance on CAT and CANS screenings requirements is included in the discussion within this section after App. A, TO 1c.

[41] CYFD's *Permanency Planning Procedures* (8.10.8 NMAC) can be found here.
[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. Additional information about the Praed Foundation can be found here.
[44] The *Turquoise Care - Children in State Custody* contract went into effect on July 1, 2024, and named PHP as the MCO serving children in custody. Most children in custody eligible for Medicaid are served by PHP, however, Native children in custody can choose which MCO they want to enroll in, or they can remain Fee-For-Service. Additional information about Turquoise Care can be found here, and additional information about PHP can be found here.

DVP Metrics and Validated Performance Data

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

There were 2,733 children whose episodes of custody lasted at least 45 days and either began in or overlapped with 2025. Fifteen of these children experienced more than one such episode of custody, resulting in a total of 2,748 episodes of custody during which a CANS screening was required.[45] The State's data show that CANS screenings were completed in 36 percent of episodes (998 of 2,748).

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

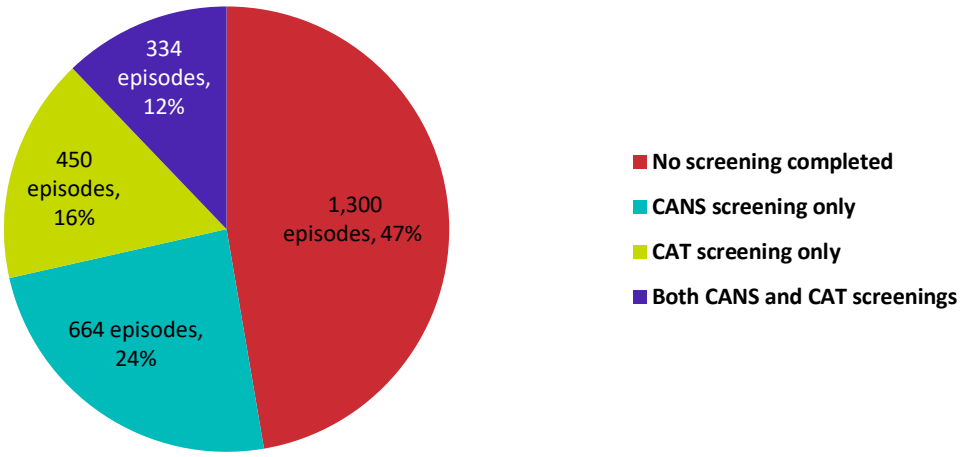
There were 2,854 children whose episodes of custody lasted at least 10 days and either began in or overlapped with 2025. Twenty-six of these children experienced more than one such episode of custody, resulting in 2,881 episodes of custody during which a CAT screening was required. The State's data show that CAT screenings were completed in 29 percent of episodes (828 of 2,881).

As additional information, the Co-Neutrals examined the rate of timely CAT completion for the 838 episodes of custody that began in 2025. Of these 838 episodes of custody, 100 (12%) documented a CAT screening that was completed within 10 days of the child's entry into custody.

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 2,748 episodes of children's custody that lasted 45 days or longer, 1,300 (47%) had no screenings completed during the episode, 450 (16%) had only a CAT screening completed during the episode, 664 (24%) had only a CANS screening completed during the episode, and 334 (12%) had both a CAT and CANS screening completed during the episode of custody (see Figure 7).

[45] 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 custody during the reporting year. Since some children experience more than one episode in custody each year, the data analysis for this and other commitments focuses not just on children but on all their episodes of custody.

Figure 7: Screenings Completed for Children in Custody for Episodes 45 Days or Longer
2025; N = 2,748 episodes of children's custody



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 for which screening results were provided to the child's MCO or other care coordinating provider or entity within five business days.*[46]

Of the 1,030 eligible CANS screenings completed during 2025, results for 36 screenings (3%) were shared with a child's MCO. Performance increased slightly from 2024, when less than one percent of the CANS screenings results were shared with MCOs.

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

Of the 313 eligible CAT screenings completed during 2025, four (1%) were shared with a child's MCO.[47] In 2024, 2023, and 2022, zero CAT screenings (0%) were shared with MCOs.

[46] Metrics (iv) and (v) count screenings, while metrics (ii) and (iii) discussed earlier count episodes of custody. Some of the 998 episodes of custody counted toward metric (ii) involved more than one CANS screening, or CANS screenings that were administered after the child had reached their 46th day in custody. Those episodes may also involve children who were not affiliated with a MCO.
[47] 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 a MCO.

ATO1(i) – qualitative metric: Qualitative review of practice used to identify and address child's trauma-related needs.[48]

To collect qualitative data for this commitment, reviewers from CYFD's OPA and the Co-Neutral team reviewed a sample of completed CANS and CAT screenings. Reviewers assessed the quality of completed CAT and CANS screenings for children who entered state custody from January 1 through September 15, 2025, remained in custody for at least 45 days, and had a completed CANS screening.[49] OPA staff also completed interviews with 22 CYFD case workers and six children in the sample to better understand their experience with the CAT and CANS screenings. In total, a sample of 45 completed CANS screenings for 45 unique children were reviewed.[50] Of those 45 children's cases, 26 also had a CAT screening completed after entering custody that were reviewed to gather information about the quality of 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 conduct the test-retest, reviewers completed case reviews of children's FACTS records up to the date the CAT or CANS screening was finalized, and then completed an independent CAT or CANS screening in accordance with the CANS and CAT Reference Guides based on the information documented in the record.[51] The retest scores are based only on information in the child's FACTS record, whereas the test scores may be based on additional information known to the case worker that is not documented in FACTS.

CAT and CANS Test-Retest

Two specific CAT domains were reviewed for the test-retest: Child Protection and Life Functioning. Overall, scores matched in the test-retest in the Child Protection domain in 74 percent of items (96 of 130 items scored), and in the Life Functioning domain in 81 percent of items (118 of 147 items scored) (see Figure 8). On the items where there was disagreement between the test-retest, the most common issue was a lack of documentation in the case record to support the CAT screening scores. For the Life Functioning and Child Protection domains, higher retest scores generally indicate that a need was documented in the case record that was not reflected in the original screening, or that there was no information in the case record to identify that a need was not

[48] 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.

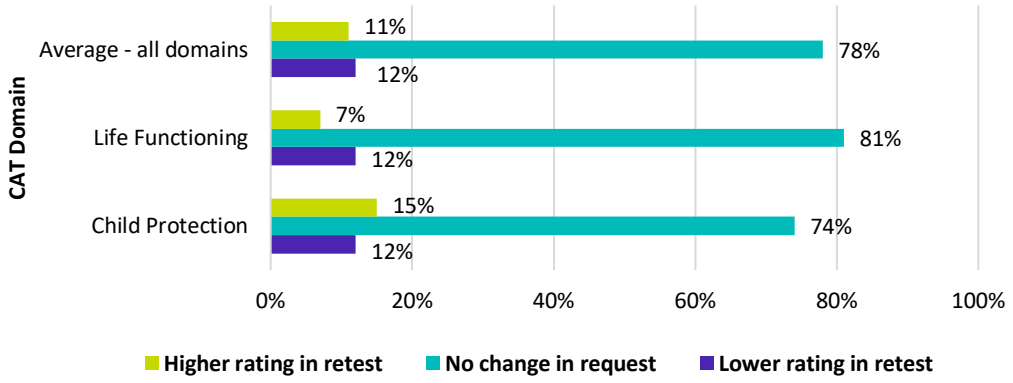
[49] BHSD STAR is the database used by CYFD to track and record all CANS and CAT screenings for children in custody; it is managed by Falling Colors.

[50] The CANS sample was statistically significant among the number of completed CANS for children who entered custody during the period under review, and represents a 95% confidence level with a 10% margin of error.

[51] 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 meet a need (needs-based scale), or that *no action is currently necessary* because a core strength is present (strengths-based scale). A score of 2 or 3 indicates *an action is necessary* to address the need (needs-based scale) or that *an action is necessary* to build up and/or identify a strength (strengths-based scale). The Individual Strengths domain assesses on a strengths-based scale, while the other domains reviewed assess using a needs-based scale.

present. Generally, lower ratings indicate that an item is identified as a strength, or as an instance where no action is necessary based on documentation in the case record.

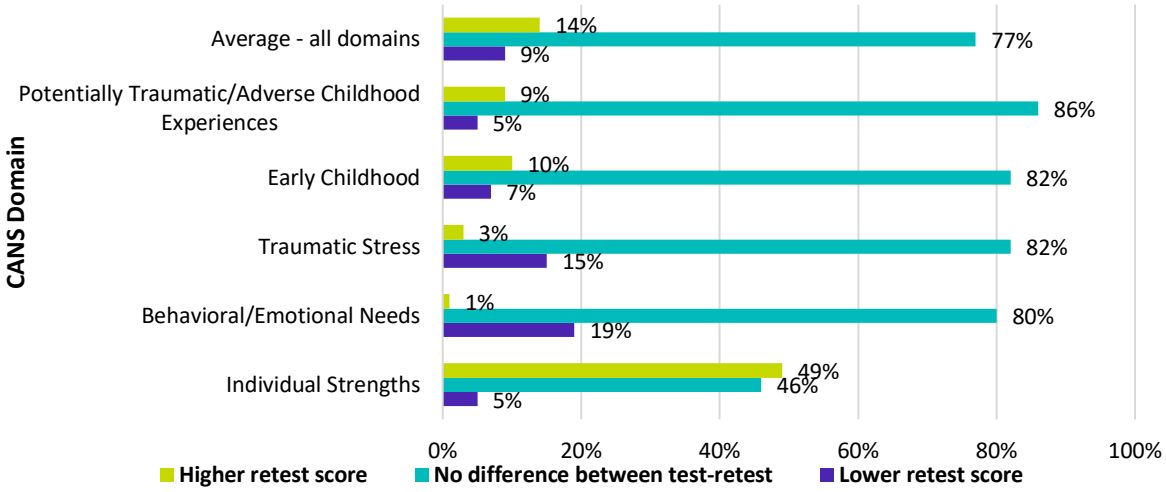
Figure 8: Difference Between CAT Screening Test-Retest Results, by Domain
2025; N = 26 CAT screenings



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

Five CANS domains were reviewed for the test-retest: Individual Strengths, Behavioral and Emotional Needs, Traumatic Stress, Potentially Traumatic/Adverse Childhood Experiences, and Early Childhood (only for children 5 years old and younger). Of the 45 CANS screening reviewed, alignment between the test-retest scores ranged between 80 and 86 percent in the Behavioral and Emotional Needs, Traumatic Stress, Potentially Traumatic/Adverse Childhood Experiences, and Early Childhood domains, but responses were different in over half (64%) of the scores in the Individual Strengths domain (see Figure 9).

Figure 9: Difference Between CANS Screening Test-Retest Results, by Domain
2025; N = 45 CANS screenings; 1,839 total scored items



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

As with the CAT test-retest, the most common reason identified for the difference between the CANS test-retest scores was a lack of available information in the case record to support the CANS screening scores. For the Individual Strengths domain – in which a higher score identifies the need to build a strength – the CANS screenings being reviewed (test) frequently identified strengths for the child that the reviewer did not find documented in the case record. Similarly, in the Behavioral and Emotional Needs domain – in which a higher score identifies a need – the CANS screenings being reviewed frequently identified behavioral or emotional needs that the reviewer did not find documented in the case record.

CAT and CANS Quality of Practice

Based on the findings of the test-retest, the overall quality of CAT and CANS screenings completed by CYFD staff was measured using a four-point scale ("0 – *no action necessary to strengthen practice"* to "3 – *immediate action necessary to strengthen practice"*). A score of "0" indicates that all CAT and CANS process-related requirements were followed (e.g., 10-day CAT and 45-day CANS guidelines followed, screenings fully completed, etc.), and that the screenings accurately reflect the child's status based on documentation found in the FACTS record. Conversely, a score of "3" indicates that no CAT and CANS process-related requirements were followed (e.g., CAT not completed or completed after CANS, CAT and CANS guidelines not followed, no indicated 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.

As detailed in Table 5, the results show that 42 percent of CAT screenings reviewed require an intervention to improve practice, and warrant on-going CAT-specific training for investigators to improve the quality of CAT screenings. Overall, the CAT screenings reviewed showed on-going practice issues, as many were completed outside of the required timeframes, did not include notes to justify the ratings as required by the CAT Reference Guide, or had scores that were not supported by information in the child's FACTS case record.

Table 5: CAT Screening Quality of Practice Scores
2025; N = 26 CAT screenings

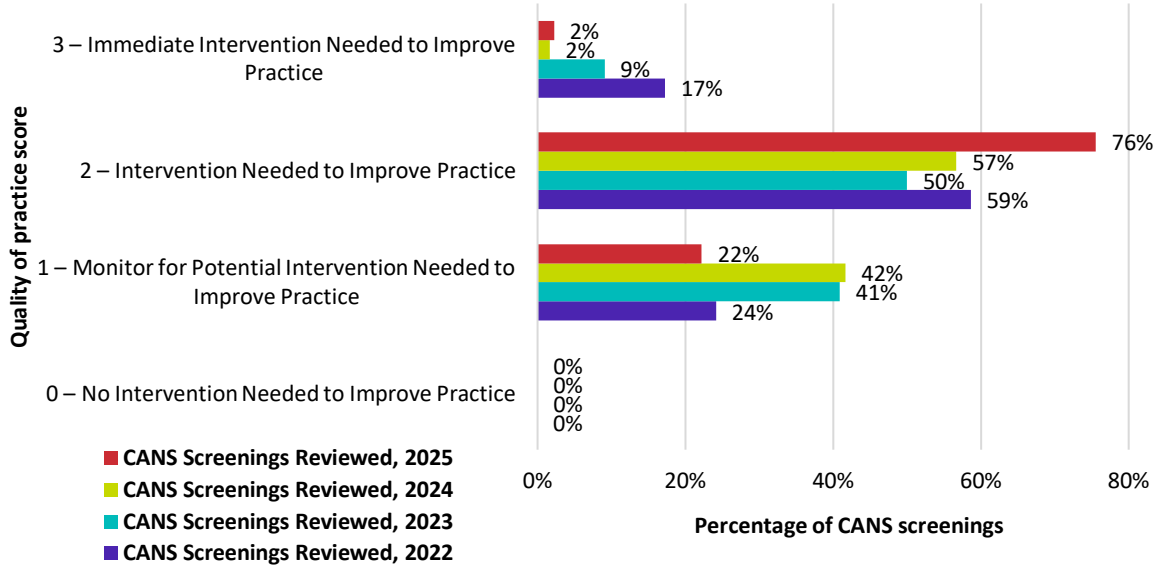
CAT Quality of Practice Score	Number of CAT screenings	Percent of CAT screenings
0 – No Intervention Needed to Improve Practice	1	4%
1 – Monitor for Potential Intervention Needed to Improve Practice	14	54%
2 – Intervention Needed to Improve Practice	11	42%
3 – Immediate Intervention Needed to Improve Practice	0	0%

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

Quality of practice scores for the CANS screenings reviewed in 2022 through 2025 are presented in Figure 10 to compare performance across years. In 2025, the CANS screenings reviewed show continued interventions are needed to improve practice. CANS screenings were often found to be misaligned with the CANS Reference Guide based on case documentation found in FACTS, did not include justification for the CANS screening scores or were otherwise incomplete, and the resulting CANS service recommendations did not result in meaningful service referral or delivery for children in custody.

Figure 10: CANS Screening Quality of Practice Scores

2022 - 2025; N = 29 CANS screenings in 2022; N = 44 CANS screenings in 2023; N = 60 CANS screenings in 2024; N = 45 CANS screenings in 2025



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

Interviews with Case Workers and Children

As part of the CAT and CANS review, CYFD OPA staff completed interviews with 22 case workers and six children who were randomly selected from the 45 CANS screenings that were reviewed. Interviews with case workers revealed their insufficient understanding of the practical use and importance of the CAT and CANS screenings, which resulted in the tools being completed as a compliance requirement rather than a screening used to guide case and treatment planning, and to communicate the child's strengths and needs to others involved in the child's team. Some children reported feeling involved in their case planning, while others did not. Some children reported participating in mental health services or medication management but reviewers did not find this documented in the child's case record.

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 2025.

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 10 days or longer 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 354 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.[52] Performance is unchanged from 2024, 2023, and 2022, when CAT screening results were filed timely with the courts in less than one percent of eligible episodes. The one compliant CAT screening was filed with the court on the same day it was completed, which was 15 business days before the child's 10-day hearing.[53]

[52] Children's episodes were eligible if they began on or after January 1, 2025, lasted 10 days or longer, and had a 10-day hearing during the reporting year. Timely is defined as a CAT screen completed 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.

[53] This child's episode of custody began on February 4, 2025, and the 10-day hearing was held on March 27, 2025. The child received a CAT screening on March 6, 2025, which was filed with the court on the same day.

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 2025.

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.

DVP Metrics and Validated Performance Data

ATO1.b(i) – primary metric: For all episodes of custody for children who were removed from home 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.

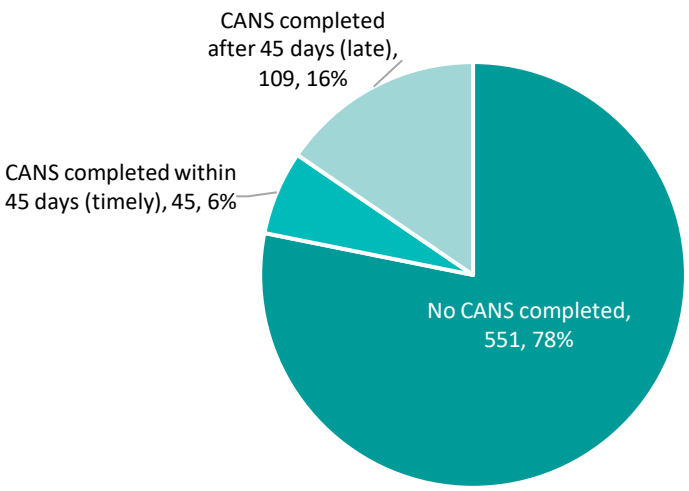
There were 702 children who entered custody in 2025 and remained in custody for at least 45 days. Three of those children were in custody for at least 45 days twice during 2025, resulting in a total of 705 episodes of custody during which a timely CANS was required. Of those 705 episodes of custody, 45 (6%) involved a timely CANS screening (see Figure 11).[54] For 551 episodes (78%), there was no record of a completed CANS screening. For the remaining 109 episodes (15%), a CANS screening was completed late (beyond 45 days). Of these 109 late CANS screenings, 30 were completed within 46 to 60 days, and 30 were completed within 61 to 90 days. In total, 154 episodes of custody out of the 705 eligible entries into custody (22%) had a completed CANS screening. Performance is unchanged from 2024, when CANS screenings were conducted timely for 41 of 723 eligible episodes of custody (6%).

As supporting information, the Co-Neutrals assessed the average time between the date of a child's removal from home and the date of the child's first completed CANS screening. On average, it took 81 days for the first CANS screening to be completed. The average for CANS screenings considered timely was 27 days, and the average for CANS screenings considered late was 103 days (see Figure 12).

[54] Eligible episodes were new episodes of custody that began and reached their 45th day in the reporting year. Episodes that began before 2025 or lasted fewer than 45 days as of the end of the reporting year were not counted.

Figure 11: Timely Completion of CANS Screenings, by Episode

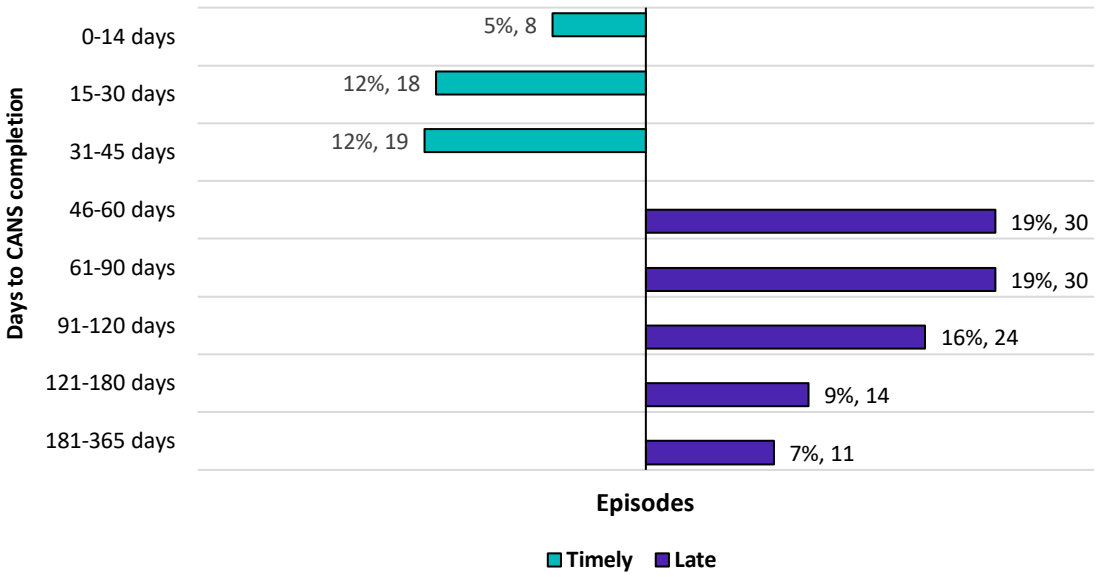
N = 705 episodes of custody that began in 2025 and lasted at least 45 days



Source: Analysis of Sandbox EpisodesOfCustody and Screenings files

Figure 12: Days Between a Child's Entry and CANS Completion

N = 154 episodes of children's custody 45 days or longer with at least one CANS completed



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 2025 data for this requirement because this metric relies on a data collection process that the State was not using consistently in 2025. 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 since then. Data from this survey tool or an alternative source will be necessary to report data and validate this metric for 2026.

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 2025.

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.

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.[55]

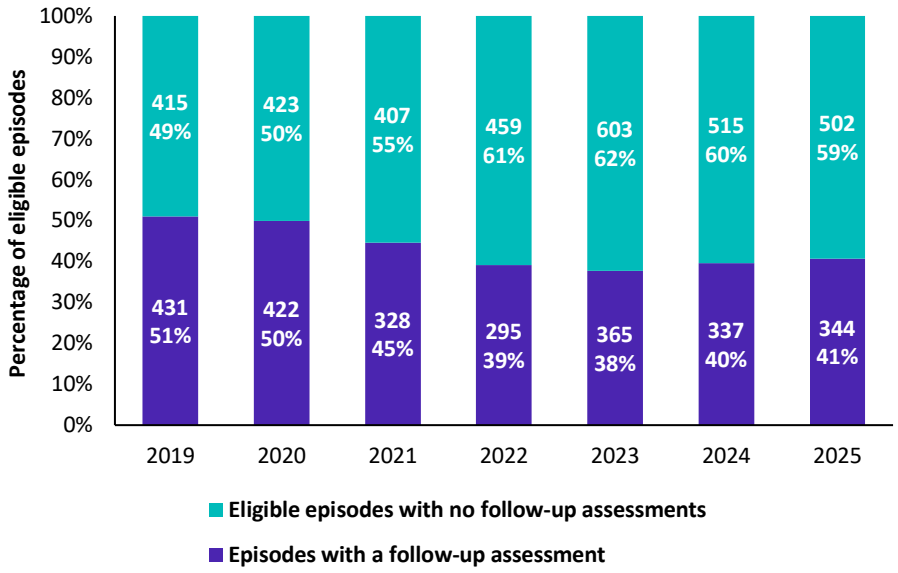
[55] Children in foster care are assigned a Level of Care (LOC) based on an assessment that determines their level of need.

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.*[56]

This metric analyzes any assessments that were completed during an episode of custody that began in 2025 based on the list of applicable follow-up assessments provided by the State to the Co-Neutrals. It does not consider if or when these assessments were formally recommended by a CAT or CANS screening, assessment, or by the child's case team. Of the 846 eligible episodes of children's custody that began in 2025, 344 episodes (41%) included at least one of the follow-up assessments identified on the State's annual list. This is below the State's baseline 2019 performance, and almost unchanged from performance in 2022, 2023, and 2024 (see Figure 13).

Figure 13: Eligible Episodes of Custody with and without at Least One Follow-up Assessment
2019 - 2025; N = 846 episodes in 2019, 845 in 2020, 735 in 2021, 754 in 2022, 968 in 2023, 852 in 2024, and 846 in 2025



Source: Analysis of Sandbox EpisodesOfCustody and Encounters files

[56] Between 2019 and 2025, this metric tracked the prevalence of the following Medicaid 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.

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 2025 data for these metrics because they rely on a data collection process that the State did not use consistently in 2025. 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 since then. Data from this survey tool or an alternative source will be necessary to validate this metric for 2026.

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

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. Of the 45 CANS screenings reviewed, the CANS screening algorithm provided recommendations for one or more services in 10 screenings (22%). However, 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.

Discussion of CANS and CAT Screenings

The State reports efforts in 2025 to improve the use and quality of the CAT and CANS screening process. Specifically, CYFD's Behavioral Health Services (BHS) staff visited 13 CYFD offices to provide additional training and technical assistance, and also trained additional staff to offer in-person CAT and CANS trainings. In November 2025, the State launched the CAT/CANS Implementation for Impact workgroup, which includes staff from CYFD BHS, Workforce Development Bureau (WDB), and the *Kevin S.* team, and focuses on improving practice for the CAT and CANS screenings. The State reported that CYFD's CANS Trainer staff collaborated with PHP to share completed CAT and CANS screenings, but few screenings were shared with PHP in 2025. State leaders said they plan to continue these efforts, as well as developing additional training and embedding the CAT and CANS screenings in the State's new data system in 2026.

Despite the importance of the CANS and CAT screening tools to guide children's treatment and their impact on the State's plan to build out children's behavioral health network as identified in Appendix D, the State made little progress in 2025 in all aspects of CAT and CANS practice. Thirty-six percent of children's episodes of custody during 2025 that lasted 45 days or longer did not

have a CAT or CANS screening completed, and only six percent of children's episodes of custody that began in 2025 and required a CANS screening had one completed within 45 days as required. Only 12 percent of children's episodes of custody that began in 2025 and required a CAT screening had one completed. Only 36 CANS screenings (3%) and four CAT screenings (<1%) were shared with MCOs, and only one CAT screening was shared with the court prior to a child's 10-day hearing. For the CAT and CANS screenings that were completed, the test-retest identified issues with the quality of the screenings, including deviations from process requirements in CYFD's policy and the CAT and CANS Reference Guides.

The State did not track the follow-up assessments or service recommendations that are made based on CAT and CANS screenings in 2025, therefore, it is not possible to identify whether children timely received the services they need, if at all. The State needs to ensure better tracking of this data, both to track service needs and delivery, and to assess the accuracy of the CAT and CANS screening algorithms to ensure the algorithm is making appropriate recommendations based on the screening scores. A focus on improving these screenings – both in practice and in data collection – is integral to meeting the commitments in the FSA.

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 2025.

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 screenings immediately when possible or within 10 days.

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

providers to use when billing for identified clinical services. Historically, providers utilizing clinical interventions such as DBT, TTF-CBT, and EMDR would bill Medicaid for non-specific psychotherapy sessions, which is typical practice.[57] The federal Centers for Medicare and Medicaid Services (CMS) approved the addition of the modifiers in late 2023, and eligible providers were able to bill for these services using the modifiers for services provided after July 1, 2023. Specific billing modifiers for HFW, MST, MCR, and FFT have been in effect in New Mexico prior to 2023.[58] 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.[59,60] With the addition of the modifiers, HCA should be able to track specific trauma-responsive interventions that are provided to children in 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.

Of the 3,083 children in custody at any point in 2025, 126 children (4%) received at least one session of HFW, MCR, DBT, MST, TF-CBT, FFT, or EMDR in 2025. After decreasing for the second consecutive year in 2024, the number of children in custody who received any indicated modality increased in 2025, returning to a number comparable to 2023 (see Table 6).[61,62] While the 2025 analysis includes additional modalities not measured in previous years (specifically DBT, TF-CBT, and EMDR), the increase in the number of children who received any indicated modality cannot be attributed to the inclusion of these modalities, as only one child received one of the additional modalities (EMDR) in 2025. The largest increase in EBP services from 2024 to 2025 was for HFW, which increased from 53 to 99 children provided with services, which was still fewer than the total number of children who received HFW services between 2019 and 2023.

[57] 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.
[58] 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.
[59] Additional information about NMSU COI can be found here.
[60] Billing guidance for each of the specific EBPs is available in the Behavioral Health Policy and Billing Manual, updated April 1, 2025, which can be found here.
[61] These data include services billed for children in custody regardless of age. Data presented in App. D, TO 1.2 (121 children) limits utilization data to applicable age ranges per EBP modality.
[62] Counts are based on analysis of data as submitted by the State; the Co-Neutral team has not validated each reported service.

Table 6: Children Who Received At Least One Session of HFW, MCR, DBT, MST, TF-CBT, FFT, or EMDR

2019 – 2025

Year	Total number of children in custody who received any indicated modality[63]	Children who received listed modality[64]						
		HFW	MCR	DBT	MST	TF-CBT	FFT	EMDR
2019	175	149	0	N/A	35	N/A	2	N/A
2020	196	171	0	N/A	20	N/A	8	N/A
2021	144	127	0	N/A	19	N/A	0	N/A
2022	152	135	0	N/A	18	N/A	1	N/A
2023	121	100[65]	0	N/A	21	N/A	1	N/A
2024	79	53	1	N/A	26	N/A	0	N/A
2025	126	99	0	0	28	0	0	1

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

As additional analysis to better understand the amount of non-specific therapeutic services provided to children in custody in 2025, the Co-Neutrals examined the number of children who received the following types of behavioral health services: psychiatric diagnostic evaluations; individual, group, or family therapy; and crisis intervention services. Of the 3,083 children in custody at any point in 2025, 1,211 children (39%) received at least one of these behavioral health services during the year. A total of 866 children received at least one diagnostic evaluation (1,248 total evaluations), 1,066 children received non-crisis behavioral health services (16,758 total services), and 27 children received crisis intervention services (37 total crisis services).[66]

[63] 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.

[64] 2025 is the first year the State provided the Co-Neutrals data on children receiving DBT, TF-CBT, and EMDR; it is possible that additional children received these services prior to 2025.

[65] HFW was a grant-only funded service prior to July 1, 2023, and became a Medicaid-billable service as of that date. The State did not provide the Co-Neutrals with data on children receiving HFW through the grant-funded program, but it is possible that additional children received HFW between January and June 2023.

[66] 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 delivered on the same date.

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 2025 data for this metric because it relies on a data collection process the State did not use consistently in 2025. 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 have been completed since then. Data from this survey tool or an alternative source will be necessary to validate this metric for 2026.

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

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 identified in the CANS screenings based on the CANS algorithm resulted in completed services. Due to the limited information documented in FACTS regarding referrals for and receipt of behavioral health services, the qualitative review could not assess whether the CANS screenings with identified service recommendations resulted in necessary referrals and service provision.

Discussion

Consistent with prior years, less than five percent of children in custody in 2025 received an EBP service specified in the FSA according to the Medicaid billing data. The number of children who received an EBP service increased from 2024, primarily due to more children receiving HFW. Also, 39 percent of children in custody at any point in 2025 received at least one session of a non-specific mental health service, such as a psychiatric diagnostic evaluation; individual, group, or family therapy; and crisis intervention services. While the EBP billing modifiers have been in effect since July 1, 2023, they did not appear to be in use by providers based on the 2025 billing data. It is possible that additional children in custody received an EBP service in 2025 that is not reflected in the billing data.

As discussed in App. A, TO 1c – *Completing Follow Up Screenings*, the State has not yet been able to effectively track the service recommendations that result from completed CAT and CANS screenings, therefore, it is not possible to assess whether services began timely or at all after an identified need.

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 2025.

The State's Trauma-Responsive Training and Coaching Plan was approved by the Co-Neutrals on December 5, 2022.[67] The approved Plan provides a framework for all CYFD staff, resource parents, respondent families, and designated HCA staff to receive trauma-responsive training appropriate to their role.[68] 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.

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 services to children in custody and their families, and MCO training staff and care coordinators.[69]

As part of the approved Trauma-Responsive Training and Coaching Plan, the State formed a Cross-Departmental Training Review Committee (CDTRC) in 2022 composed of CYFD and HCA staff from various departments, including HCA's Deputy of Clinical Services and/or their designee(s); Director

[67] The approved Trauma-Responsive Training and Coaching Plan can be found here.
[68] The FSA defines respondents as defendant(s) in an abuse and neglect case under the New Mexico Children's Code.
[69] The FSA defines designated HCA employees as Social and Community Services Coordinators; their supervisors and managers (including the BHSD Director); and any HCA employee or their designee involved in care coordination activities, EPSDT services, or determinations about service utilization for children in custody, including supervisory and management level employees.

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, 2025, there were 1,786 staff employed at CYFD, 1,441 of whom were required to receive trauma-responsive training based on a list of job titles submitted by the State. Of those 1,441 staff, CYFD reported that 29 (2%) completed the trauma training listed in the DVP (*Trauma: A Journey of Self-discovery (2025)*) during 2025. An additional 433 of these staff were counted as having received trauma training in 2024. Therefore, the total number of staff who were up-to-date on their trauma-responsive training as of December 31, 2025, was 462 (32%).

The training data submitted by HCA included 43 staff in the BHSD who were employed on December 31, 2025, and were required to receive trauma-responsive training.[70] Of these staff, 10 (23%) had a listed completion date in 2025 for trauma training developed under contract by Dr. Bobbi Beale.[71] Nine of these 10 staff completed their training within the first three months of employment, as required by the Trauma Training and Coaching Plan.[72]

> *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.*

> *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 State's data indicate that a total of 532 MCO staff completed trauma training in 2025.[73] There

[70] Four staff were excluded from the data due to incomplete hire date information which meant their employment status on December 31, 2025 could not be verified.
[71] The State contracted with Dr. Bobbi Beale in 2022 to develop trauma-responsive training. Both CYFD and HCA have integrated the training into their trauma-responsive training modules for staff.
[72] The Co-Neutrals were unable to validate the number of HCA staff trained in 2024 that received required refresher trainings in 2025, as there was no common identifier between the data sets submitted by the State for 2024 and 2025.
[73] The Trauma Training and Coaching Plan does not specify the names of the required trainings for MCO staff as well as other external staff and consultants.

were also 528 individuals who completed two modules of READi NM trauma trainings in 2025.[74] The data submitted by the State did not contain enough detail for the Co-Neutrals to determine the number of external staff, consultants, and resource parents who were required to receive trauma training.[75]

> *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 Co-Neutrals were unable to calculate this metric involving trauma training for respondent families in 2025 based on data submitted by the State.[76]

> *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 2025.

> *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 2025.

[74] READi NM is CYFD's pre-service training curriculum for resource parents. The two trauma training modules were listed as *READi NM Module 8: Trauma-Informed Support* and *READi NM Module 12: Trauma-Responsive Discipline*.

[75] The data files submitted by the State (*KS_NonStaffTraining 05.01.2026.xlsx* and *KS_Trauma_Training_MCO 05.01.2026.xlsx)* listed 2,121 external staff, consultants, and resource parents, 1,060 of whom were listed as having completed trauma training. However, the files did not contain enough information for the Co-Neutrals to determine whether 2,121 is the full universe of external staff, consultants, and resource parents required to receive trauma training (i.e., the denominator for this metric). The State submitted a supplemental file containing guidance on how to identify which staff in the Sandbox *Non-Staff Training* file should count towards this metric. Based on this guidance, the Co-Neutrals counted toward this metric individuals with User Type "Community," "Fictive Kin," "Relative," and "Unknown," as well as all individuals identified in the data as MCO staff; 605 individuals with User Type "Unknown" were counted towards this metric, 435 of whom completed two modules of READi NM trauma training.

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

ATO3.a – validation strategies.

From January through December 2025, 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 227 case workers and supervisors interviewed by Co-Neutral staff, 161 reported taking trauma-responsive training in 2025, and were asked to rate how useful the training was in preparing them to work with children and families. Slightly over half of staff (55%) interviewed rated the training as "extremely" or "very" useful.[77]

Table 7: Percentage Rating of Trauma-Responsive Training, by Staff Type
2025

Rating	All		Investigations		Licensing and Support		Permanency	
	N	%	N	%	N	%	N	%
Extremely useful	37	23%	9	16%	14	29%	14	26%
Very useful	51	32%	24	41%	13	27%	14	26%
Somewhat useful	49	30%	15	26%	13	27%	21	39%
Not so useful	19	12%	8	14%	7	14%	4	7%
Not at all useful	5	3%	2	3%	2	4%	1	2%
Total	**161**	**100%**	**58**	**100%**	**49**	**100%**	**54**	**100%**

Source: Co-Neutral Team Interviews with CYFD Case Workers and Supervisors, January – December 2025

Discussion

Since the approval of the Trauma-Responsive Training and Coaching Plan in 2022, CYFD and HCA have focused on the initial staff training modules identified in the Plan. In 2025, CYFD began expanding the trauma-responsive training offered to new and existing staff to include Nonviolent Crisis Prevention Intervention (CPI) training. Additionally, in late 2025, CYFD began efforts to expand the types of trauma-responsive training offered to staff and to develop advanced-level training for existing staff as committed to in the Plan.

Despite the efforts to develop additional training, both CYFD and HCA struggled with data collection in 2025 that prevented the State from clearly identifying all contractors, resource parents, and respondent families who were required to complete or completed training. Further, only 35 percent of CYFD staff and 23 percent of required HCA staff completed the trainings as required in 2025.

[77] Among the 73 staff who rated the training as "somewhat useful" or "not useful," 30 stated that the training was too broad and required more depth. When staff were asked if there were additional topics the training should have covered, 18 staff mentioned needing more in-depth explorations of different types of trauma, and 16 staff mentioned the need for more details on how to address trauma in practice (including de-escalation techniques).

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 2025.

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 2025.

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.

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 reports that trauma-responsive competency assessments are a required part of the trauma training, and an employee, provider, or contractor cannot be counted as having completed training without passing a competency assessment. The State reports that its performance for these metrics is the same as its performance on ATO3.a(i), which was two percent.

Discussion

Appendix A focuses on the development of a trauma-responsive system of care in which child welfare and behavioral health staff are equipped with the appropriate knowledge to identify and understand trauma, and the necessary skills and supports to provide trauma-responsive case practice in their work with children and families. While the State reports that the trainings taken by CYFD and HCA staff include competency assessments, the State's data collection issues prevent the Co-Neutrals from validating these data.[78]

[78] Additional information about the ARTIC scale can be found here.

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 2025.

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. The approved IPM Plan 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; 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 approved Plan as "a facilitated approach to conducting teaming meetings to support children and families involved with CYFD."[79] The current IPM Plan is applied as a framework across a number of CYFD's child and family team meeting types.

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 issues reported by the State, the Co-Neutrals were unable to validate the State's performance in 2025.[80]

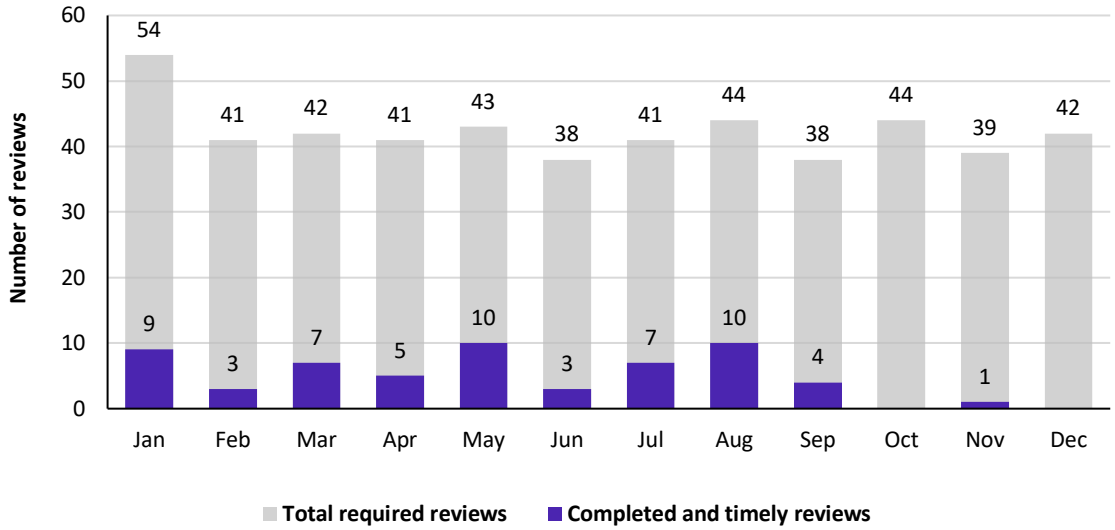
[79] IPM Plan, pg. 1. The State's current IPM Plan (titled "IPP" Plan) can be found here.

[80] The State reported a technical issue in FACTS that affected the quality of the data. Specifically, 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

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.

In 2025, there were a total of 507 30-day reviews required for a child who was missing or had run away. Fifty-nine (12%) of these reviews were conducted on time (see Figure 14).[81]

Figure 14: Required and Completed IPPs for Missing or Runaway Children, by Month
2025; N = 507 required IPPs (59 IPPs completed timely)



Source: Analysis of Sandbox Placements, Meetings, Cohort, and CourtDisposition files.

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 2025.

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 staffings 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.

[81] 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.

Discussion

In 2025, CYFD proposed changing the approved IPM Plan based on the recommendations of its consultant, Child Welfare Policy and Practice Group (CWG) and the Co-Neutrals due to on-going practice concerns and implementation challenges of the approved IPM Plan.[82] The State intends the revised IPM Plan to streamline the process of IPMs and to simplify the meeting types and requirements while still meeting the requirements set forth in the FSA.[83]

During 2025, many required IPP meetings were not documented as completed, both for children who were missing or who had run away from their placement, and for children placed in congregate facilities such as out-of-state (OOS) facilities, in-state clinical congregate settings, and shelters.[84]

[82] CYFD has worked with CWG since 2020 to develop and implement child and family teaming practice, among other responsibilities; CYFD ended its contract with CWG in 2026. More information on CWG can be found here.

[83] As of the writing of this report, the State has not submitted a revised IPM Plan to the Co-Neutrals for review and approval.

[84] Specific findings for these meetings can be found in App. B, TO 2.1 – *Joint Clinical Reviews of Out-of-State Placements*, App. B, TO 2.3 – *Out-of-State IPP Meeting and Development of Discharge Plans*, and App. B, TO 3.2 – *30-Day IPP Meetings for Clinical Congregate Care*.

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 2025.

Discussion

The State's "Phase 1" Quality Assurance, Improvement, and Evaluation Plan (QAIEP) was approved by the Co-Neutrals on December 9, 2022.[85] 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, the QAIEP Steering Committee, and the QAIEP Executive Leadership Team – were created as integral to implementing the QAIEP, and to support building a culture where policy and process decisions are driven by data. Additionally, as planned, an effectively implemented QAIEP would include data that are regularly shared with leadership and frontline staff to increase awareness, and to inform sustainable, effective changes for

[85] 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. The State's Phase 1 QAIEP can be found here.

improvement. As with prior years, significant staff turnover at both agencies inhibited progress toward implementation of the QAIEP. However, the State reports that QAIEP meetings resumed during the last quarter of 2025.

In 2023, CYFD added a *Kevin S.* unit to CYFD's 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. In 2025, OPA began developing internal reports that detailed the findings of these reviews as well as implications and suggestions for practice improvements. Additionally, CYFD and HCA requested funding through the New Mexico Legislature to expand the State's ability to conduct Quality Service Reviews (QSRs). QSRs involve completing case record reviews and interviews with individuals currently receiving agency services, which are used to identify both strengths and areas for improvement in the agency's practice. The funding was approved in April 2025, and became available on July 1, 2025.[86] The State contracted with NMSU's COI to use the QSR on PSD cases, with the first round completed in October 2025 and additional reviews to occur in 2026. A final report with findings from this review were not provided by the State to the Co-Neutrals.

[86] 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."[87] 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."[88]

In prior reports, the Co-Neutrals assessed that the State met the Performance Standard for all FSA Appendix B ITs.[89] There are 14 FSA Appendix B TOs discussed in this section of the report. They include the restrictions on child placements in out-of-state (OOS) facilities and CYFD offices; that children who are placed in OOS facilities receive monthly visits by workers they know; that placements in congregate care settings only be made pursuant to medical necessity or a best interest determination and that meetings are conducted and discharge plans are developed at regular intervals; that children experience placement stability and a limited number of non-family-based placements; that CYFD recruit and license a specified number of new non-relative resource homes each year; that children in need of treatment foster care (TFC) placements receive such placements; and that CYFD case workers have reasonable caseloads within the required limits.

In 2025, fewer children experienced office placements than in 2024 and the overall number of placements in offices decreased from 709 in 2024 to 449 in 2025. None of these placements were made pursuant to the extraordinary circumstances standard as necessary to protect the safety and security of the child. The number of new placements to OOS facilities in 2025 (35) remained relatively unchanged from 2024 (33). Placements in OOS facilities require a finding of both extraordinary circumstances and medical necessity – for the 35 OOS facility placements made in 2025, 31 percent were made pursuant to the medical necessary standard, and none (0%) were made due to extraordinary circumstances.

Data collected in 2025 on critical incidents experienced by children placed in these settings raise concern for children's safety and well-being. For example, there were 103 911 calls made during

[87] FSA, pg. 5a.
[88] Ibid.
[89] 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.*

children's placements in offices between August 18 and December 31, 2025, and 182 incidents of restraint and/or seclusion experienced by children placed in OOS facilities between October 1 and December 31, 2025.

Quantitative and qualitative data collected for children experiencing placements to OOS facilities, clinical and non-clinical congregate care settings, and shelters found that meetings are frequently not documented as occurring when required, and for those that do occur, the necessary team members are not present and/or the required discussion topics – such as discharge planning – are not documented. Specific findings from the quantitative data show:

- 34 percent of monthly meetings (96 of 284) for children placed in OOS facilities occurred on time (App. B, TO 2.1),
- Three percent of monthly meetings (4 of 152) for children placed in in-state clinical congregate care settings were documented as conducted on time (App. B, TO 3.1),
- Four percent of 90-day meetings (5 of 122) for children placed in non-clinical congregate care placements were documented as completed on time (App. B, TO 4.1), and
- One percent of required meetings (2 of 260) were held within 48-hours of shelter placements (App. B, TO 4.2).

The State recruited 51 percent of its 2025 annual target of new non-relative resource homes (134 of 265) by December 31, 2025, and 134 new TFC placements were made in 2025 (55% of the annual target). Fifty-three percent of the TFC placements in 2025 (38 of 72) that ended by December 31, 2025 lasted for less than one month. The Co-Neutral team's analysis of supplemental data provided by HCA and CYFD shows that while nearly all requests for TFC services are approved as medically necessary by the MCO, less than half of children referred for TFC placement in 2025 (47%, or 45 of 96) were placed in a TFC home.

Placement stability for children improved in 2025 (3.2 moves per 1,000 days) compared to 2024 (3.64 moves per 1,000 days), though it is not yet at the level established in the FSA.

Twenty-seven percent of children who had been in care between 12 and 23 months as of January 1, 2025 exited to permanency by December 31, 2025. Although the State's performance toward permanency exits exceeded the 40 percent target every year between 2020 and 2023, it has been far below those levels for the past two years.

A foundational and necessary component to positive outcomes in all FSA Appendices is that case workers have reasonable caseloads within required limits that allow them to engage, support, and plan for the children and families they serve. Of all workers assigned as primary on at least one case on December 15, 2025, 20 percent (74 of 376) had caseloads consistent with the caseload standards. Performance was highest for in-home services workers (57%), and lowest for investigation workers (9%). Fifteen percent of permanency workers and 25 percent of licensing and support specialists had compliant caseloads on that date.

b. Target Outcomes[90]

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 2025.

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.*

Ten percent of children in custody in 2025 (306 of 3,083) experienced a placement in at least one of the settings covered by this commitment: hotel/motel, office, or out-of-state (OOS) facility.[91,92] As shown in Table 8, this rate has decreased by four percentage points from 2024. In 2025, 306 children experienced a total of 485 applicable placements, most of which were CYFD office and Receiving Center placements (93%, 449 placements).

[90] Ibid.

[91] 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 submitted by the State on May 1, 2026, but did not appear in the real-time data. As a result, the Co-Neutral team reviewed most, but not all, office placements.

[92] 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 40 placements. The State corrected most of these discrepancies in the data. One of the uncorrected placements was recorded in the State's placement data as an out-of-state facility but was determined during qualitative review to be an acute hospitalization, which is not subject to the requirements of App. B, TO 1.

The number of children who experienced at least one placement to an office, hotel, or OOS facility grew by 269 percent between 2019 (83) and 2025 (306), despite an overall reduction by 21 percent (798) in the number of children in custody from 2019 (3,881 children) to 2025 (3,083 children).

Table 8: Children with any Placement to a Hotel/Motel, Office, or Out-of-State Facility
2020 – 2025

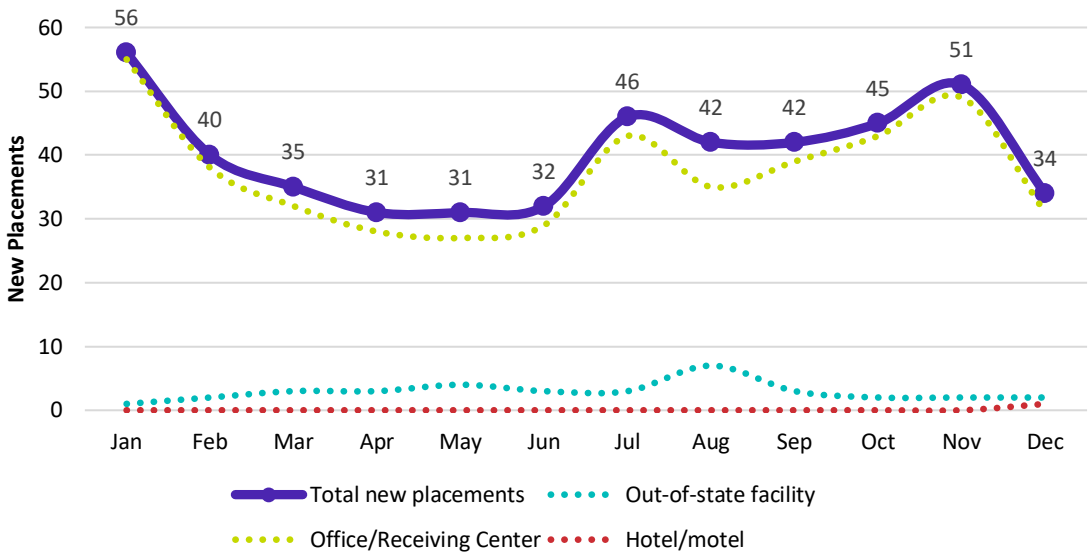
Category	2025 (N = 3,083)		2024 (N = 3,026)		2023 (N = 2,944)		2022 (N = 2,755)		2021 (N = 2,949)		2020 (N = 3,344)	
	N	%	N	%	N	%	N	%	N	%	N	%
Children with any placement in applicable setting[93]	306	10%	412	14%	199	7%	82	3%	102	4%	63	2%
Children with placement to any applicable setting, by type of setting												
Office (including Receiving Center)	293	10%	404	13%	185	6%	71	3%	85	3%	32	<1%
OOS facility	28	1%	32	1%	18	<1%	14	<1%	27	<1%	31	<1%
Hotel/motel	1	<1%	0	0%	0	0%	6	<1%	23	<1%	2	<1%

Source: Analysis of Sandbox Placements file

This metric is reported at the child level, in that a child with multiple placements to a hotel/motel, office, or OOS 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 in each placement type by month (see Figure 15 and Table 9). New placements in 2025 to applicable settings were highest in January (56), declined steadily from January through May, and then increased in July and November before falling in December.

[93] 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.

Figure 15: New Placements to Hotel/Motel, Office, and Out-of-State Facility, by Month
2025



Source: Analysis of Sandbox Placements file

Table 9: New Placements to Hotel/Motel, Office, and Out-of-State Facility, by Month
2025

Month	Total new placements	New placements by setting		
		Out-of-state facility	Office (including Receiving Center)	Hotel/motel
January	56	1	55	0
February	40	2	38	0
March	35	3	32	0
April	31	3	28	0
May	31	4	27	0
June	32	3	29	0
July	46	3	43	0
August	42	7	35	0
September	42	3	39	0
October	45	2	43	0
November	51	2	49	0
December	34	2	31	1
Total	**485**	**35**	**449**	**1**

Source: Analysis of Sandbox Placements file

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 OOS facility meets the extraordinary circumstances standard. The Co-Neutral team reviewed children's records to validate whether these placements met the extraordinary circumstances standard with required approvals. The Co-Neutral team determined that none of these children's placements met the extraordinary circumstances standard set forth by the Parties in Appendix B of the FSA.

BTO1.1(ii) – qualitative metric: Qualitative review of extraordinary circumstance determination for placements to hotels, motels, or offices.[94]

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.[95]

Office Placements

The Co-Neutral team reviewed 442 CYFD office and Receiving Center placements experienced by 280 unique children in 2025.[96] Of the 280 unique children, 21 percent were ages five and younger, 34 percent were between the ages of six and 11, 25 percent were ages 12 to 14, and 22 percent were age 15 to 17.

One-third of office placements lasted no more than two nights (33%, 146), and over half lasted five or more nights (54%, 239). In 2023, 21 percent of office placements reviewed were for seven or more nights; that category rose to 39 percent in 2024, and increased again in 2025 to 45 percent. Of the office stays that lasted seven or more nights, 61 percent of children were 12 years

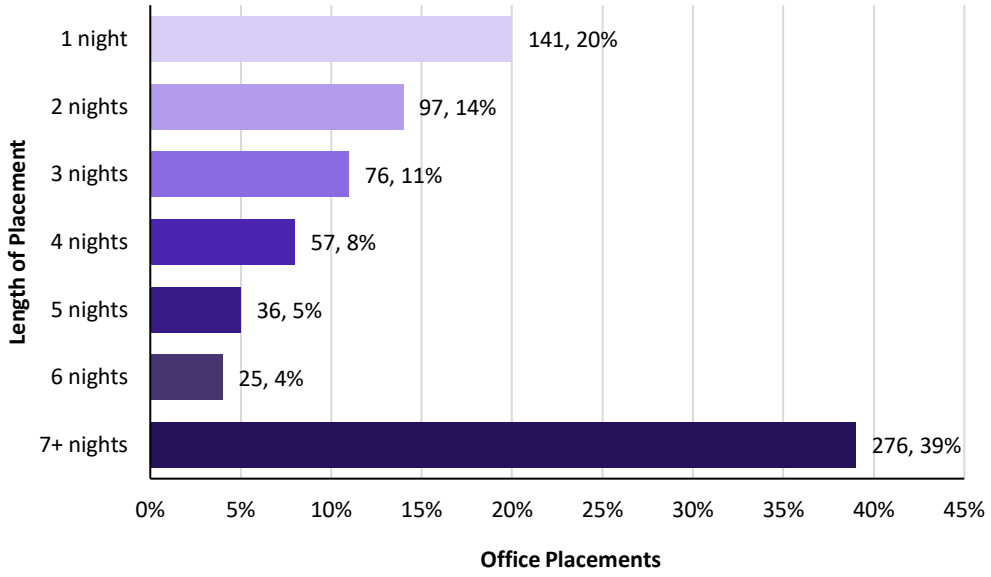
[94] In reviewing extraordinary circumstances determinations, the Co-Neutral team assessed whether documentation in the child's record demonstrated the placement was necessary to protect the safety and security of the child, and that the placement was approved by the CYFD Secretary or PSD Director prior 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.

[95] 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/or 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.

[96] 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 placements that appeared in the Sandbox placement data submitted by the State on May 1, 2026, but did not appear in the real-time data. As a result, the Co-Neutral team reviewed most, but not all, office placements. One hotel placement identified in the Sandbox data was not included in the Co-Neutral team's qualitative review.

old and older, and 39 percent were ages 11 and younger. The lengths of stay for the 442 office placements reviewed are shown in Figure 16.

Figure 16: Length of Stay of Office Placements Reviewed
2025



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

CYFD policy requires daily staffings when children are placed in offices to identify an appropriate placement. Of the 353 placements that lasted longer than one night, only 22 placements (6%) had documentation showing that daily staffings occurred for the length of the child's stay.

Of the 442 office placements that were reviewed, 33 percent were made following a discharge or disruption from a non-relative resource home (146), and 26 percent served as the child's first placement upon entering foster care (116). The next most common prior placement types were shelter (11%, 49), acute hospitalization (8%, 36), and relative resource home (7%, 29).

None (0%) of the 442 office placements in 2025 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. All records lacked documentation that referenced safety and security threats which necessitated the office placement, and documentation in FACTS does not show that a Memorandum for Decision (MFD) was submitted for approval of any of the placements.[97] The most common reasons cited for the office placement were the child disrupting from the prior

[97] A MFD is the CYFD template that case workers complete to request approval by a PSD Manager, Deputy Director, Director, and/or CYFD Secretary. For 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 due to their behavior without another placement secured, discharge from an acute hospitalization without a placement identified, and return from runaway and in need of a placement.

> *BTO1.1(iii) – qualitative metric: Qualitative review of extraordinary circumstance and medical necessity determinations for placements to out-of-state congregate settings.*[98]

Out-of-State Facility Placements

The number of new child placements in OOS facilities in 2025 (35) has more than doubled since 2022 (14 placements). The 35 placements in 2025 were experienced by 29 unique children; four children experienced two placements in OOS facilities during the year, and one child experienced three placements.[99] Demographics and other relevant information for the 29 unique children placed out of state are bulleted below:

- Nearly half were between the ages of 12 to 14 years old (45%, 13 children), 31 percent were between the ages of six to 11 (9 children), and 24 percent were ages 15 to 17 (7 children).
- The assigned permanency goal at the time of placement was adoption for most children (72%, 21 children), reunification for six children (21%), and planned permanent living arrangement (PPLA) for two children (7%).
- The most common diagnoses for children at the time of placement were: Post-Traumatic Stress Disorder (19 children); Attention-Deficit/Hyperactivity Disorder (17 children); Major Depressive Disorder (13 children); Disruptive Mood Dysregulation Disorder (10); and Oppositional Defiant Disorder (10 children).[100,101] Four of the children placed in an OOS facility had a diagnosis of Autism Spectrum Disorder and three of those four children also had a diagnosis related to intellectual disability or functioning.
- For the 35 placements reviewed, more than half of children (57%, 20 children) were placed in an acute hospitalization (10) or in another facility (10) immediately prior to the OOS facility. The other most common prior placement types prior to the OOS placement

[98] 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.

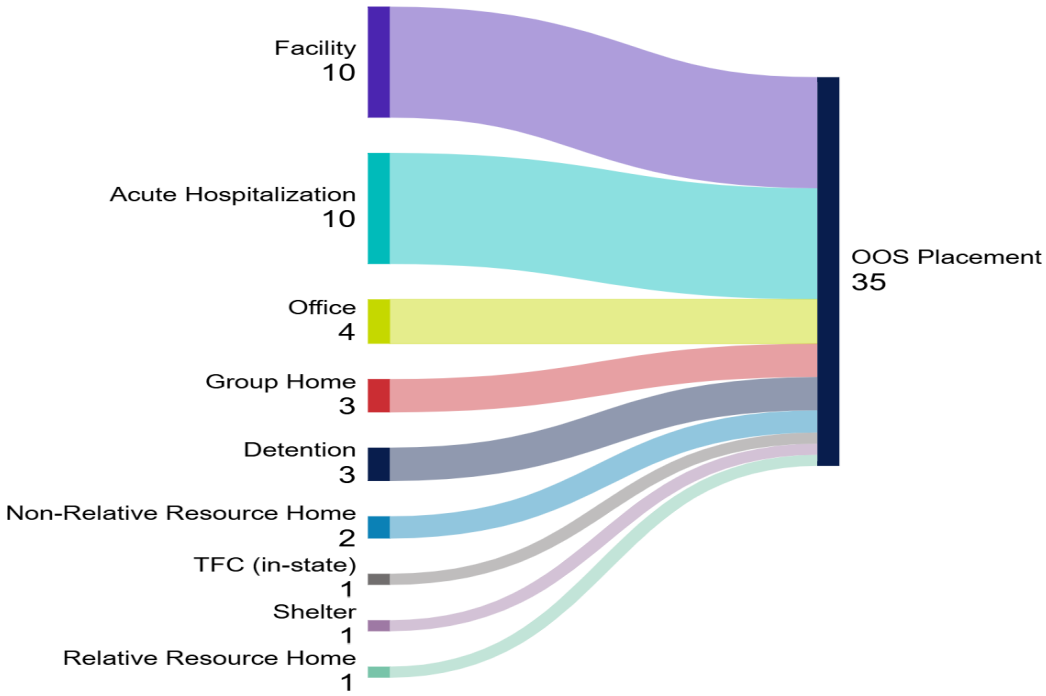
[99] The State pulled a universe of OOS facility placements for the review that included 35 placements experienced by 29 unique children. The quantitative data provided by the State as part of its annual data submission included 35 placements experienced by 28 unique children, thus, there is a small difference between the quantitative and qualitative analysis.

[100] Reviewers were unable to find a diagnosis for two children prior to their out-of-state placement within the records available for the review.

[101] Most children had multiple diagnoses. Diagnoses at the time of each of the 35 placements are included as several of the 29 unique children with multiple placements had different diagnoses at the time of each placement.

were office or Receiving Center (11%, 4 children), group home or community home (9%, 3 children), and detention (9%, 3 children).

Figure 17: Placement Prior to OOS Placement
2025



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

Extraordinary Circumstances

The FSA requires the State to ensure that a child's OOS placement in a facility meets both the extraordinary circumstances standard and is medically necessary. Also, "[t]he finding of medical necessity must take into consideration whether community-based mental health services have been or could be provided."[102]

The Co-Neutrals assessed that none (0%) of the 35 OOS facility placements in 2025 were made pursuant to extraordinary circumstances necessary to protect the safety and security of the child, as required by FSA Appendix B. Thirteen of the OOS placements (37%) included no documented reference to safety and security threats. The most common issues noted were aggression, self-harm, runaway behaviors, inability to regulate emotions, and sexual behaviors.

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

[102] FSA, pg. 6a.

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 five (14%) of the 35 OOS congregate placements.[103]

Medical Necessity

Reviewers from CYFD OPA 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 35 OOS placements reviewed, FACTS and MCO documentation showed that the placement was made pursuant to the medical necessity standard in 11 placements (31%); a decline from 2024 when 59 percent of placements met medical necessity. Of the 24 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 18 placements, a determination of medical necessity was made by the MCO but such determination was not documented as taking into account whether community-based services had 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.[104] 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 OOS 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 25 of the 35 OOS placements. The following participants attended the 25 meetings: PC worker (18 meetings); PC supervisor (19 meetings); CBHC (24 meetings); MCO care coordinator (18 meetings); child or youth's GAL or Youth Attorney (YA) (10 meetings); child or youth (6 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 25 completed triage meetings, documentation from case records shows that a recent behavioral health evaluation was provided prior to one meeting.[105]

Discussion

The 10 percent of children in custody in 2025 who experienced a placement in an office or OOS facility is a decline from 2024 (14%). The number of new office placements in 2025 (449) is a

[103] For three placements, an MFD was completed and submitted but was not documented as approved by the CYFD Secretary or PSD Director prior to the placement. All five MFDs that were approved by the CYFD Secretary or PSD Director were also approved by the HCA Secretary or Deputy Secretary.
[104] CYFD's *Permanency Planning Procedures* (8.10.8 NMAC), paragraph 11.3. 8.10.8 NMAC can be found here.
[105] For 28 placements – including 18 placements that had a documented triage team meeting – there was no recent behavioral health evaluation available.

decline from 2024 (709), while the number of new OOS facility placements rose slightly (from 33 in 2024 to 35 in 2025). Although the FSA requires that children's placements in offices and OOS facilities only be made due to extraordinary circumstances to protect the safety and security of a child, the Co-Neutrals assessed that none of the children's placements in office or OOS facilities in 2025 met this standard. In fact, data show that many children placed within these settings experienced critical incidents that could create threats to the child's safety, security, and well-being.[106]

Office Placements

Five years into FSA implementation, CYFD's continued practice in 2025 of placing children in offices remained sharply at odds with the FSA. Between August 18 and December 31, 2025, CYFD reported 124 critical incidents within office placement settings. These include 103 calls to 911, 10 allegations of abuse or neglect, three allegations of harm to a child, three serious injuries, one suicide attempt, one allegation of restraint, and three incidents categorized as "other."[107] In reviewing these data and following the Co-Neutrals' conversations with scores of CYFD staff in Bernalillo County, the Co-Neutrals concluded that the practice of housing children in offices poses an immediate danger to children, youth, and staff.[108]

The Co-Neutral team interviewed 227 CYFD case managers and supervisors from all regions of the state between January and December 2025, and asked about their experiences with children staying in CYFD offices. At the time of the interview, 50 percent of staff stated that their offices were experiencing children's overnight office stays; Region 3 had the highest percentage of staff reporting this practice (93%), followed by Region 5 (62%), Region 4 (46%), Region 1 (40%), and Region 2 (5%). Seventy-nine percent of staff reported that they had been asked to volunteer or had been assigned to stay overnight with children in the office in recent months. More than half (56%) of staff stated that they are sometimes expected to spend their regularly scheduled on-call shifts supervising children placed in the offices.

In January 2026, Governor Lujan Grisham signed Executive Order 2026-003 which prohibits the placement of any child overnight in CYFD offices for any reason, effective March 1, 2026. In December 2025, CYFD provided the Co-Neutrals with a list of 29 children who were placed in a CYFD office or the Receiving Center for whom planning was underway to identify a new placement.[109] Approximately one-third of these 29 children (34%, 10 children) were ages 16 and 17, 21 percent were ages 13 to 15 (6 children), 28 percent were ages 10 to 12 (8 children), and 17

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[106] Pursuant to RO#2, the parties agreed to a definition of critical incidents which identifies the following: any fatality; any near fatality to mean when a child experiences a serious or critical condition; any serious injury that requires medical attention or hospitalization; any suicide attempt; any allegation of restraint/seclusion; any change in licensure within any facility; any 911 call for a child placed in hotels, motels, out-of-state, or in congregate care; and allegations of abuse or neglect of children in custody.

[107] Other critical incidents include an alleged physical assault on a staff by a child, a child who identified as wanting to self-harm, and a child who ran away from the office.

[108] The Co-Neutrals' January 30, 2026 Arbitration Report provides additional information on these critical incidents and can be found here. Data in this report differ slightly from the Arbitration Report as additional critical incidents were identified following publication of the January 2026 report.

[109] CYFD initially identified 30 children, but the Co-Neutral team assessed that one of the children listed had moved from their office placement in November 2024.

percent were ages five to seven (5 children). Over half (59%, 17 children) were cases managed by Bernalillo County.

The Co-Neutral team reviewed the records for these 29 children and determined that all were moved from CYFD offices by early March 2026. The most common placements after the office for the 29 children were non-relative resource home (6), acute hospitalization (5), and group home (5). Case records for 22 children showed that they did not experience any additional placement moves after their transition from the office, five children had one additional placement move, and two children had two additional placement moves as of March 9, 2026. The Table below shows children's placements following the office, and as of March 9, 2026.

Table 10: Placement Types Following Move from CYFD Office and as of March 9, 2026
December 17, 2025 – March 9, 2026

Placement Type	Number of Children Placed Following Discharge from Office	Number of Children Placed as of March 9, 2026
Non-Relative Resource Home	6	8
Relative Resource Home	0	1
TFC	2	2
Return to Parent or Trial Home Visit	2	2
Acute Hospitalization	5	3
Group Home	5	2
Shelter	3	4
Valley Home	4	2
Independent Living Placement	2	2
Detention	0	2
Runaway Status	0	1
Total	**29**	**29**

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

There was limited documentation in case records regarding what services were provided or planned for the 29 children after they moved from the office. For 22 children, case records included some documentation of at least one of the services included in the Table below. The documentation may have referenced an identified need for the service or that the service was being provided to the child.

Table 11: Services or Supports Provided or Identified for Children Moved from CYFD Office
N = 22 children[110]

Type of Service/Support	Number of children
Medication Management	12
Outpatient Therapy – Individual	12
Outpatient Therapy – Family	4
HFW	4
Other Evidence-Based Practice	4
Foster Care Plus (FC+) Support[111]	2

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

Ten of the 22 children were identified as receiving or recommended for one of these services. Nine children were identified as receiving or recommended for two services and three children were receiving or recommended for three or four services. One child was recommended for individual therapy but declined to participate.

Out-of-State Facility Placements

Between October 1 and December 31, 2025, there were 182 incidents of restraint and/or seclusion experienced by children placed in OOS facilities. The State did not consistently nor uniformly report these incidents to the Co-Neutrals, and the Co-Neutrals were unable to confirm that the State was tracking and monitoring these incidents on a routine basis. The Co-Neutrals asked the State repeatedly for a policy or guidelines for the use of restraint and seclusion for children in custody, and were informed that it did not exist at that time and was under development.[112]

During the case review of the 35 OOS placements made in 2025, reviewers from CYFD OPA and the Co-Neutral team assessed what information CYFD and/or HCA collected about the safety record of the facility prior to the decision to place the child in the facility. This information was absent in the records for most (26) of the 35 placements reviewed. For six placements, documentation showed that the team confirmed that the license for the facility was active.

[110] Unique children may receive and/or be recommended for more than one service.
[111] Foster Care Plus (FC+) is a therapeutic treatment program provided in relative and non-relative resource homes and is designed to help children with elevated behavioral health needs begin to heal from their trauma. One component of the program is providing resource parents with clinically supported guidance on what therapeutic approaches are needed based on each child's clinical needs in order for them to experience empathic, predictable and nurturing care and build trust.
[112] The Co-Neutrals' January 30, 2026 Arbitration Report provides additional information on these critical incidents and can be found here.

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 2025.

The Joint Clinical Review (JCR) process is outlined in paragraph 11.4 of CYFD's *Permanency Planning Procedures* (8.10.8 NMAC). The procedure states that the JCR is a process for children who are placed in OOS 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 should 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 OOS facility, GAL or YA, Tribal representative (as applicable), and representative from the Office of Tribal Affairs (OTA) (as applicable).

DVP Metrics and Validated Performance Data

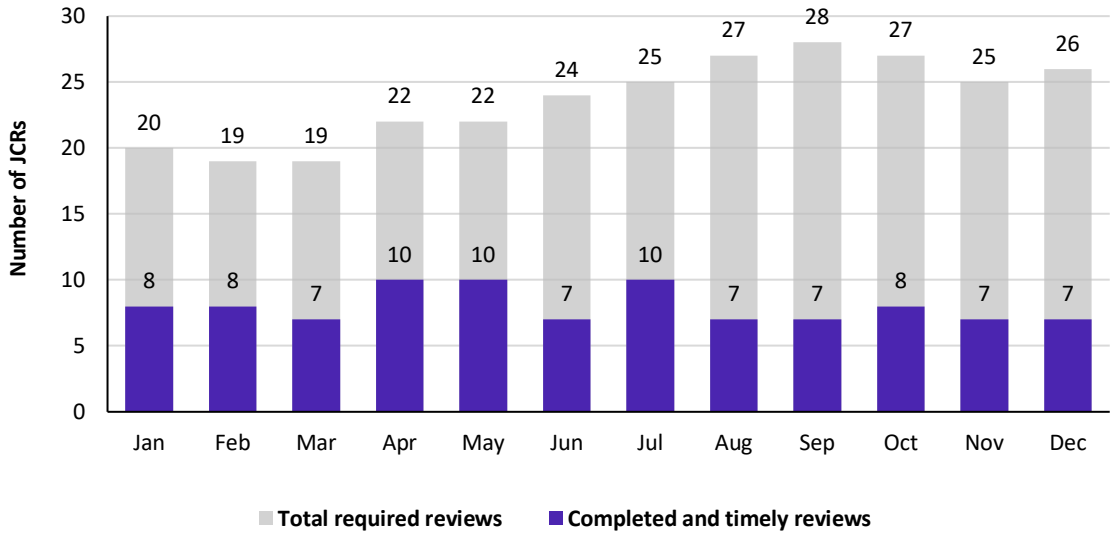
BTO2.1(i) – primary metric: Of all the joint clinical reviews required during the reporting year, the percent that were conducted timely.

There were 284 JCR meetings required in 2025 for children in OOS facilities, and approximately one-third (34%, 96) were conducted on time.[113] This is a slight increase from 2024 performance (32%). A higher percentage of required JCR meetings were conducted on time during the first half of 2025 (40%) compared to the second half of 2025 (29%).

[113] 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 18: Required and Completed Joint Clinical Review Meetings for Out-of-State Placements, by Month

2025; N = 284 required reviews



Source: Analysis of Sandbox Placements and Meetings

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

Reviewers from CYFD OPA and the Co-Neutral team reviewed the FACTS and MCO records for all placements of children who were in OOS facilities between January and November 2025, including children placed out-of-state prior to 2025 who remained in those placements for at least 30 days in 2025.[114] For the 50 placements reviewed (involving 43 unique children), a total of 254 JCR meetings were required between January and November 2025. Reviewers confirmed that 100 JCR meetings (39%) were documented as completed.[115] None of the completed JCR meetings (0%) 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.

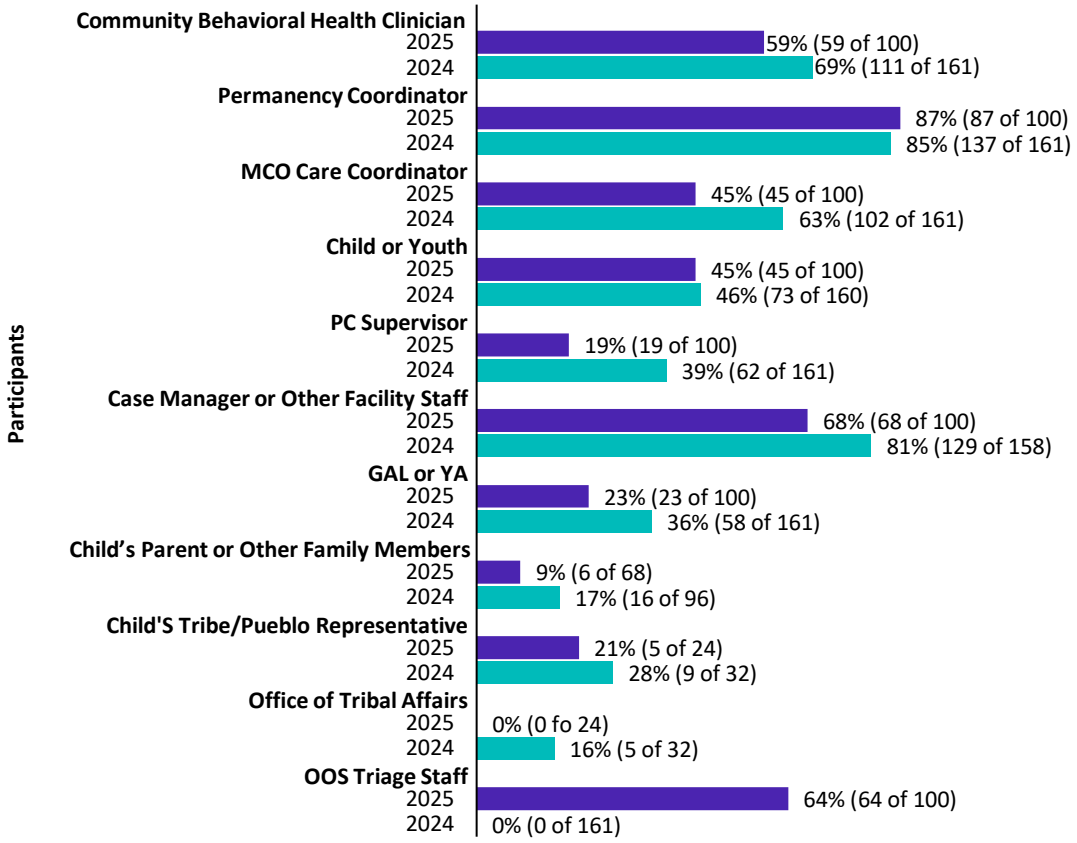
Of the 100 JCR meetings that were documented as completed between January and November 2025, the PC case worker (87%) and case manager or other staff from the facility (68%) were the most consistently documented attendees in the meetings (see Figure 19). An OOS triage staff was present in 64 percent of meetings, the CBHC worker attended 59 percent of meetings, and the

[114] The review was conducted in January 2026; to account for possible delays in data entry and receipt of medical necessity documentation, performance during the month of December 2025 was not assessed for most App B, TO 2. metrics.

[115] 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.

MCO care coordinator was present in less than half (45%) of meetings.[116]

Figure 19: Documented Participants in Completed Joint Clinical Review Meetings
2024 - 2025

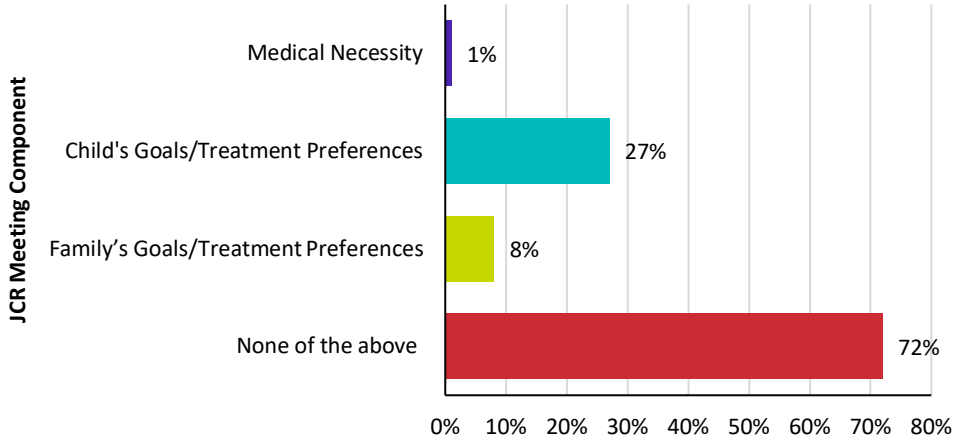


Source: Case record review of FACTS and MCO documentation conducted by CYFD OPA staff and Co-Neutral team

As shown in Figure 20, nearly three-quarters of the meetings (72%) 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.

[116] In August 2024, CYFD created a new unit comprised of a secondary assigned OOS triage worker who visits monthly with the child. 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.

Figure 20: JCR Meeting Components Discussed
2025; N = 100



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

Discussion

The quantitative data show that timely completion of JCR meetings occurred in approximately one-third of required instances (34%). Of the JCR meetings that the qualitative review determined were to be held at any point during an applicable month, 72 percent lacked documentation that any of the required meeting components were discussed.

The CYFD OPA review team conducted interviews with the primary case worker assigned to 13 of the children whose OOS placements were reviewed. Though only 39 percent of meetings required between January and November 2025 were documented as completed, most case workers identified few barriers to completing monthly meetings. Case workers shared that meetings may have occurred but were not always named or entered into FACTS with the language used to measure compliance with this FSA commitment. Three case workers noted barriers in communicating and scheduling with the OOS facility.

Interviews were also conducted with three children whose OOS placements were reviewed. None of the children reported that they were included in the decision-making process for the OOS placement that they experienced, and only one child was aware of monthly meetings being held to discuss their progress and discharge planning. Two of the three children reported that the placement was the best option for them at that time, and the same two children responded affirmatively when asked if they felt like their case worker was including them in decisions that are made about their placements and services.

Out-of-State IPP Meeting and Development of Discharge Plans (App. B, TO 2.3) [117]

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 2025.

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 OOS facilities. 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'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 2025 data for this metric because it relies on a data

[117] Although out of sequence, this report discusses App. B, TO 2.3 prior to discussion of App. B, TO 2.2 in order to provide a more comprehensive assessment of discharge planning during JCR meetings.

collection process that the State was not using consistently in 2025. 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 have been completed since then. Data from this survey tool or an alternative source will be necessary to validate this metric for 2026.

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

Reviewers from CYFD OPA and the Co-Neutral team reviewed the FACTS and MCO records for all children who were in OOS facilities for at least 30 days in 2025 to determine if monthly discharge plans were 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 254 required monthly discharge plans between January and November 2025, 13 plans (5%) were documented that included at least one of the required components; none (0%) of the plans included all required components.[118] The 13 plans were developed for eight (16%) of the 50 placements reviewed, meaning there was no discharge plan documented in FACTS as developed during monthly JCR meetings for most (84%) children's placements.

Of the 13 discharge plans that were developed, 10 plans documented the steps necessary to promote discharge (related to 5 of the 50 placements), two plans identified available community-based mental health services and supports that could be provided (related to 2 of the 50 placements), and two plans identified in-state resources that need to be developed for the child to return to New Mexico (related to 2 of the 50 placements).

Discussion

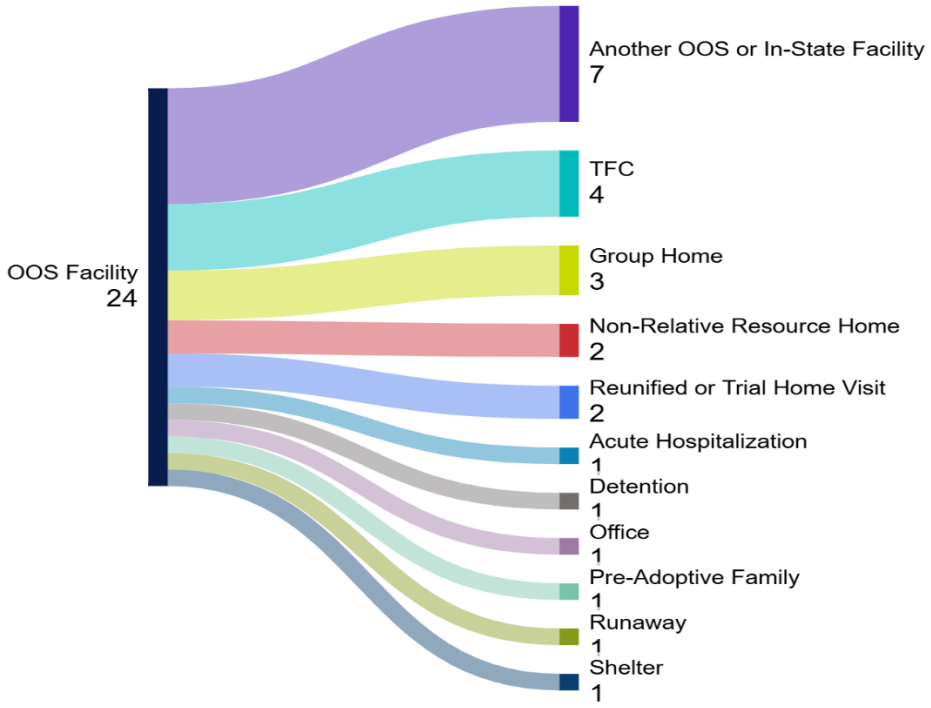
Documentation of practice in 2025 shows that discharge planning was documented for only 16 percent of the OOS placements reviewed (8 of 50). Absent or inadequate discharge planning caused some children to remain in restrictive OOS settings longer than medically necessary. Of the 50 OOS facility placements in 2025 that were reviewed, CYFD or MCO documentation showed that six of these OOS placements (12%) were assessed by either the MCO or the child's treatment team as no longer medically necessary and that the child was ready for discharge but remained in the facility. The most common reasons cited for their continued stays were insufficient discharge planning and inability to secure an appropriate placement in New Mexico. These six children remained in the placements for between 28 days and five months longer than was medically necessary.

There were 24 children who were discharged from OOS facilities in 2025. Upon discharge, seven children were placed in another OOS or in-state facility; five children were placed in a group

[118] One plan included two of the required components.

home, shelter, or office; and four children were placed in a TFC home. Data for all placements upon discharge are shown in Figure 21.

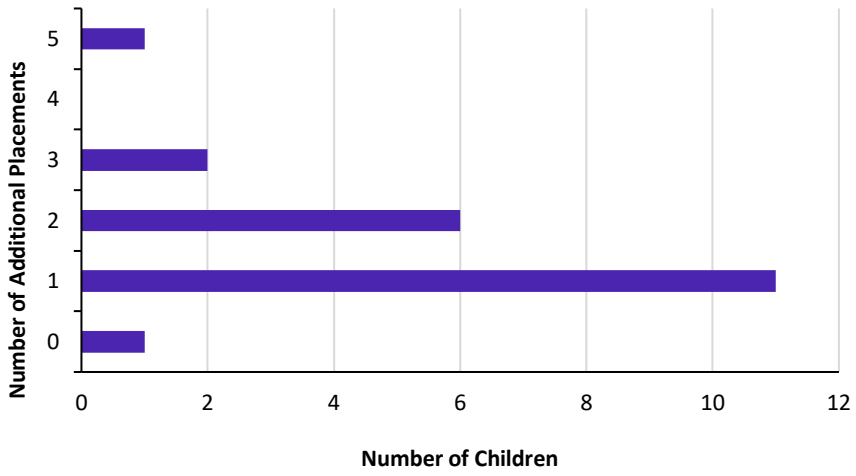
Figure 21: Placement Following Discharge from Out-of-State Facility
2025; N = 24



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

Of the 21 children who did not return home or were on runaway following their discharge, reviewers examined how many additional placements the children experienced within 90 days. Forty-two percent of children had three or more placements within 90 days after discharge from the OOS facility (Figure 22).

Figure 22: Number of Placements within 90 Days Following Discharge from Out-of-State Facility
2025; N = 21



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

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 2025.

Monthly visits to children in OOS 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. 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 a 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 was no longer allowed to travel out of state to visit with the child, and was 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.*

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).[119]

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.[120,121]

BTO2.2(ii) – qualitative metric: Validation of known worker indicator.[122]

Reviewers from CYFD OPA and the Co-Neutral team reviewed the FACTS records for all children placed out-of-state for at least 30 days in 2025 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 primary 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 60 percent of the 50 OOS placements (30), the child experienced at least one change in their assigned primary worker during their time in the OOS placement; nine children had three or four different primary workers assigned during

[119] If the placement began before the start of the reporting year, the first visit was due in January.
[120] In 2025, data submitted by the State show there were 44 children in OOS facilities for at least 30 days during the reporting year, with a total of 270 visits required; the State's data show that 262 of those visits (97%) were conducted on time by any person, not limited to a case worker known to the child. These data were unable to be validated during the qualitative review.
[121] Quantitative data submitted by the State for the 270 visits due for 44 children placed in OOS facilities show 203 visits (75%) were completed on time and by a case worker recorded in FACTS as "known to the child." These data were unable to be validated during the qualitative review; the CYFD OPA and Co-Neutral team's qualitative review of children's FACTS records identified performance was 19 percent.
[122] Since 2020, 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.

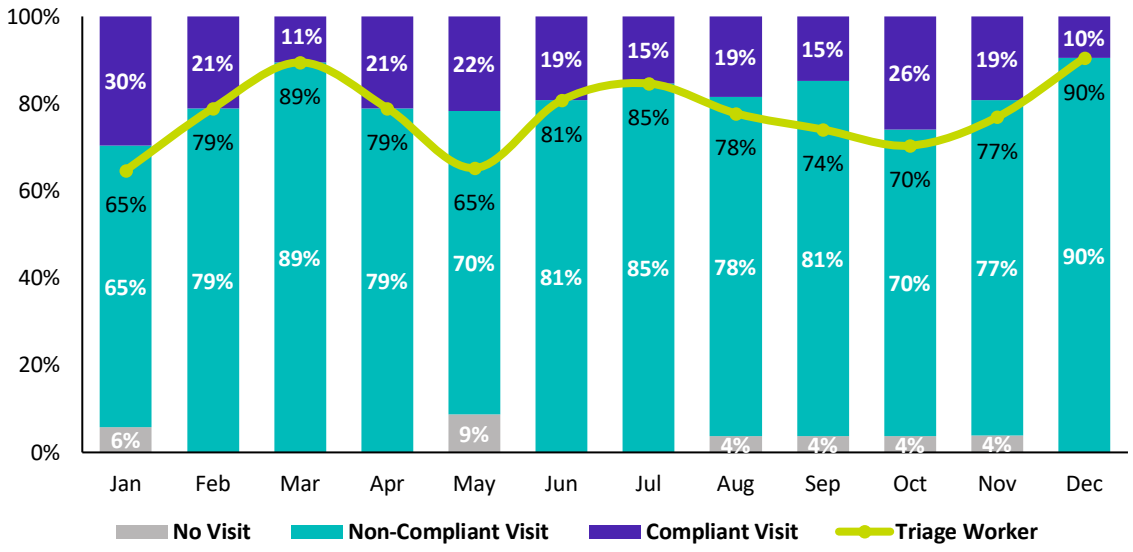
their OOS placement, and 10 children had five or six workers assigned during their placement.[123]

Prior to the case reviews collecting data for 2025 performance, the Co-Neutrals and CYFD QA staff requested clarity from CYFD on any written 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 met the FSA requirement.

Of the 277 required worker visits between January and December 2025 identified during the qualitative review, 13 visits were completed by the child's primary PC (5%). One additional visit was completed by the assigned worker's supervisor (<1%), and 38 visits were completed by a worker known to the child as approved by the supervisor (14%). Thus, based upon documentation in the children's records, 19 percent of required visits in 2025 were conducted by a worker known to the child. Three percent of required visits in 2025 were not documented as completed at all.

Performance ranged monthly between 10 and 30 percent (Figure 23). A monthly range of 65 to 90 percent of visits were completed by an OOS triage worker.

Figure 23: Worker Visits to Children Placed Out-of-State, Required and Completed
January - December 2025



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

[123] Seven of the 10 children who experienced five or six different primary workers during their placement were managed through Bernalillo County.

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, evaluating their treatment progress, planning for their discharge, and maintaining connections when they are far from home. The data show CYFD has changed practice expectations and guidance for staff on how these visits should be conducted and who is responsible for conducting them; this needs to be communicated in written policy and procedure for accountability, consistency, and transparency.

The CYFD review team conducted interviews with the primary case worker assigned to 13 of the children whose OOS placements were reviewed. Four of the primary case workers reported having visited the child in person while they were placed out-of-state. These visits occurred on a three or six-month basis, with the OOS triage worker conducting monthly visits. Primary case workers reported having good communication with the OOS triage worker, either through phone conversations, by reviewing notes entered into FACTS from the triage worker's visits, and/or through their participation in team meetings.

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 2025.

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:

- essential to prevent, diagnose or treat medical conditions or are essential to enable the child to attain, maintain or regain functional capacity;
- 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;
- provided within professionally accepted standards of practice and national guidelines; and

- 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.[124]

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.

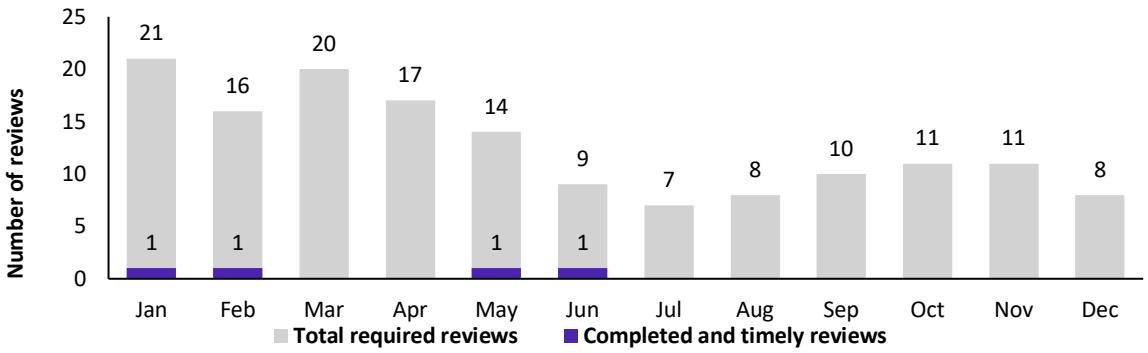
DVP Metrics and Validated Performance Data

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 clinical congregate care placement at least every 30 days.[125] There were 152 required medical necessity reviews for children in clinical congregate care settings in 2025, and four of these (3%) were conducted on time.[126] There were more reviews required in the first half of 2025 (97) compared to the second (55), and all four timely reviews were completed in the first half of the year (see Figure 24).

Figure 24: Required and Completed Reviews for In-State Clinical Congregate Placements, by Month

2025



Source: Analysis of Sandbox Placements and Meetings files

[124] NMSA § 1978, 32A-6A-4(T). CYFD's Procedure mirrors most of the Children's Code definition of medically necessary with the exception of the last bullet. In CYFD's procedure, the last bullet states, "are required to meet the physical and behavioral health needs of the child or youth and are not primarily for the convenience of the child or youth."

[125] Before validation of 2025 performance began, the DVP was revised to exclude OOS facility placements from the requirements of App. B, TO 3, as such placements are already covered by App. B, TO 1. As a result, the quantitative findings from 2025 for App. B, TO 3 are not comparable to the findings from past years.

[126] 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. 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.

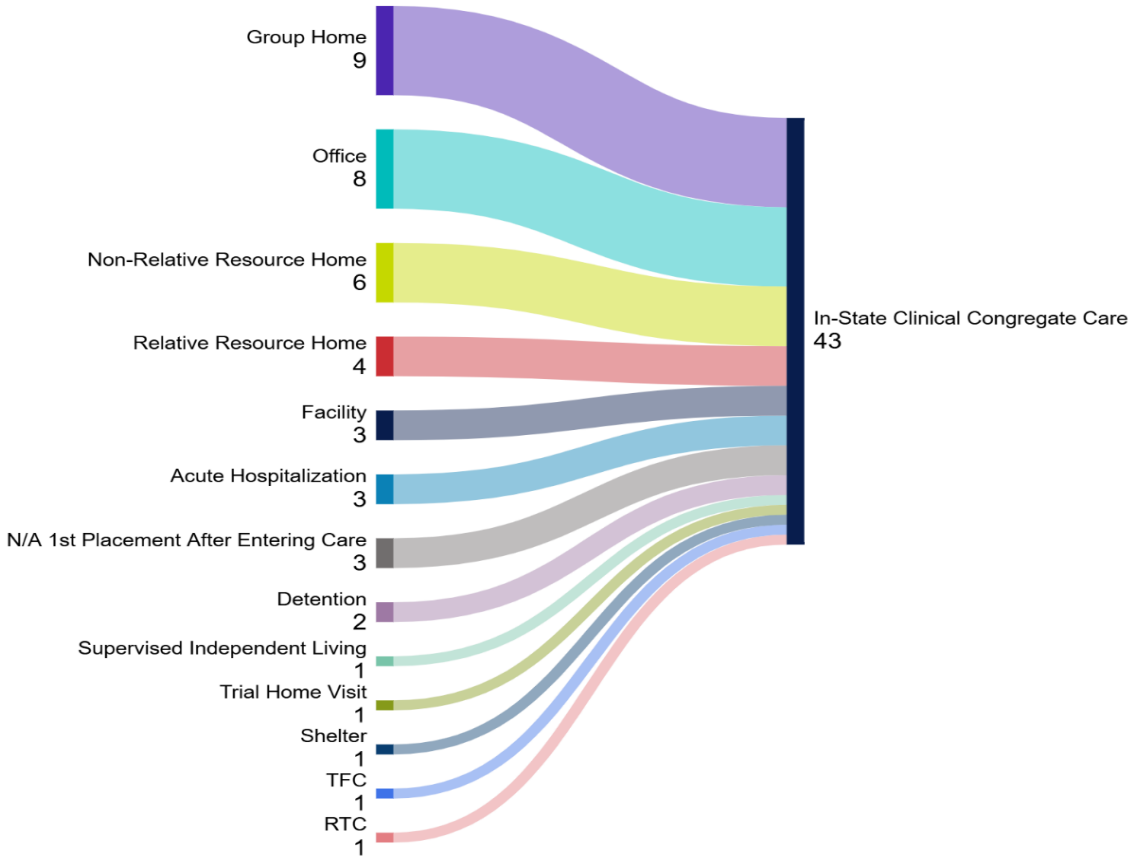
BTO3.1(ii) – qualitative metric: Qualitative review of medical necessity determinations for placements to congregate settings.

Reviewers from CYFD OPA and the Co-Neutral team reviewed the FACTS and MCO records for children who were newly placed in clinical congregate care in New Mexico between January and December 2025 to assess whether a medical necessity determination had been made to support clinical congregate care for the child. The review included 43 placements experienced by 37 unique children.[127,128] The most common diagnoses of the children at the time of placement were: Attention Deficit Hyperactivity Disorder, Post-Traumatic Stress Disorder, Major Depressive Disorder, and Disruptive Mood Dysregulation Disorder. Five of the children placed in an in-state clinical congregate care setting had a diagnosis related to intellectual disability or functioning including three children diagnosed with Autism Spectrum Disorder.[129,130]

Forty percent of children were placed in either a group home (21%) or CYFD office (19%) immediately prior to the in-state clinical congregate placement (Figure 25). The other most common prior placement types were non-relative resource home (14%) and resource home (9%).

[127] Six children experienced two in-state clinical congregate placements in 2025.
[128] The State pulled the universe of in-state congregate care placements for the review. Following the completion of the review and in assessing the State's 2025 data submission, the Co-Neutrals identified inconsistencies in how some placements were categorized due to lack of clarity in the DVP and/or how placement service types were entered by workers in FACTS. Thus, the qualitative review includes eight placements that are not included in the quantitative data discussed earlier in this section but were assessed by the review team as being in-state clinical congregate care placements. Additionally, four clinical congregate care placements that were made in 2025 and lasted less than 30 days were not included in the qualitative review.
[129] Reviewers were unable to find a diagnosis for 14 children prior to their clinical congregate care placement within the records available for the review.
[130] Most children had multiple diagnoses. Diagnoses at the time of each of the 43 placements are included as several of the 37 unique children with multiple placements had different diagnoses documented at the time of each placement.

Figure 25: Placement Prior to In-State Clinical Congregate Placement of Placements Reviewed
2025



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

Of the 43 clinical congregate placements reviewed, 17 placements began as acute hospitalizations and lasted longer than 30 days (40%). At the time each of the acute hospitalizations were made, documentation shows that the placement was medically necessary due to the child exhibiting either suicidal or homicidal ideations, behavior that posed imminent safety concerns, or an emergency medical condition that required intervention.

Of the remaining 26 clinical congregate care placements, eight had documented medical necessity determinations by the MCO for the initial placement, and reviewers assessed that three of those took into consideration whether community-based mental health services had been or could have been provided. Overall, for the 26 applicable (non-acute) placements, 12 percent were made pursuant to the FSA medical necessity standard (3 placements).

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 23 placements that did not meet the medical necessity standard, none included documentation supporting that the placement was in the child's best interest (0%).

One of the 43 placements had a documented IPP or child and family team meeting prior to the placement.

Discussion

In response to practice issues identified during case record reviews in prior years, CYFD OPA and the Co-Neutral team collected data in 2025 on how many of the in-state clinical congregate care placements began as acute hospitalizations and were intended to be short term to address an immediate need. As discussed above, 40 percent of the placements reviewed were made for the purpose of acute care, and the child remained within the acute hospital setting for 30 days or longer. The State has committed to reducing the number of days children spend in acute hospitals as part of the metrics to measure implementation of the Behavioral Health Workforce Development Review (App. D, TO 1). Specifically, the State committed to decrease by five percent the number of days all children in custody spend in acute inpatient hospitalization per every 1,000 days during a 12-month period, with a target to decrease acute hospitalizations by five percent each year.

The State's quantitative data show that only four of the 152 required medical necessity reviews for children placed in-state in clinical congregate care settings in 2025 were conducted on time. And qualitative data collected by reviewers from CYFD and the Co-Neutral team show only 12 percent of applicable placements had documentation that the placement was made pursuant to the FSA medical necessity standard.

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 2025.

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. Similar to the JCR monthly meetings for children placed in OOS facilities, 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 2025 data for this metric because it relies on a data collection process the State did not use consistently in 2025. 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 have been completed since then. Data from this survey tool or an alternative source will be necessary to validate this metric for 2026.

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

Reviewers from CYFD OPA and the Co-Neutral team reviewed the FACTS and MCO records for children who were placed in clinical congregate care facilities in New Mexico between January and December 2025, including children placed in 2023 and 2024 who remained in those placements for at least 30 days in 2025. In total, there were 58 placements experienced by 51 unique children.[131] Fifty-two percent of placements were in facilities (30), 21 percent were in residential treatment centers (12), and 12 percent were in group homes (7).[132,133]

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

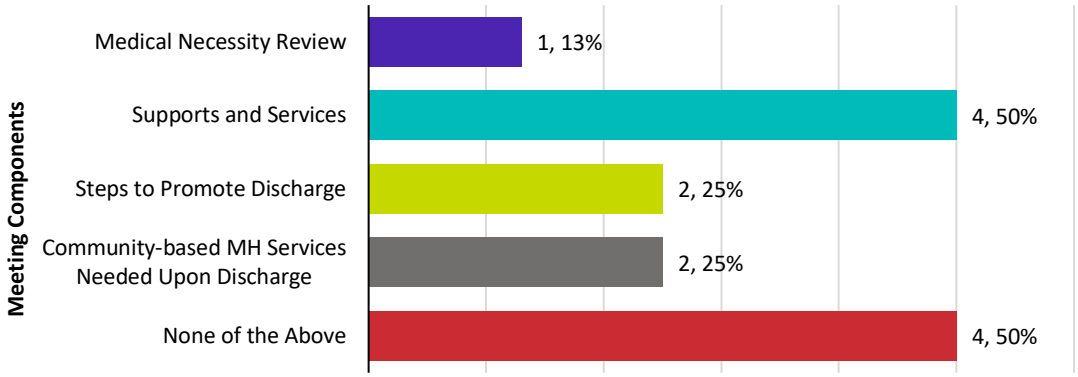
- Half of children were ages 15 to 17 years old (50%, 29) at the time of placement, and almost one-third were 12 to 14 years old (29%). Ten children (17%) were between the ages of seven and 11, one child was six years old, and one child was three years old at the time of placement.[134]
- The assigned permanency goal at the time of placement for the 51 children was reunification for over half (57%, 29), adoption for 31 percent (16), planned permanent living arrangement (PPLA) for six percent (3), permanent guardianship for four percent (2), and one child was in custody pursuant to a voluntary placement agreement.

[131] Five children experienced two in-state clinical congregate placements in 2025, and one child experienced three placements.
[132] The remaining nine placements were with three providers that were inconsistently entered into FACTS by workers as either a community home, supervised independent living placement, or "facility special arranged." CYFD confirmed that each of these placements were to congregate care facilities that provided clinical services to children.
[133] Placements reviewed were with the following providers: Healing Addiction DBA Serenity Mesa (13); Peak Psychiatric Hospital (12); Sequoyah Treatment Center (7); AMI Kids – Sandoval Inc (5); Mesilla Valley Hospital (4); New Mexico Behavioral Health CARE (3); Presbyterian Hospital (3); University of NM Hospital – BCMC (3); Carrie Tingley Hospital (2); Casa Angelica (2); New Mexico Behavioral Health LLC (2); Children's Psychiatric Hospital (1); and Evershine Care LLC (1).
[134] Both young children were placed at Casa Angelica.

- For 18 (31%) of the placements reviewed, the child experienced a change in their assigned primary PC case worker between the time they were placed and through the duration of their placement.[135]

For the 58 placements reviewed, a total of 117 IPP meetings to discuss discharge planning were required between January and December 2025.[136] Reviewers confirmed that eight meetings (7%) were documented in FACTS as completed, and these eight meetings involved four unique children.[137,138] None (0%) of the eight completed meetings 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 (4 meetings), and a review of the child's continued medical necessity to remain in the placement was documented as reviewed in one of the eight meetings (Figure 26).

Figure 26: In-State Clinical Congregate Placement IPP Meeting Components Discussed
2025; N = 8



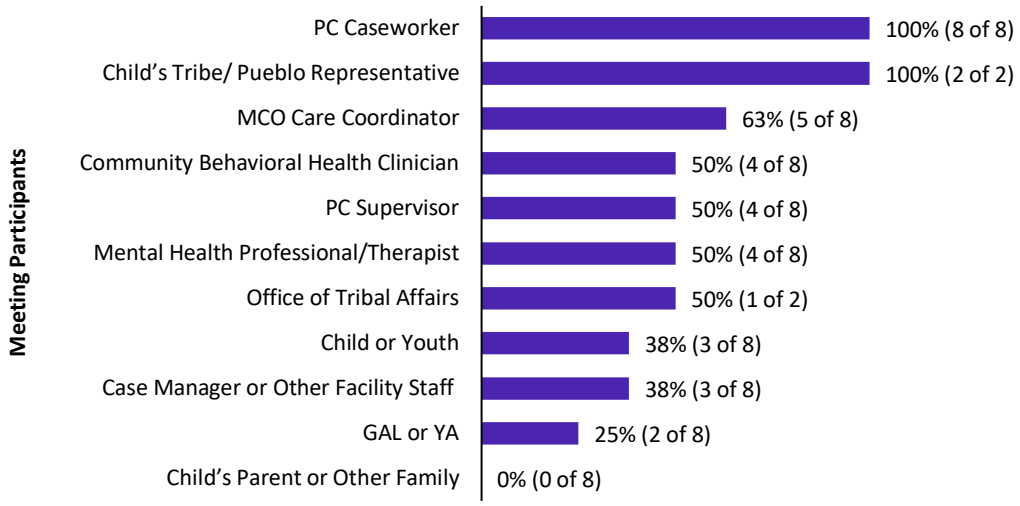
Source: Case record review of FACTS and MCO documentation conducted by CYFD OPA staff and Co-Neutral team

[135] Ten of the children's cases with changes in the assigned primary case worker were managed by Bernalillo County, and two of these children had five different primary case workers assigned during the length of their placement.
[136] To provide more current performance data to CYFD on these metrics, two reviews covering six-month periods under review were conducted – one for January through June 2025, and the second for July through December 2025. Required meetings limited to each of these six-month periods (the periods under review) were assessed.
[137] One child had three meetings documented, two children had two meetings documented, and one child had one meeting documented. All meetings occurred between January and July 2025; there were no meetings documented for any of the applicable placements between August and December 2025. Completed meetings were for cases managed by Dona Ana County (5 meetings), McKinley County (2 meetings), and Grant County (1 meeting).
[138] 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.

Of the eight IPP meetings that were documented as completed in 2025, the PC case worker (100%) and the MCO care coordinator (63%) were the most consistently documented attendees in the meetings (see Figure 27). The CBHC worker was present in 50 percent of meetings, and the PC supervisor attended 50 percent of meetings. Of the two meetings that involved a Native child, a Tribal representative was present in both meetings, and OTA attended one of the meetings.

Figure 27: Documented Participants in Completed IPP Meetings for Children Placed In-State Clinical Congregate Care Placements

January - December 2025



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

Discussion

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

The CYFD review team conducted interviews with the primary case worker assigned to 18 of the children whose placements were reviewed. When asked why meetings did not occur prior to the placement under review, case workers cited the following reasons: the urgent need for the placement prohibited a meeting, guidance from their supervisor that a meeting was not needed, and/or that other types of meetings or staffings had been held instead. Additional barriers identified to meetings being completed were case workers' inability to coordinate schedules with all team members, high case worker caseloads and competing priorities, and a general lack of sufficient time.

Interviews were also conducted with eight children whose placements were reviewed. Six of the eight children reported that they were included in the decision process for the in-state clinical congregate care placement, and four children reported that the placement was the best option for them at that time. When asked if they felt like their case worker was including them in decisions that are made about their placements and services, seven of the eight children responded

affirmatively. Although only a small number of children were interviewed, the data provide examples of positive communication and collaboration between children and their case workers even if this is not occurring during documented IPP meetings.

A lack of team meetings and discharge planning impacts how long children remain in higher and more restrictive levels of placement and in the appropriateness and stability they experience in their next placement. In 11 of the 58 placements reviewed (19%), though medical necessity may have been determined for the initial placement decision, the placements were determined at some point to no longer be medically necessary. However, the children remained in the placement, primarily due to the lack of an appropriate alternative placement when the child was ready for discharge.

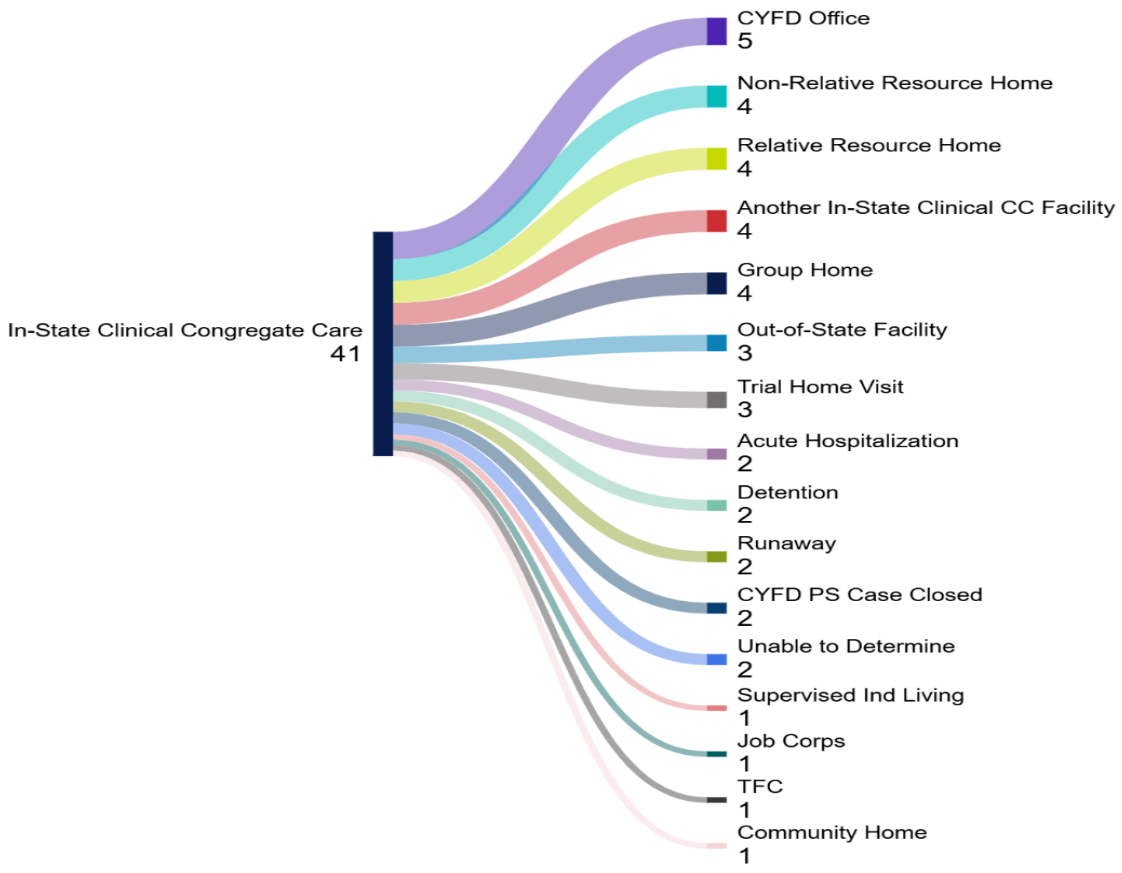
The State's 2025 *Kevin S.* Annual Report states the following regarding the information collected during the CYFD OPA and Co-Neutral teams' qualitative review:

> *The documentation reflects that discharge plans did not show clear or consistent updates from month to month. Documentation across multiple youth files reflected repeated discharge goals, missing IPM or team meeting notes, and limited evidence of follow-up on identified plans. In several cases, discharge discussions were not documented at all, or progress updates appeared only at the point of discharge. Systematic issues such as TFC placement denials, behavioral incidents, and lack of coordination between agencies contributed to delays and incomplete planning records. Overall, the evidence suggest that discharge plans lacked continuity and actionable monthly updates necessary for successful transitions into lower levels of care.*[139]

Of the 58 placements reviewed, 41 placements ended during the period under review. The most frequent placement after discharge from the clinical congregate care placement was a CYFD office (5), non-relative resource home (4), relative resource home (4), another in-state clinical congregate care facility (4), group home (4), and OOS facility (3) (Figure 28). There was documentation of services in place to meet the child's needs upon discharge in less than half (39%, 16) of the 41 placement records.

[139] State's 2025 *Kevin S* Annual Report, pg.40. The report is available here.

Figure 28: Placement Following Discharge from Clinical Congregate Facility
2025; N = 41



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

Similar to the review of children in OOS placements, reviewers identified the use of physical and chemical restraints as well as seclusion for children in in-state clinical congregate placements. Of the 58 placements reviewed, 29 percent documented at least one instance of use of chemical restraint (17 placements), 19 percent documented at least one instance of physical restraint (11 placements), and five percent documented at least one instance of use of seclusion (3 placements).

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 2025.

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 the placement is in the child's best interest.[140] 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.

An IPP team is required to review the determination of best interest for a child's non-clinical congregate placement at least every 90 days. There were 122 required best interest reviews for children in non-clinical congregate settings in 2025, and five of these (4%) were conducted on

[140] 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."

time.[141,142,143] This performance is similar to prior years.

BTO4.1(ii) – qualitative metric: Qualitative review of best interest determinations for placements to congregate settings.[144]

Reviewers from CYFD and the Co-Neutral team reviewed the FACTS records for a random sample of non-clinical congregate placements – including group homes, community homes, and supervised independent living facilities – made between January and December 2025. The sample included 77 placements experienced by 68 unique children.[145,146] Demographic and other relevant information are bulleted below:

- Of the 68 children reviewed, the average age at the time of non-clinical congregate placement was 14; over half of the children were age 15 and older (57%, 39), one-quarter were between the ages of 12 and 14 (25%, 17), six children were between the ages of seven and 11 (9%), and six children were between the ages of two and six (9%).
- The assigned permanency goal at the time of placement for the 68 children reviewed was reunification for over half of children (54%, 37), adoption for 29 percent of children (20), other planned permanent arrangement (PPLA) for 12 percent of children (8), and permanent guardianship for four percent of children (3).
- For the 77 placements reviewed, 25 children (32%) 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%, 19 placements) and group home, shelter, or community home (22%, 17 placements).

[141] There were 34 children with one review due, 20 children with two reviews due, eight children with three reviews due, and six children with four reviews due.
[142] The five completed reviews were for five unique children.
[143] 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.
[144] 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.
[145] The State pulled the universe of non-clinical congregate care placements for the review. The State's data included 99 new non-clinical congregate care placements that began in 2025; sampling represents a 95% confidence interval with a <6% 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. Following completion of the review and in assessing the State's 2025 data submission, the Co-Neutrals identified inconsistencies in how some placements were categorized due to lack of clarity in the DVP and/or how placement service types were entered by workers in FACTS. Thus, the data used for the qualitative review differs slightly from the quantitative data discussed earlier in this section. Placements included in the qualitative review sample were assessed by the review team as being in-state non-clinical congregate care placements.
[146] 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.

The CYFD OPA and 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 77 placements, and none showed that the best interest standard was affirmatively determined by an IPP team (0%). For five 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.

Of the 77 non-clinical congregate care placements reviewed, 19 of the placements lasted 90 days or longer and required an additional IPP meeting.[147,148] The team reviewed documentation in FACTS for each of the 19 placements, and none (0%) showed that an IPP team met to discuss if the child's continued placement was in their best interest.

Discussion

Documentation of practice in 2025 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.

The CYFD review team conducted interviews with the primary case worker or supervisor assigned to 38 of the children whose placements were reviewed. Similar to the interview responses collected for clinical congregate care placements, when asked why meetings did not occur prior to the placement under review, case workers cited the following reasons: there were informal meetings held with CYFD staff but these did not meet the IPP requirements for participants and documentation; efforts were focused on finding a placement for the child and there was insufficient time to convene as a team; and/or the case worker was unaware that a meeting was required.[149]

Additional barriers to meetings being completed were case workers reporting that they do not have enough time to complete what is required in every case, the urgent need to secure a placement preventing the ability to schedule a meeting, and difficulty coordinating schedules with all meeting attendees.

Interviews were also conducted with 19 youth whose placements were reviewed. Eight of the 19 youth reported that they were included in the decision process for the congregate care placement, and 10 youth reported that the placement was the best option for them at that time.

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[147] To provide more current performance data to CYFD on these metrics, two reviews covering six-month periods under review were conducted – one for January through June 2025, and the second for July through December 2025. Required meetings limited to each of these six-month periods (the periods under review) were assessed.

[148] Eighteen of the placements were for 90 days or longer and the 90 days was beyond the end of the period under review (either June 30, 2025 or December 31, 2025).

[149] Sixteen of the staff interviewed were unaware of the policy surrounding congregate care placements and meeting requirements.

When asked if they felt like their case worker was including them in decisions that are made about their placements and services, 10 of 19 youth responded affirmatively.

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 2025.

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 260 48-hour shelter placement reviews required in 2025, and two of them (1%) were conducted on time.[150] Of the 258 required shelter placement reviews in 2025 that were not conducted on time, 17 were conducted late (after 48 hours) and 241 were not conducted at all. The late reviews occurred an average of 52 days after the shelter placement.[151] The percentage of

[150] 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.

[151] For late meetings, there were often multiple shelter placements that occurred before the meeting took

required shelter placement reviews conducted on time has decreased every year since 2022 (see Table 12).

Table 12: Required and Completed 48-Hour Reviews for Shelter Placements, by Year
2022 - 2025

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%
2025	260	2	1%

Source: Analysis of Sandbox Placements and Meetings 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 2025 data for this metric because it relies on a data collection process that the State did not use consistently in 2025. 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 have been completed since then. Data from this survey tool or an alternative source will be necessary to validate this metric for 2026.

BTO4.2(ii) – qualitative metric: Qualitative review of extraordinary circumstance determinations for placements to emergency shelter.[152]

The Co-Neutral team reviewed a random sample of 107 shelter placements experienced by 85 unique children to determine if the placements were made pursuant to extraordinary circumstances necessary to protect the safety and security of the child, as required by FSA Appendix B.[153] Demographic and other relevant information are bulleted below:

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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 March 29th and April 8th and the earliest meeting for either placement was on May 11th, the 43 days from March 29th to May 11th and the 33 days from April 8th to March 11th would both be included in the average.

[152] 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.

[153] The Co-Neutral team pulled the universe of shelter placements using real-time data provided by the State in 2025. Samples representing a 95% confidence interval with a 10% margin of error were pulled from

- Over one-third of the 85 children were aged 15 or older (36%), 45 percent were between the ages of 12 and 14, 14 percent were between the ages of seven and 11, and four children were six or younger (5%).
- For the 107 placements reviewed, 31 children (29%) were placed in a CYFD office immediately prior to the shelter placement. The other most common prior placement types were non-relative resource home (19%, 20 placements) or another shelter placement (20%, 21 placements). For 13 children (12%), the shelter placement was their first placement upon entering foster care.
- Most children (71%) had a permanency goal of reunification, 22 percent had a goal of adoption, six percent had a goal of permanent guardianship, and one child (1%) had a goal of planned permanent living arrangement (PPLA).

The Co-Neutral team reviewed documentation in FACTS for the sample of 107 placements, and none of the shelter placements identified specific safety and security threats which necessitated the shelter placement (0%). Most children's records had limited documentation on what other placement and support options were considered prior to the shelter placement, and other records noted challenges engaging with the child's relatives for placement or was made due to no other placements being identified for the child despite applications being sent statewide to resource homes, shelters, and other congregate care facilities. For 15 shelter placements, documentation in the child's record showed that a TFC placement had been recommended for the child but placement had not been secured.

For 10 shelter placements reviewed there was a pre-placement IPP meeting held; the child's primary PC attended eight meetings, CBHC worker attended six meetings, PC's supervisor attended four meetings, MCO care coordinator attended two meetings, the GAL or YA attended one meeting, and the child attended one meeting.

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

Of the sample of 107 shelter placements reviewed by the Co-Neutral team, 13 of the placements lasted for less than 48 hours. Documentation in FACTS for the remaining 94 placements was reviewed, and none (0%) had documentation of a meeting within 48 hours of the placement.

Discussion

Documentation of practice in 2025 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

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the universe of placements made between January and June 2025, and the universe of placements made between July and December 2025. Following completion of the review and in assessing the State's 2025 data submission, the Co-Neutrals identified inconsistencies in how some placements were categorized due to lack of clarity in the DVP and/or how placement service types were entered by workers in FACTS. Thus, the data used for the qualitative review differs slightly from the quantitative data discussed earlier in this section. Placements included in the qualitative review sample were assessed by the review team as being shelter placements.

lowest level since 2022.

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 2025.

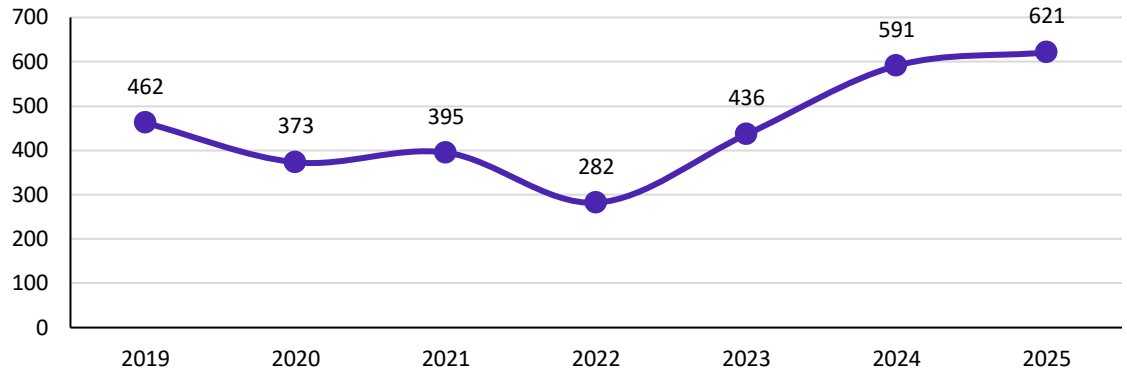
Paragraph 10 of CYFD's *Permanency Planning Procedures* (8.10.8 NMAC) requires that every child be placed in a licensed foster home placement unless a current finding of medical necessity requires placement in a clinical congregate setting, or an IPP team determines that a non-clinical setting is in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

DVP Metrics and Validated Performance Data

BTO5.1(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 State's data show that in 2025, 20 percent of children (621 of 3,083) experienced at least one placement to a setting that was not a licensed resource home.[154] This is the same percentage as in 2024 (20%, or 591 of 3,026), and continues to be the highest annual percentage of children placed in settings other than licensed homes since reporting began in 2019 (see Figure 29).

Figure 29: Children with Placements to Settings Other Than Licensed Foster Homes
2019 - 2025



Source: Analysis of Sandbox Placements and ProviderLicenses files

[154] Licensed resource homes include relative, non-relative, fictive kin, pre-adoptive, or TFC placements.

Of these 621 children, 134 children (22%) experienced at least one placement in a resource home that was not licensed at the time of placement. Nearly half of these children (46%, or 61 of 134) spent 10 or fewer days in that setting before it was licensed, and 21 percent spent 60 or more days in that setting before it was licensed (28 of 134).[155]

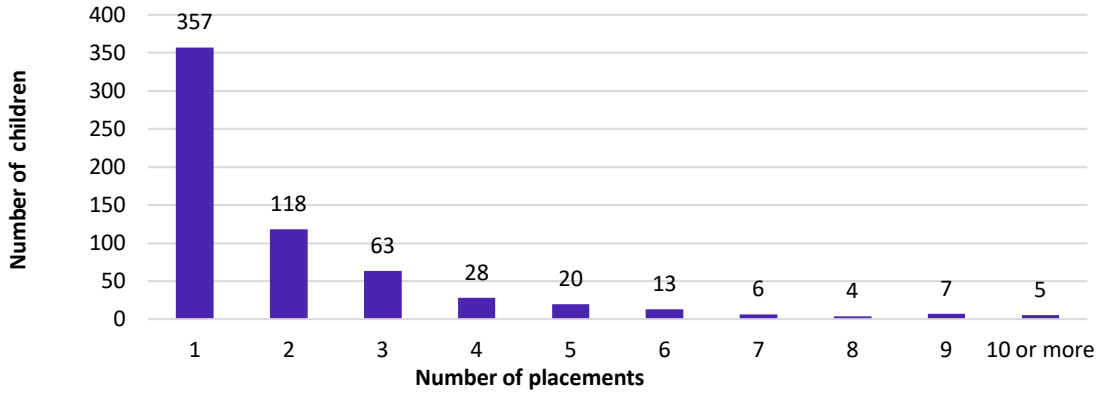
Table 13: Children with Placements to Resource Homes Not Licensed at Time of Placement
2019 - 2025

Placement setting	2025		2024	2023	2022	2021	2020	2019
	N=3,083		N=3,026	N=2,944	N=2,755	N=2,949	N=3,344	N=3,881
	N	%						
Resource Family Home (Relative)	66	2%	3%	2%	2%	2%	1%	1%
Resource Family Home (Fictive Kin)	9	<1%	1%	1%	<1%	<1%	<1%	<1%
Resource Family Home (Non-Relative)	59	2%	<1%	<1%	<1%	0%	<1%	<1%
Pre-Adoptive Family	3	<1%	0%	0%	0%	0%	<1%	0%

Source: Analysis of Sandbox Placement and ProviderLicenses files

In 2025, over half of the children who experienced a new placement in a setting other than a licensed resource home experienced only one of these placements (57%, 357 children) (see Figure 30). More than one-third had two to six of these placements in 2025 (39%, 242 children), and 22 children experienced more than six of these placements (4%).

Figure 30: Distribution of the Number of Placements to Settings Other Than Licensed Resource Homes Per Child
2025



Source: Analysis of Sandbox Placements and ProviderLicenses files

[155] Five children spent 11 to 20 cumulative days in unlicensed resource homes, 18 children spent 21 to 60 days in unlicensed resource homes, and 28 children spent more than 60 days in unlicensed resource homes.

ICWA-eligible children were equally likely as children identified as other racial or ethnic groups in the cohort to experience at least one placement to a setting other than a licensed resource home (20%, or 70 of 342).[156] Black (non-Hispanic) children were more likely to experience a placement to a setting other than a licensed resource home (27%, or 37 of 136).

> *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 2025 has remained consistent with 2024, and continues to be the highest level since 2019 when reporting began.

[156] These 70 ICWA-eligible children experienced a total of 139 placements to a setting other than a licensed resource home. Of these 139 placements, the biggest group was the office and Receiving Center (36%, 50), followed by shelters (39, 28%). Only nine children were placed in unlicensed relative resource homes (13 total placements).

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 2025.

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 non-relative resource homes in New Mexico 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. The Co-Neutrals approved a recruitment target for 2025 of 265 newly licensed non-relative resource homes.[157] CYFD recruited 134 homes in 2025, 51 percent of the target.[158,159] The number of new non-relative homes licensed each month ranged between five and 24 (see Table 14).

[157] The Co-Neutrals and the State worked together to estimate current need in late 2022 using the Annie E. Casey Foundation's Wildfire Foster Home Estimator 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 new non-relative resource homes licensed for 2024 and 2025.

[158] Ahead of the 2025 report, the Co-Neutral team and the State agreed to adjust the methodology to include only homes with the license type "Foster Care" and exclude homes with the license type "Specialized Foster Care," which were previously counted. In past Annual Reports, the Co-Neutrals had understood based on guidance from the State that a license type of "Specialized Foster Care" indicated a non-relative resource home; the Co-Neutrals' final performance calculations for this metric were the same as or very close to the State's. However, during revisions of the DVP ahead of this report, the State informed the Co-Neutrals that a license type of "Specialized Foster Care" does not necessarily indicate a non-relative resource home and may include relative homes. Using the methodology from previous years that includes homes with a license of "Specialized Foster Care," the number of newly licensed resource homes in 2025 would be 286. Due to this change, performance in prior years is not included for comparison.

[159] The count of new non-relative homes for 2025 based on the DVP methodology was 141. However, based on findings from the Co-Neutral team's qualitative review, eight homes were removed from the total number of new non-relative homes and one was added, bringing the total number of homes counted towards the target to 134. Additionally, these data differ from what was included in the Co-Neutrals' January 30, 2026 Arbitration Report; in an effort to provide analysis of current performance and prior to the State's formal submission of the 2025 data, the Co-Neutrals' Arbitration report utilized a different data source than what is identified in the DVP.

Table 14: New Active Non-Relative Resource Homes Recruited, by Month License was First Active and Effective[160]

2025

Month license was first active and effective	Number of homes recruited
All months	**134**
January	15
February	5
March	8
April	6
May	13
June	10
July	9
August	9
September	8
October	15
November	14
December	24

Source: Analysis of Sandbox ActiveProviders file, with adjustments based on qualitative review

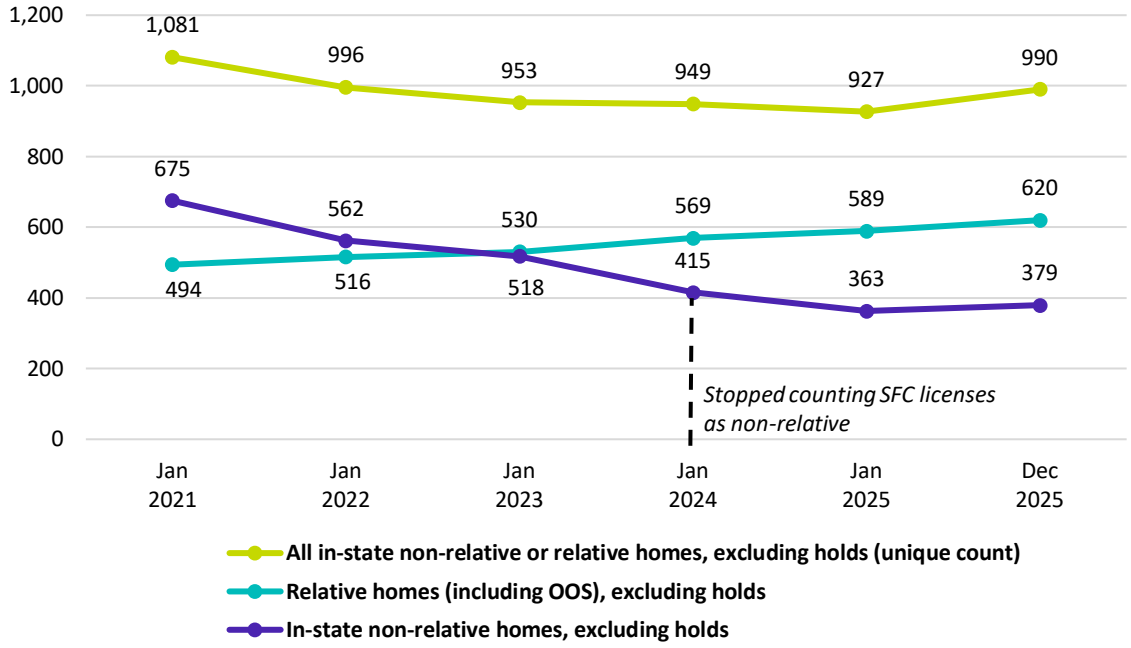
As additional detail to inform the Co-Neutrals' assessment of the State's efforts, the Co-Neutrals examined the total number of homes available in this period, including relative homes. As shown in Figure 31, the total number of homes with a foster care, specialized foster care, or relative foster care license has increased since January 2025.[161] The number of relative homes has steadily increased since 2021, while the number of non-relative homes has declined over the same period.

[160] This table shows the number of active homes (i.e., no placement hold) with effective "Foster Care" 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 365 days. TFC homes were not counted.

[161] The number of non-relative homes includes in-state homes with effective "Foster Care" licenses. The number of relative homes includes out-of-state homes. Monthly counts exclude homes with placement holds during the specified month. Homes with both relative and non-relative licenses are counted only once in the total but appear separately in each count. Specialized Foster Care homes were counted as non-relative homes prior to 2025. In 2025, these homes were only counted in the total.

Figure 31: Total Number of Resource Homes with Active Effective License by Month and Type[162,163]

2021 – 2025



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 2025, 134 non-relative resource homes were recruited and licensed in New Mexico (see Tables 15 and 16). Seventy-five percent of the 134 new homes licensed in 2025 (101) had at least one non-relative placement during the calendar year, 24 percent did not have any placements (32), and the remaining home (1%) was dually-licensed with only relative placements.[164]

[162] This figure does not reflect changes made as a result of the qualitative review process. The maximum number of homes removed from the count each month would be seven (<1% of total homes, or 2% of in-state non-relative homes in December 2025).

[163] There was a large increase in the number of resource homes on hold in 2025 as compared to 2024. The Co-Neutrals requested more information from the State on the cause of this and did not receive a response.

[164] The Co-Neutral team examined the first active month for the 32 new homes active in 2025 that did not have a placement, as placements are less likely for homes licensed late in the year. Four homes (13%) were first active in the 1st quarter of the year, two homes (6%) in the 2nd quarter, none in the 3rd quarter (0%), and 26 homes (81%) in the 4th quarter (81%).

Table 15: New Active Non-Relative Resource Homes Recruited, by Placement Status[165]

2025

Placement status of new active non-relative resource homes	Number of new active non-relative resource homes	Percentage of new active non-relative resource homes
With at least one non-relative placement	101	75%
With only relative placements	1	<1%
With no placements	32	24%
Total	**134**	**100%**

Source: Analysis of Sandbox Placements and ActiveProviders files, with adjustments based on qualitative review

Table 16: New Active Non-Relative Resource Homes Recruited, by County[166]

2025

County	All new homes	New homes with non-relative placement	New dually-licensed homes with only relative placement	New homes without placement
Statewide	**134**	**101**	**1**	**32**
Bernalillo	49	38	0	11
Dona Ana	12	7	0	5
Sandoval	10	7	0	3
Chaves	9	6	1	2
Otero	7	6	0	1
Lea	6	6	0	0
San Juan	6	5	0	1
Eddy	5	3	0	2
Valencia	4	3	0	1
Curry	3	3	0	0
Grant	3	3	0	0
Quay	3	3	0	0
San Miguel	3	3	0	0
Santa Fe	3	2	0	1
Los Alamos	2	2	0	0
Cibola	2	1	0	1
Rio Arriba	2	1	0	1
Roosevelt	2	1	0	1
Torrance	1	1	0	0
Lincoln	1	0	0	1
Taos	1	0	0	1

Source: Analysis of Sandbox Placements and ActiveProviders files, with adjustments based on qualitative review

[165] Includes homes dually licensed as relative and non-relative homes. Relative placements include fictive kin. Percentages do not total 100 due to rounding.

[166] 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-relative resource homes recruited in 2025. Of the 134 new non-relative homes, 57 percent had at least one parent who was identified as Hispanic (77); five percent had a parent who was identified as American Indian or Alaskan Native (non-Hispanic) (7); five percent had at least one parent who was identified as Black (non-Hispanic) (7); 35 percent of new homes had at least one parent who was identified as White (non-Hispanic) (47); and two percent of new homes had a parent who was identified as Asian or Pacific Islander (non-Hispanic) (3).[167]

Table 17: New Active Non-Relative Resource Homes Recruited, by Race and Ethnicity[168]
2025; N = 134 new resource homes

Race/ethnicity of resource parent(s)	Number of new homes	Percentage of new homes
Hispanic	77	57%
White (non-Hispanic)	47	35%
American Indian or Alaskan Native (Non-Hispanic; alone or in combination)	7	5%
Black (Non-Hispanic; alone or in combination)	7	5%
Asian or Pacific Islander (Non-Hispanic; alone or in combination)	3	2%

Source: Analysis of Sandbox Placements and ActiveProviders files, with adjustments based on qualitative review

The percentage of newly recruited non-relative homes with at least one Hispanic resource parent was 57 percent. The percentage of children in custody identified as Hispanic at the end of 2025 was 63 percent. The percentage of newly recruited non-relative homes with at least one White parent was 35 percent. The ratio of children in custody identified as White is 19 percent. The percentage of newly recruited non-relative homes with at least one parent who identified as American Indian or Alaskan Native (non-Hispanic) is five percent.[169]

Discussion

The State licensed 134 new non-relative resource homes in 2025, 51 percent of the annual target. CYFD reports that it prioritizes relative placements for children, and the data show a steady increase in the number of licensed relative homes since 2021.

One of CYFD's primary strategies in 2025 to recruiting new non-relative resource homes was to dedicate one placement staff within each of the five identified high-needs counties (Bernalillo,

[167] This includes individuals for whom other races were also indicated.
[168] This table does not sum to 134 new homes or 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. Five newly recruited households did not have a specified race.
[169] The number of children in custody on December 31, 2025 who were ICWA-eligible (10%, 202 children) is slightly higher than the number of children in custody identified as American Indian or Alaskan Native using the race and ethnicity data in the Sandbox cohort files at the end of 2025 (8%, 163 children).

Dona Ana, Santa Fe, San Juan, and Chavez/Eddy) to focus exclusively on resource home recruitment.[170] This work began in February 2025 and continued through the end of the year. Between March 2025 and January 2026, the Co-Neutral team conducted 14 interviews with the staff assigned to these roles to assess what worked, where there were challenges, and what additional resources might be needed to determine whether these recruitment strategies were proving effective.

Overall, with information collected during regular monthly interviews with CYFD recruiter staff, and in review of the data on the number of inquiries for new non-relative resource homes as well as data on the number of newly licensed homes, the Co-Neutrals were unable to conclude that this strategy, as implemented, had been implemented effectively. The initiative was slow to establish itself (as full-time recruiters were not in place in all high needs counties until July 2025), and the recruiters recounted frequent shifts in focus between recruitment, navigation, and retention activities, with no clearly articulated set of strategies. During the same period, staff reported fewer and fewer recruitment events, a byproduct of multiple factors, including a more stringent event approval process. It is not clear to the Co-Neutrals to what extent a reported pause in funding between July and November 2025 may have also impacted event participation.[171]

Another one of CYFD's strategies to improve the process of recruiting and licensing new non-relative homes was to create the Resource/Foster Parent Training Unit (RFPTU) within CYFD's WDB to deliver the READi NM pre-service training to prospective resource parents. In the past, LSS staff -- many of whom are not professional trainers – would provide trainings within their counties to new prospective parents. The RFPTU includes a manager, administrative support staff, and five regional trainer/coaches. The creation of this unit is intended to relieve LSS staff of this ongoing responsibility, provide more regularity in training schedules and the data collected, and ensure consistency in the quality and content of training provided.

CYFD engaged several consultants in 2025 to assess CYFD's recruitment and retention processes, collect and analyze quantitative and qualitative data, and make recommendations for improvements. Many of the strategies and recommendations identified – including increased staffing to fill vacant positions, improved resource parent support to increase retention, and improvements to the placement process – were incorporated in a Recruitment and Retention Plan developed by the State in December 2025 for implementation in 2026.

[170] This strategy was a commitment in RO#1.
[171] A more detailed report on the Co-Neutrals' assessment of the State's implementation of this RO#3 strategy is available within Attachment C of the Co-Neutrals' January 30, 2026 Arbitration Report, which can be found here.

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 2025.

DVP Metrics and Validated Performance Data

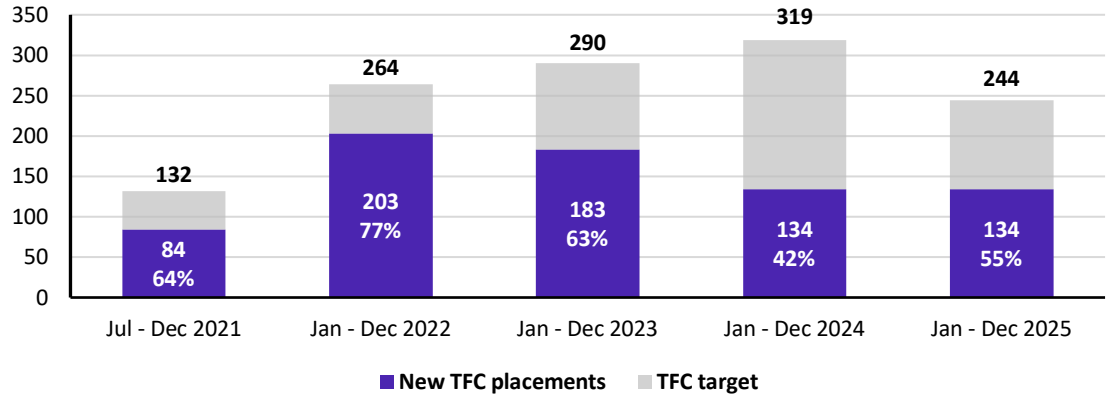
BTO6.4(i) – primary metric: Percentage of yearly target reached for new licensed treatment foster care (TFC) placements statewide.

The DVP defines a new TFC placement as the placement of a child who is eligible for treatment foster care, or their accompanying sibling, to a licensed TFC home in which the child has not resided within the previous 365 calendar days. The Co-Neutrals approved a target of 244 new TFC placements for 2025. The State made 134 new TFC placements during the year, 55 percent of the target.

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

The State's data show there were 134 new TFC placements from January 1, 2025 to December 31, 2025 that meet the definition above. This is the same number as in 2024 and lower than 2023 (183) and 2022 (203).

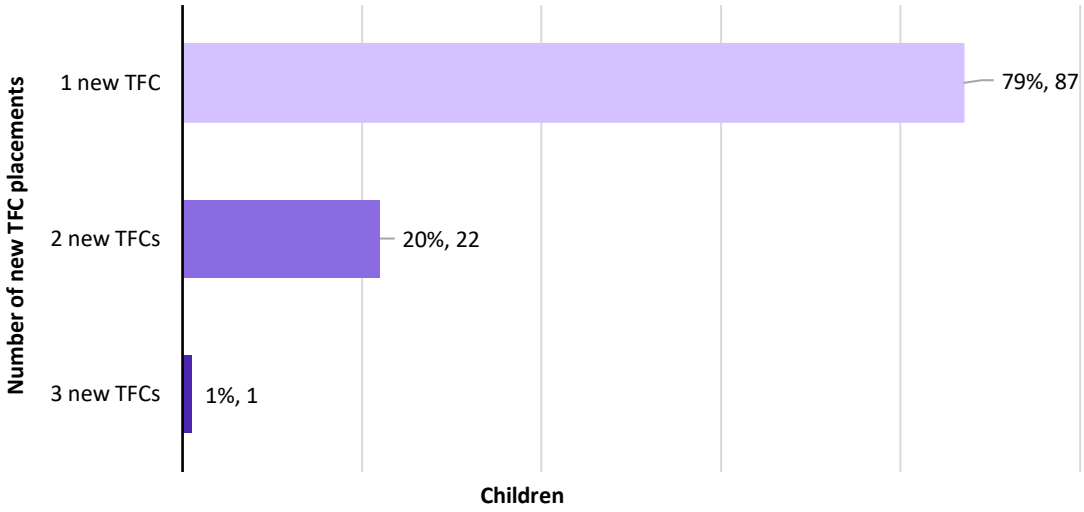
Figure 32: Number of New TFC Placements Made Toward Annual Target
2021 - 2025



Source: Analysis of Sandbox Placements files, with manual corrections

As additional information, the Co-Neutrals examined the number of eligible new TFC placements per child. In 2025, 110 unique children had at least one new TFC placement (including one child who was placed with a sibling eligible for TFC services).[172] Most of these children (79%, 87 children) experienced one new TFC placement in 2025, 22 children (20%) were placed in two TFC homes, and one child (1%) was placed in three TFC homes (see Figure 33).

Figure 33: Number of Eligible New TFC Placements Per Child
2025; N = 110 children with at least one new TFC placement



Source: Analysis of Sandbox Placements file, with manual corrections

The Co-Neutrals examined the length of time children spent in new TFC placements that ended by December 31, 2025. Of the 134 new TFC placements that counted towards the target in 2025, 72 ended by December 31, 2025 (54%), and 62 were ongoing (46%). Of the 72 placements that ended, 23 of these placements lasted one week or less (17% of 134), 15 lasted two to four weeks (11% of 134), and 34 lasted longer than one month (25% of 134).

[172] This does not include moves between homes after initial placement.

Table 18: Duration of Eligible New TFC Placements Made
2025

Duration of placement	Number of new TFC placements	Percent of new TFC placements[173]
Ended by 12/31/2025	**72**	**54%**
A week or less	23	17%
2- 4 weeks	15	11%
1-3 months	15	11%
4-6 months	14	10%
7+ months	5	4%
Ongoing as of 12/31/2025	**62**	**46%**
A week or less	2	1%
2- 4 weeks	5	4%
1-3 months	18	13%
4-6 months	15	11%
7+ months	22	16%
Total	**134**	**100%**

Source: Analysis of Sandbox Placements file, with manual corrections

Discussion

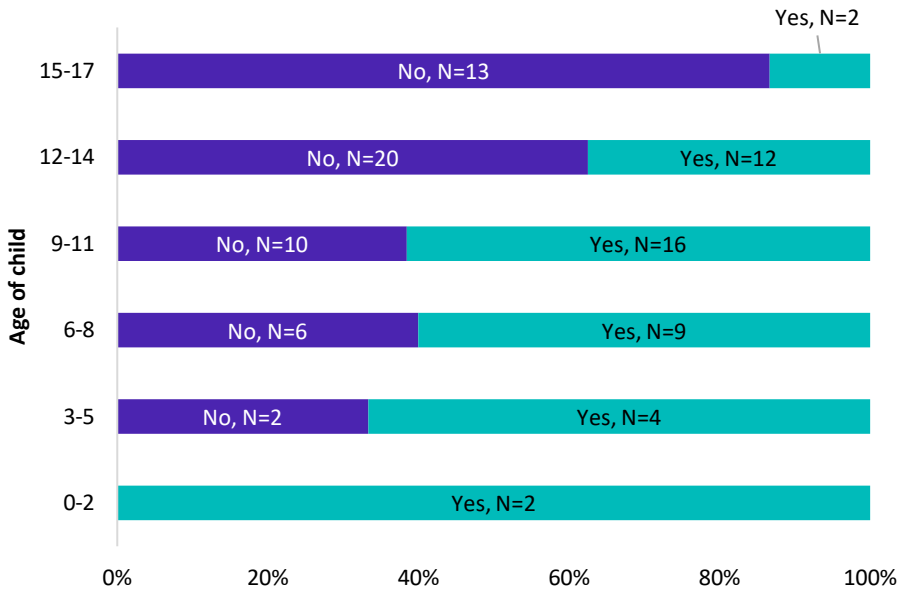
The State reached 54 percent of the 2025 target for TFC placements. Over half (53%, or 38 of 72) of the TFC placements that ended by December 31, 2025 lasted less than one month, raising significant questions about the TFC placement process and model in New Mexico. TFC placements lasting less than one month severely limit opportunities for children to benefit from the therapeutic setting and services and support that could be provided.

The State provided data to the Co-Neutrals on children referred for TFC services in 2025. Of the 98 unique children who were referred at least once for TFC during the year, 97 children (99%) received pre-approval from the MCO for the services. One child who was approved was ultimately not referred for TFC services. Of the remaining 96 children, 45 children (47%) began TFC services at some point during the year, and 51 children did not receive the service. Data on the child's age at time of first referral and provision of TFC services during 2025 is included in Figure 34.

[173] Percentages may not sum to 100 due to rounding.

Figure 34: Provision of TFC Services in 2025 by Age of Child

2025; N = 96



Source: Analysis of Data Provided by CYFD and HCA

The State reports that CYFD and HCA have collaborated with TFC providers to advance initiatives to improve the referral process, strengthen placement stability, increase clinical and non-clinical supports, and expand overall TFC capacity. In 2025, HCA required PHP to submit a Corrective Action Plan (CAP) to recruit and retain a comprehensive network of providers, including TFC providers, to provide timely medically necessary services for children in custody. the TFC network.

In 2026, the State began collecting data on the reason that children who are determined medically necessary for TFC services do not receive such services, and what alternative services are provided to meet their needs.

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 2025.

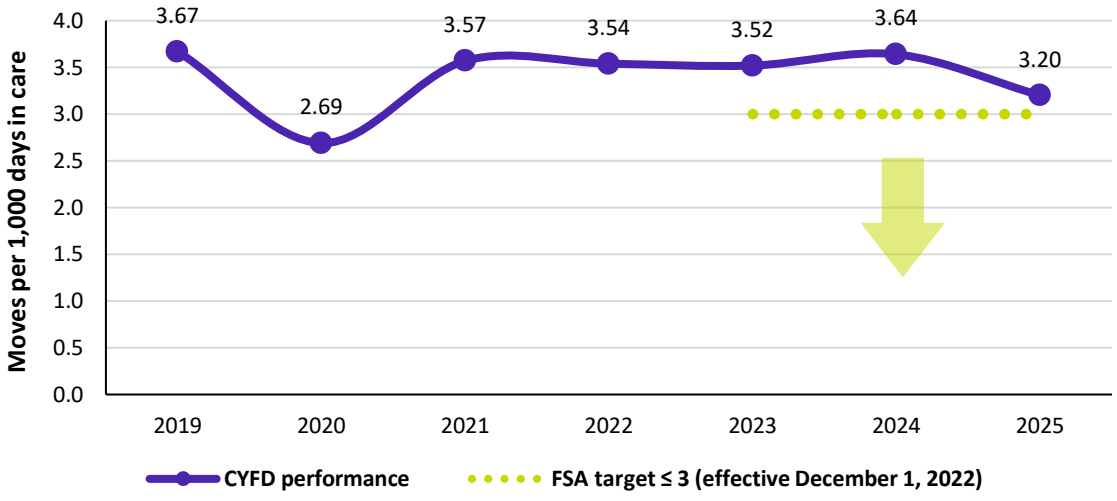
DVP Metrics and Validated Performance Data

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 2025, children in custody spent a total of 744,975 days in care and experienced 2,385 total placement moves.[174] This is a rate of 3.20 moves per 1,000 days, which exceeds the FSA maximum of three moves per 1,000 days. The rate of placement moves changed relatively little from 2021 through 2024, before decreasing in 2025 to its lowest rate since 2020 (see Figure 35).

Figure 35: Placement Moves Rate Versus Settlement Target

2019 – 2025

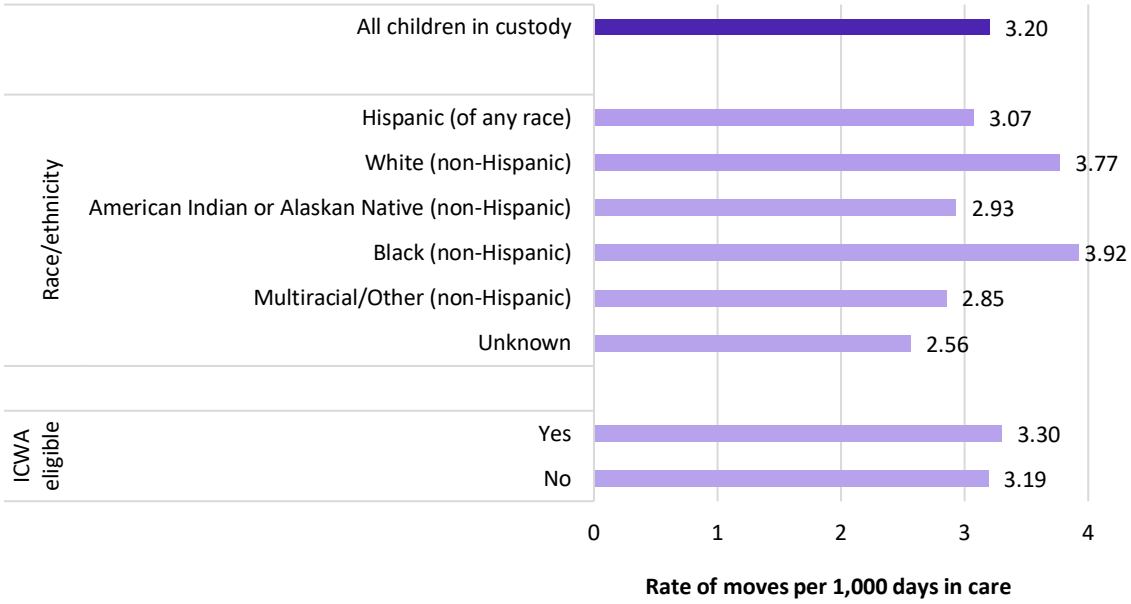


Source: Analysis of Sandbox Placements file and FACTS episodes file

[174] 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.

As additional information, the Co-Neutrals also compared the rate of placement moves for different racial and ethnic groups of children (see Figure 36). The rate of moves per 1,000 days in care was higher for Black (non-Hispanic) children (3.92) than for White (non-Hispanic) children (3.77), American Indian or Alaskan Native (non-Hispanic) children (2.93), and Hispanic children of any race (3.07). The placement moves rate was similar for ICWA-eligible children (3.30) and non-ICWA-eligible children (3.19).

Figure 36: Number of Placement Moves and Days, by Race/Ethnicity and ICWA Eligibility
2025



Source: Analysis of Sandbox Placements and Cohort file and FACTS episode file

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 2025.

Discussion

The State's performance in 2025 has improved since 2021 and 2025 represents a positive change from the uptick in placement instability seen in 2024. In the State's 2025 Annual Report published in August 2026, the State calculated its 2025 placement stability rate as significantly higher, at 3.67, but the Co-Neutral team independently validated the lower rate.

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 2025.

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.

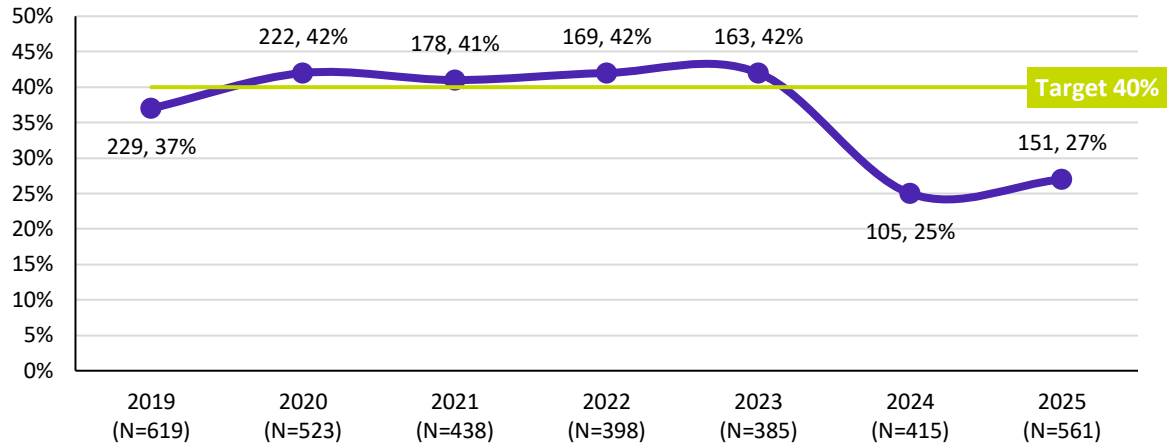
Of the 561 children who had been in custody for 12 to 23 months on January 1, 2025, 151 children (27%) reached permanency by the end of the year.[175,176] While this is an improvement from the State's performance in 2024 (25%), it remains significantly below the performance standard requirement of 40 percent and a significant decline from 2023. The number of children who had been in custody for 12 to 23 months at the start of each reporting period declined each year from 2019 (619 children) to 2023 (385 children) and then increased over the last two years to 561 children in 2025 (Figure 37).

[175] 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.

[176] The Sandbox *Exits* and *EpisodeOfCustody* files submitted by the State on May 1, 2026 were missing exit reasons for two children who were in care for 12 to 23 months at the start of the reporting period. These children were not counted as having reached permanency.

Figure 37: Children Who Achieved Permanency of Those Who Had Been in Custody Between 12 and 23 Months

2019 - 2025



Source: Analysis of Sandbox EpisodesOfCustody and Cohort files

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 Black (non-Hispanic) children reached permanency (10%, or 2 of 20), and a comparatively high percentage of ICWA-eligible children reached permanency (38%, or 20 of 53).

The Co-Neutrals also examined the ages as of exit date and custody end reasons of eligible children who reached permanency in 2025. Of the 151 children who had been in care for 12 to 23 months and who reached permanency in 2025, 54 percent (82 children) were six years old or younger; this age group makes up just 48 percent of all children in custody on December 31, 2025. Twenty percent (30 children) were seven to 11 years old (this age group makes up 25% of all children in custody on December 31, 2025), and 26 percent (39 children) were 12 to 17 years old (this age group makes up 28% of all children in custody on December 31, 2025). Of the 32 children who exited to an adoption, 78 percent (25 children) were six years old or younger.

Table 19: Age at Exit and Custody End Reason for Children Who Had Been in Care 12 to 23 Months and Achieved Permanency

2025

Age at exit	All reasons	Custody end reason			
		Adoption finalized	Non-subsidized guardianship	Subsidized guardianship	Reunification
0-6 years	82	25	1	23	33
7-11 years	30	2	0	11	17
12-17 years	39	5	0	10	24
All ages	**151**	**32**	**1**	**44**	**74**

Source: Analysis of Sandbox EpisodesOfCustody and Cohort files

Discussion

Twenty-seven percent of children who were in custody for 12 to 23 months as of January 1, 2025 achieved permanency due to reunification, adoption, or guardianship by December 31, 2025. Performance continued to be significantly below the Performance Standard requirement of 40 percent.

During conversations in 2025 and 2026 with CYFD managers, supervisors, case workers, and Children's Court Attorneys (CCAs), the Co-Neutrals repeatedly heard about the factors impeding permanency for children: high PSD workforce turnover; high caseloads; CCA vacancies; and a "collapse" of legal staffing within some areas of the state in 2025 that had a significant negative impact on the timeliness of hearings and resulted in many unnecessary continuances. Legal staffing and processes play a significant role in permanency, but case workers and supervisors also need to have the time, knowledge, and skills to engage with and support children and families and develop and monitor case plans to achieve timely positive outcomes.

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 2025.

DVP Metrics and Validated Performance Data

CYFD's Workforce Development Plan (WDP) was approved by the Co-Neutrals on July 13, 2023.[177] 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 a mentorship program.

As reported in prior years, the Co-Neutrals conducted caseload validation interviews with CYFD staff in 2025 with a main goal of verifying primary case assignment information provided by CYFD. Between January and December 2025, the Co-Neutral team spoke with 203 case workers and supervisors within investigations, permanency, and licensing and support units. Across all staff types, 85 percent of point-in-time cases (3,689 out of 4,350) were determined to be accurate.[178] Permanency staff caseloads had the highest accuracy rate (90%, or 1,139 out of 1,268 point-in-time cases), followed by investigations (83%, or 1,444 out of 1,747 point-in-time cases) and licensing and support caseloads (83%, or 1,106 out of 1,335 point-in-time cases).

Of the 156 case-carrying non-supervisory staff interviewed by the Co-Neutral team, FACTS data showed that 47 staff (30%) had caseloads compliant with the relevant standard. Based upon the staff's self-reported caseload data, 42 staff (27%, or 5 fewer than in the FACTS data) reported caseloads that met the compliance standard. Thus, the percentage of staff who met the caseload compliance standard according to self-reported caseloads was three percentage points lower than the percentage based on the FACTS caseload data. Throughout 2025, the Co-Neutrals provided caseload discrepancy data and analysis to the State following each round of interviews, and the Co-Neutrals noted improvement in the accuracy of primary assignments reported in FACTS data as the year progressed.

The Co-Neutrals examined CYFD data on all staff who were assigned as the primary case worker on any case in FACTS for a point-in-time during the last two quarters of 2025: specifically, September 22, 2025 and December 15, 2025.[179,180] The State provided caseload data with detail on New Employee Training (NET), hire date, position title, and primary case assignments to

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[177] CYFD's Workforce Development Plan can be found here.

[178] In August 2025, the Co-Neutral team and the Enterprise Project Management Office (EPMO) team agreed to no longer categorize instances where staff reported that they had submitted primary cases on their caseload for closure as discrepancies because CYFD policy still considers a case to be active until a supervisor formally closes it out in FACTS. Prior to the August 21, 2025 interviews, when staff reported that such cases were no longer active on their caseloads, those cases would be counted as inaccurate if they were listed on the staff's caseload in the CYFD data.

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

[180] Per the DVP, the Co-Neutrals selected one point-in-time date per quarter for analysis of BTO10.2(i) and (ii). In 2025, the State submitted real-time caseload data on a biweekly cadence. Beginning March 2025, the State began producing the caseloads data using a different methodology. The Co-Neutral team worked with CYFD's EPMO to produce accurate data that met the goal of reporting, improving the data quality and usability each month. The Co-Neutrals selected the latest data submission for quarters 3 and 4 for 2025 reporting and excluded quarters 1 and 2 due to ongoing quality assurance testing and improvements through August 2025.

determine the applicable caseload standard for each staff assigned as primary on a case.[181]

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.[182]

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 the case worker completed NET.[183] 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 two 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.[184]

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[181] 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. The full list of case-assignable titles is available in the technical appendix of the DVP.

[182] CYFD WDP, pgs. 11-12.

[183] 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 a full caseload. There is no graduated caseload standard for licensing and support or in-home services cases.

[184] 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

Pursuant to the ROs issued in 2025, the Co-Neutrals have been reporting CYFD's caseload compliance to the parties and Arbitrator. The methodology used in that reporting assesses all workers assigned as primary on at least one case, and identifies the percentage compliant with the caseload standard, the percentage with caseloads above the standard, and the percentage ineligible for case assignment due to either their assigned role or because they have not completed pre-service training requirements. As of December 15, 2025, there were 376 staff assigned as primary on at least one case, and 74 staff (20%) had caseloads compliant with the caseload standard (Table 20). By worker type, caseload compliance was as follows: nine percent of investigation workers, 15 percent of permanency workers, 25 percent of LSS workers, and 57 percent of IHS workers.[185]

Table 20: Caseload Compliance for All Workers Assigned Primary on at Least One Case, by Worker Type[186]

December 15, 2025

Compliance category	All case types		Investigations		Permanency		LSS		IHS	
	N	%	N	%	N	%	N	%	N	%
Workers assigned as primary on any case	**376**	**100%**	**157**	**100%**	**163**	**100%**	**79**	**100%**	**37**	**100%**
Total caseload compliant with standard	**74**	**20%**	**14**	**9%**	**24**	**15%**	**19**	**24%**	**21**	**57%**
0-50%	37	10%	9	6%	5	3%	4	5%	19	51%
51-100%	37	10%	5	3%	19	12%	15	19%	2	5%
Total caseload above standard	**195**	**52%**	**96**	**61%**	**92**	**56%**	**36**	**46%**	**8**	**22%**
101-150%	68	18%	19	12%	34	21%	22	28%	1	3%
151-200%	40	11%	23	15%	18	11%	3	4%	2	5%
201-400%	64	17%	37	24%	29	18%	9	11%	4	11%
>400%	23	6%	17	11%	11	7%	2	3%	1	3%
Ineligible for assignment	**107**	**28%**	**47**	**30%**	**47**	**29%**	**24**	**30%**	**8**	**22%**
Ineligible - role	82	22%	30	19%	40	25%	20	25%	7	19%
Ineligible - new hire with NET	7	2%	7	4%	0	0%	0	0%	0	0%
Ineligible - no NET, hired after 2020, and non-senior	17	5%	10	6%	7	4%	3	4%	1	3%
Ineligible - HR information missing	1	0%	0	0%	0	0%	1	1%	0	0%

Source: Data provided by EPMO

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.

[185] Workers assigned as primary to multiple case types are counted in the Co-Neutral team's compliance analysis under each case type represented in their caseload. In other words, the compliance summary for permanency, for example, shows compliance not just for workers with the job title of "Permanency Coordinator" but for all workers assigned as primary to at least one permanency case, regardless of job title.

[186] Excludes temporary workers and workers who have been terminated (5), as well as new cases assigned to county desktops. Workers with a senior title who have a recent NET date were considered eligible for graduated caseloads. Post-2020 hires missing NET dates are assumed NOT to have completed NET unless they have a senior title. In December 2025, a new employee was included for whom no HR information was available. The State's data did not contain the number of children associated with each ICPC case. Therefore, ICPC Permanency cases are counted at the case level and could involve more than one child.

BTO10.2(i) – primary metric: Of all casework staff, the share who have primary caseloads consistent with established caseload standards[187]

Among case workers who were eligible to carry cases, the share who had caseloads at or below the caseload standard (taking into account graduated caseloads for case workers within six months of NET completion), was 34 percent on September 22, 2025, and 35 percent on December 15, 2025. Most eligible case-assignable workers at each point in time had caseloads above the standard. A sizable number of workers not eligible to carry cases were assigned as primary on at least one case at each point in time (discussed further in BTO10.2[ii]).

The share of eligible case-assignable workers with compliant caseloads was highest for IHS staff (100% in the third quarter and 75% in the fourth quarter), and lowest for investigations staff (10% in the third quarter and 25% in the fourth quarter). The share of eligible case-assignable workers with compliant caseloads remained below 50 percent at each point-in-time for LSS staff, and below 35 percent for permanency.

BTO10.2(ii) – primary metric: Of all children in state custody or with CYFD cases, the number whose cases are assigned to any non-case-assignable casework staff, including supervisors, managers, case aides, administrators, or directors.[188]

The share of cases assigned to staff who were not case-assignable was 17 percent in the third quarter (1,261 cases), and 15 percent in the fourth quarter (1,100 cases) (see Table 21).[189,190] Most of the non-case-assignable workers assigned as primary were supervisors (57 of 96 in the third quarter, and 53 of 101 in the fourth quarter), 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 staff assigned as primary before NET completion in both quarters, with a high of 18 staff in the fourth quarter.

[187] The State reported an issue with the production of their HR/staff data that may affect the reliability of the metric calculations presented here.
[188] Ibid.
[189] The State's data includes the number of children associated with each permanency case, but it does not include the number of children associated with each investigation, IHS, and LSS case. As a result, the Co-Neutrals calculated this metric at the child level for permanency cases and at the case level for the other three case types.
[190] This counts only primary assignments (and cases assigned to county desktops, which are considered unassigned), not secondary assignments.

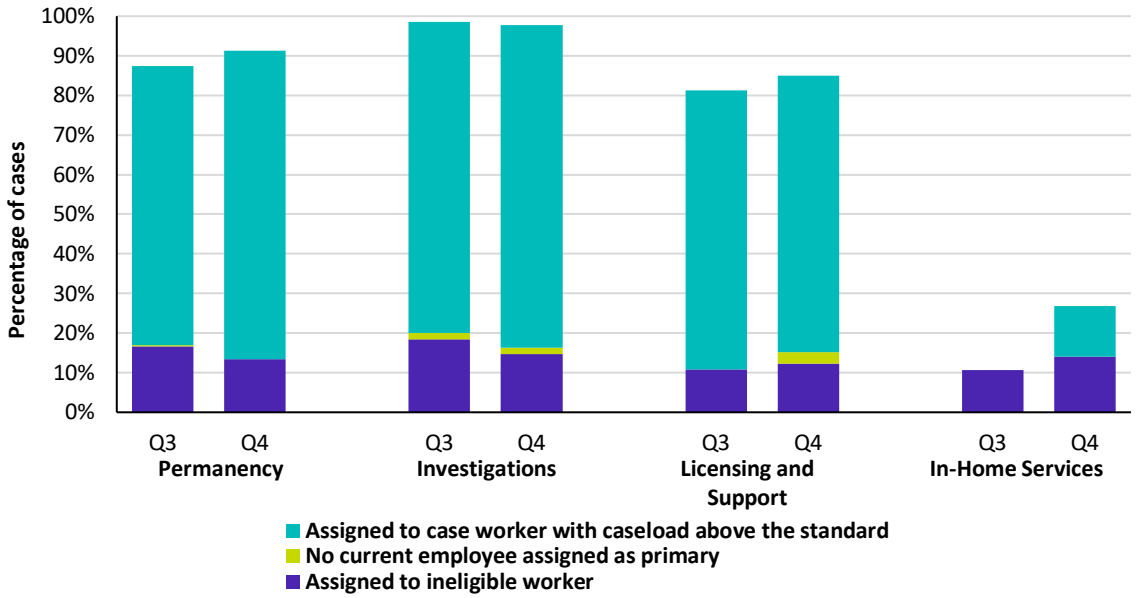
Table 21: Summary of All Case Types Assigned to Non-Case-Assignable Staff, by Quarter
Q3 and Q4 2025

Total cases:	Q3 – Sept. 22, 2025	Q4 – Dec. 15, 2025
	7,312	7,244
Total cases assigned to non-case-assignable staff	**1,261**	**1,100**
Percent of cases assigned to non-case-assignable staff	**17%**	**15%**
Total unassigned or assigned to terminated worker[191]	65	103
Total assigned to non-case-assignable worker[192]	1,196	997

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

Across the third and fourth quarter points-in-time, more than 80 percent of investigations, permanency, and LSS cases were assigned to non-case-assignable staff or to staff who had caseloads above the standard. This percentage was highest for investigation cases: 99 percent on September 22, 2025, and 98 percent on December 15, 2025.

Figure 38: Percentage of Cases Assigned to Ineligible Workers, with no Primary Case Worker, or to Case-Assignable Workers with Caseload Above Standard
2025



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

On December 15, 2025, only two percent of investigation cases were assigned to a case worker with a compliant caseload, and 81 percent of investigations cases were assigned to a case worker

[191] Includes cases assigned to county desktops, terminated workers, and cases assigned to workers with no available HR information.
[192] Includes cases assigned to supervisors, senior leadership, workers with no record of NET completion, temporary workers and contractors, and other roles with a title that is ineligible to be assigned as primary.

with a caseload above the standard. Nine percent of children in foster care (permanency cases) were assigned to a case worker with a compliant caseload, and 78 percent of children in foster care were assigned to a case worker with a caseload above the standard. Fifteen percent of LSS (placement) cases were assigned to a case worker with a compliant caseload, and 70 percent of placement cases were assigned to a case worker with a caseload above the standard. Seventy-three percent of IHS cases were assigned to a case worker with a compliant caseload, and 13 percent were assigned to a case worker with a caseload above the standard.[193]

BTO10.2(iii) – primary metric: In a given reporting year, the rate of voluntary separations among caseworker staff positions per 100 days worked.[194]

There were 507 case workers with at least one day of employment at CYFD in 2025, and a combined total of 86,662 workdays during the year.[195] Of the 507 staff, 124 voluntarily terminated employment in 2025, resulting in a turnover rate of 0.14 voluntary terminations per 100 days worked – roughly equivalent to one case worker leaving voluntarily for every four full-time equivalents (FTEs) each year.[196,197] The voluntary turnover rate in 2025 was the highest it has been since 2022.

Table 22: Voluntary Turnover Rate for Case Workers
2019 - 2025

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[198]	82	0.10
2024	480	83,498	84	0.10
2025	507	86,662	124	0.14

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

[193] Percentages by case type in this paragraph do not sum to 100 because only cases assigned to case-assignable staff are included.
[194] The State reported an issue with the production of their HR/staff data that may affect the reliability of the metric calculations presented here.
[195] For this metric, the DVP defines a workday as any weekday, with no exclusions for holidays or time off.
[196] No staff had a voluntary termination more than once in 2025.
[197] A rate of 0.14 terminations per 100 days worked (calculated as (124 ÷ 86,662 × 100) equates to 1.4 terminations per 1,000 days worked). There were 261 DVP-defined workdays in 2025, so 1,000 days roughly equates to four full-time equivalents (FTEs) for the year.
[198] 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. This makes 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 124 staff who voluntarily terminated employment (see Table 23).[199] More than half (59%, 73 staff) had been employed at CYFD for less than one year. Twenty-six percent had been employed at CYFD for one to three years (32), while 15 percent had been employed for four years or longer (19). In 2024, the share of staff who had been employed less than one year when they voluntarily terminated employment (45%) was lower than in 2025, and the share who had been employed one to three years was higher (37%). Additionally, the number of staff who voluntarily terminated in 2025 is 48 percent higher than in 2024.

Table 23: Length of Tenure Before Termination for Eligible Employees[200]
2024 - 2025

Length of tenure before voluntary termination	2025		2024	
	N	%	N	%
Less than one year	73	59%	38	45%
1 to 3 years	32	26%	31	37%
4 to 6 years	11	9%	6	7%
7 to 9 years	3	2%	6	7%
10 or more years	5	4%	3	4%
Total	**124**	**100%**	**84**	**100%**

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

Discussion

As the foregoing data, Tables, and Figure indicate, unacceptably high caseloads continued to be a significant problem for CYFD in 2025. Though CYFD focused on hiring new workers to alleviate the caseloads of current staff and bring more resources into offices, over half of staff (59%) who voluntarily terminated from their positions in 2025 had been in that position for less than one year.

During the Co-Neutrals' site visits to CYFD offices in September and October 2025, staff reported that the pillar system that had been developed and implemented the prior year – creating separate reporting and management lines for investigations, permanency, and placement – had largely been dissolved except for a few county offices. The silos created by the pillars were reported in some county offices to have a continuing negative impact on communication and collaboration among staff. Some offices also reported poor communication from CYFD leadership on new directives and how they should be implemented; excessive caseloads; issues with pay equity between investigators, permanency, and placement staff; and delays in hiring and enrollment in NET.

From January through December 2025, members of the Co-Neutral team conducted 227

[199] Caseloads data and the included HR information submitted by CYFD were used to identify the original hire date for workers who had a voluntary termination. There were 50 case-assignable workers who had a voluntary termination for whom the original hire date could not be identified using the submitted HR data. For these workers, the job start date was used to calculate the length of tenure.
[200] Percentages do not sum to 100 due to rounding.

interviews with case workers and supervisors across all three case work types 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:[201]

- One-quarter of staff (25%, or 56 of 222) identified additional major job responsibilities that fall outside their job description, such as excessive on-call and/or office stay supervision requirements, additional supervision responsibilities, transporting children, and providing trainings – either for staff or resource parents. Investigations staff (34%, or 28 of 83) were most likely to report additional job duties, followed by LSS (26%, or 17 of 65) and permanency (15%, or 11 of 63). Staff in Region 3 (33%, or 15 of 45) and Region 5 (27%, or 13 of 48) reported higher than average instances of additional job responsibilities.
- More than one-third (37%, or 82 of 138) of staff stated that their workload at the time of the interview did not feel manageable, mostly citing high caseloads and lacking sufficient time to fully meet the needs of the children and families on their caseloads. Supervisors (43%, or 27 of 63) were more likely than non-supervisors (35%, or 55 of 157) to state that their workload did not feel manageable. Staff in Region 3 (64%, or 30 of 47) were by far the most likely to state that their workload did not feel manageable, compared to 30 percent (52 of 173) across the other four regions. Permanency staff (42%, or 30 of 71) were most likely to state that their workload did not feel manageable, followed by investigations (35%, or 29 of 82), and licensing and support (34%, or 23 of 67). The group who most often stated that their workload did not feel manageable were non-supervisor licensing and support staff in Region 3 (77%, or 10 of 13).
- Among the 71 first-time interviewees hired within the last year, 14 percent (10) reported having been assigned primary cases prior to completing NET. Permanency staff (17%, or 4 of 24) most frequently cited primary assignments prior to completing NET, followed by licensing and support (13%, or 3 of 23) and investigations (13%, or 3 of 24). The 10 first-time non-supervisor interviewees who reported receiving primary assignments prior to completing NET reported an average of five case assignments.

An important and significant strategy employed by CYFD in 2025 was development of a data dashboard by the Enterprise Project Management Office (EPMO). This work began in 2024 with the goal of providing a tool for leadership, managers, and supervisors to monitor caseload compliance at the state and county office level, and by worker type. The dashboard also allows supervisors to more easily track application of the graduated caseload standards for new staff. The Co-Neutrals worked with EPMO in 2025 to understand how the dashboard was built and is utilized, and in 2026, validated the accuracy of the dashboard, within a minimal margin of error.

[201] The Co-Neutral team conducted 227 interviews involving 217 staff. Ten staff participated in two interviews throughout the year. Not all staff were asked every question, either due to running out of time or lack of applicability to their role, thus, the denominator may be slightly different across questions and data points.

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."[202, 203]

There are five ITs and nine TOs from FSA Appendix C that have not yet been achieved by the State and are discussed in this section of the report.[204] These include the requirement that the State provide assistance to New Mexico's Nations, Pueblos, and Tribes to access federal funding through Medicaid and Title IV-E, and the development and implementation of policies and procedures to:

- Support Native children's access and participation in traditional ceremonies and culturally responsive services,
- Enhance accountability for NM's Indian Family Protection Act (IFPA) placement preferences,
- Increase recruitment and retention of Native resource families, and
- Ensure CYFD staff receive the training outlined within CYFD's ICWA/IFPA Training Plan.[205]

CYFD and HCA are also required to collect and analyze data sufficient to understand the needs of Native children in custody, and the capabilities of the State to meet those needs.

The Office of Tribal Affairs (OTA) continued its work in 2025 to routinely collaborate and engage with New Mexico's Nations, Pueblos, and Tribes to provide technical assistance, share information about OTA initiatives, discuss culturally responsive practices, and identify issues affecting Native children and families. One significant accomplishment of this collaboration was finalization of a CYFD policy to provide reimbursement for cultural activities and traditional healing services to Native children in care; the one IT and two TO Appendix C commitments that were met in 2025.[206]

On October 1, 2025, the HCA launched a 1115 Waiver benefit that provides Medicaid funding for traditional healing services delivered through Indian Health Services, Tribal 638 facilities, and the Navajo Nation for eligible Medicaid members. This benefit is in addition to the Traditional Healing Benefits (THBs) that are available as value added services to Native children. With these

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[202] FSA, pg. 8a.
[203] Indian Child Welfare Act (ICWA) is a federal law enacted in response to a history of disproportionally 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.
[204] 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.*
[205] 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.
[206] Specifically, App. C, IT 2.1 – *Development of Processes and Procedures to Promote Traditional Interventions*; App. C, TO 2.3 – *Policies to Support Native Children to Receive Traditional or Culturally Responsive Services;* and App. C, TO 3.1 – *Policy to Provide Direct Assistance for Traditional Ceremonies*.

considerations, the FSA Appendix C IT requirement to pursue federal funding through Medicaid was also met in 2025, and utilization will be monitored through the relevant TOs that have not yet been achieved.[207]

CYFD has continued to demonstrate a willingness to expand access to Title IV-E funds to Nations, Pueblos, and Tribes. As of September 2025, OTA reported that four Tribes had executed Joint Power Agreements (JPAs) during the year. The Agreements are complicated and CYFD reports that the terms of the new JPAs had been in negotiation for several years. While there have been efforts to accelerate this work with other potentially interested Pueblos and Tribes, additional progress is likely to require more intensive and proactive technical assistance. The work to support JPA development could be accelerated with additional resources within CYFD's general counsel's office which are currently very limited to work on these issues. Strategies to support Pueblos and Tribes for legal and other administrative expenses beyond a formal JPA also need to be considered.

There was limited progress toward other FSA Appendix C IT and TO commitments. Seventy-one percent of ICWA-eligible children in custody at any point in 2025 spent at least one day in an IFPA-preferred placement during the year. Only 23 percent of the required 30-day meetings for children who were not in IFPA-preferred placements for 30 days or longer in 2025 were conducted on time; this is a decrease from 2024 when 38 percent were conducted on time. Qualitative reviews of a sample of monthly meetings that were documented as completed in 2025 showed that a Tribal representative or case worker attended 38 percent of the meetings (84 of 219), the Native child's parent or guardian was present in two percent of meetings (3 of 170 applicable meetings), and the Native child attended one percent of meetings (2 of 192 applicable meetings). Tribal and family representation and participation are essential components to identify and secure IFPA-preferred placements for Native children.

Quantitative data show that 38 percent of required CYFD staff received the ICWA/IFPA Tier 1: *Novice* training by December 31, 2025, a significant decrease since 2024 when 73 percent of required staff completed the training. The *Novice* training is required for new PSD staff within their first 12 months of employment, and provides essential information related to the legal requirements of ICWA and IFPA and best practices in working with Native children, families, and communities. Tier 2 trainings are required for PSD supervisors and managing attorneys, and Tier 3 is required for county office managers and directors; the curriculums for Tier 2 and 3 were scheduled to be completed in 2023, however, only Tier 2 modules became available in 2025 and attendance by required participants was low. These knowledge and skills are foundational to PSD staff in order to practice with cultural humility and to be aware of and meet the requirements of federal and state law.

In October 2025, the Co-Neutrals met with representatives from New Mexico's Nations, Pueblos, and Tribes to hear about their current experiences engaging with CYFD and HCA. Positive collaboration was reported between OTA and representatives of the Nations, Pueblos, and Tribes, but concerns were expressed related to inconsistent communication, collaboration, and meaningful engagement from CYFD PSD. Practice from county level staff was reported as varying

[207] The IT that was met is App. C, IT 3.1 – *Pursue Federal Funding through Medicaid and Title IV-E*.

depending on the area and individual worker. Many expressed that vacancies and turnover in CYFD PSD staff and poor attendance in required trainings have contributed to a lack of knowledge about required notices being sent to Nations, Pueblos, and Tribes for new allegations of abuse or neglect that involve Native children as well as the findings of these investigations. The delays in required notice can prevent opportunities to engage and work together with families and Tribal staff prior to a potential removal of a child. Tribal representatives also report that bias and lack of understanding of the importance of maintaining cultural connections for children remain a barrier.

In late 2025, the Director of the OTA left her position. Much of what was accomplished in 2025 was the result of the work of the OTA team that developed under leadership since the beginning of *Kevin S.* reforms. From an office that began with one staff, OTA developed policies and procedures that promote collaboration with Nations, Pueblos, and Tribes; nurtured and cultivated meaningful relationships with Nations, Pueblos, and Tribes that respected their sovereignty; maintained a focus on regular meetings and accountability for Native children who are not placed with their relatives; and developed processes for Native children to receive direct assistance to facilitate their participation in cultural and traditional activities. As of the writing of this report, CYFD has not yet appointed a new permanent OTA Director.

a. *Implementation Targets*

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 met the Performance Standard for this IT in 2025.

Discussion

Beginning in 2021, CYFD collaborated with New Mexico's Nations, Pueblos, and Tribes to begin to develop processes and procedures to promote traditional interventions as first-line interventions and services for Native children and families. This work led to development of a policy titled, Cultural Activities and Traditional Healing Services for Indian Children/Youth that was effective September 1, 2025.[208] This policy is discussed in more detail in App. C, TO 2.3 – *Policies to Support*

[208] CYFD's policy, *Cultural Activities and Traditional Healing Services for Indian Children/Youth* can be accessed here.

Native Children to receive Traditional or Culturally Responsive Services below.

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 met the Performance Standard for this IT in 2025.

Discussion

The State has developed two primary mechanisms for Native children to access Medicaid funds for traditional and culturally responsive treatments.[209] In July 2024, New Mexico transitioned to Turquoise Care which provided for one MCO, PHP, to serve most children in custody. Native children in custody can choose the MCO in which they want to enroll, or they can remain Fee For Service.[210] Turquoise Care covers value added services which include Native American Traditional Healing Benefits (THBs), providing reimbursement for traditional health practices for treatment of diagnosed conditions.

In October 2024, the federal Centers for Medicare and Medicaid Services (CMS) approved HCA's Medicaid 1115 Waiver proposal to provide Medicaid funding for traditional healing. HCA launched the reimbursement benefit on October 1, 2025. The coverage applies to services delivered by or through Indian Health Services and Tribal 638 facilities for eligible Medicaid members. The benefit is voluntary to those Nations, Pueblos, and Tribes who choose to participate. The Navajo Nation is currently the only one of New Mexico's Nations, Pueblos, and Tribes who have chosen to participate in the waiver program. Information provided by the State indicates that reimbursement under the Waiver was not utilized for any Native children in custody in 2025. Native children's access to and utilization of THBs and traditional healing benefits will continue to be assessed and reported through App. C, TO 2.1 - *Identification, Access, and Expansion of Culturally Responsive Services.*

[209] The State's efforts 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.*

[210] Fee for Service is a payment model where New Mexico pays providers directly for each individual service they deliver, as opposed to a managed care plan.

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 2025.

Discussion

The State did not provide an updated plan to increase recruitment and retention of Native resource families in 2025. The State also did not include a description of its efforts toward this TO in its 2025 Annual Report. Though the Nations, Pueblos, and Tribes have voiced preferences for Native children to be placed with relatives, the number of children who continue to be placed in non-IFPA-preferred placements suggests that there continues to be a need for non-relative Native resource homes for some children. For example, data in App. B, TO 6.2 – *Annual Target for New Culturally Reflective Resource Homes*, show that the percentage of newly recruited non-relative homes in 2025 with at least one resource parent who identified as American Indian or Alaskan Native (non-Hispanic) (5%) is lower than the number of children in care on December 31, 2025 identified as ICWA-eligible.[211]

In October 2025, the Co-Neutrals met with representatives from NM Nations, Pueblos, and Tribes and discussed barriers to placement of Native children with relatives and in IFPA-preferred placements. One barrier identified was lack of outreach by PC case workers to relatives when a Native child enters care, and although relatives may be identified at some point in the case, consistent efforts to engage and support a relative beyond an attempted phone call may be lacking. When a relative cannot be identified, placement with a non-relative tied to the child's Tribe is important and based upon the preferences of the Nation, Pueblos, or Tribe, could be considered as an IFPA-preferred placement.

[211] The number of children in custody on December 31, 2025 who were ICWA-eligible (10%, 202 children) is slightly higher than the number of children in custody identified as American Indian or Alaskan Native using the race and ethnicity data in the Sandbox cohort files at the end of 2025 (8%, 163 children).

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 2025; foundational work continued.

Discussion

CYFD has committed to creating additional opportunities for New Mexico's Nation, Pueblos, and Tribes to leverage IV-E federal funding for children in foster care or who are at risk of entering foster care.[212] CYFD's primary strategy for this action has been through development of 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.[213]

As in prior years, OTA had reserved time each week for meetings with Nations, Pueblos, and Tribes seeking consultation on Title IV-E funding and other child welfare agreements. During 2025, CYFD reports meeting with five Nations, Pueblos, and Tribes regarding, among other topics, JPAs, Title IV-E administrative claiming, amendments to existing Intergovernmental Agreements, billing processes, and administrative requirements. As of September 2025, OTA reported that four Tribes had executed JPAs during the year, and that they had been negotiating the terms of those for several years.

CYFD reports that it recognizes the sovereign authority of each Nation, Pueblo, and Tribe to determine whether to pursue a JPA, amend an existing agreement, or seek direct Title IV-E administration, and that CYFD remains committed to supporting Tribal decision-making through education, technical assistance, government-to-government collaboration, and respect for Tribal sovereignty.

[212] 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 eligibility criteria, and are in the custody of the Nation, Pueblo, or Tribe as a result of caregiver abuse or neglect.

[213] 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 2025; foundational work continued.

Discussion

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. OTA had a Quality Assurance (QA) manager who maintained quarterly reporting to Nations, Pueblos, and Tribes in 2025, and established a process for Tribes to request data from CYFD respective to their communities. Data elements include timely Tribal notification of a CYFD investigation, notification of investigation outcome, permanency goals, and the number of Native children in IFPA-preferred placements. Co-Neutral staff met with representatives of New Mexico's Nations, Pueblos, and Tribes and in October 2025 and there were reports of difficulty getting timely and complete information about Native children who are involved in a CYFD investigation or case.

Data are not routinely available to OTA or case workers in county offices on how many and which licensed resource homes have at least one parent who identifies as Native. As in prior years, case record reviews conducted jointly with CYFD OPA staff and the Co-Neutral team, identified discrepancies within the data 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. CYFD and the Co-Neutral team have discussed this as a need for continuing data improvement.

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 2025.

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.[214]

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 2025.

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 was not provided to the Co-Neutrals. Thus, the Co-Neutrals are unable to report performance toward this metric for 2025.

[214] 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 2025.

DVP Metrics and Validated Performance Data

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

There were 279 ICWA-eligible children in custody for at least eight days in 2025 who were affiliated with a MCO, and 42 of those children (15%) were documented as having received Traditional Healing Benefits (THB) during the year.[215,216] This is an increase from 2024, when 23 of 236 eligible children (10%) received a THB.

[215] 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.

[216] Source: Analysis of Sandbox *Encounters, MCO Affiliation, Cohort* and *Episodes of Custody* files. In the *Sandbox Encounters* data submitted, THBs are referred to as Traditional Healing and Managed Care Value Added Services.

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 Healing Benefits, THBs).

There were 312 ICWA-eligible children in custody for at least eight days in 2025 (regardless of whether they were affiliated with a MCO), and 43 of those children (14%) were documented as having received payments and/or reimbursements for cultural activities (including THBs) during 2025. This is an increase from 2024, when 26 of 276 eligible children (9%) were documented as having received payments and/or reimbursements for cultural activities during the year.

Discussion

The number and percentage of Native children who received THBs in 2025 has increased over the prior year; data do not show that traditional healing benefits under the 1115 Waiver – effective October 1, 2025 – were provided to any Native children in care. In prior years, CYFD provided information on the number of Native children who received payments or reimbursements from CYFD for traditional or culturally responsive services; these data were not provided for 2025 though the Co-Neutrals have heard anecdotal information and confirmation about these reimbursements being provided.

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 2025.

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[217]

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 2025.

[217] 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 met the Performance Standard for this TO in 2025.

Discussion

In 2024 and 2025, CYFD drafted, piloted, and finalized a policy and processes to facilitate and support use of cultural activities and traditional healing services for Native children in foster care as the first line of intervention that will take precedence over westernized interventions and practices. The policy is titled, *Cultural Activities and Traditional Healing Services for Indian Children/Youth* and was effective September 1, 2025.[218]

Through this policy, CYFD outlines a procedure to provide funding for cultural activities and traditional healing services that support the well-being and cultural identity of Native children. Case workers are required to continually and consistently make active efforts to ensure Native children receive cultural activities and traditional healing services, and at every opportunity – including during meetings, CAT or CANS screenings, IPPs, or OOPPs – inquiries should be made as to what cultural activities and traditional healing services are available for the Native child to participate in. Case workers must inform the child's family and Nation, Pueblo, and Tribe about the availability of financial coverage for cultural activities and traditional healing services, and assure them that financial coverage does not require disclosure of sacred or spiritual information.

The policy requires CYFD staff to communicate with Nations, Pueblos, and Tribes in a culturally sensitive manner, that is respectful of their cultural practices, attitudes, and beliefs. It also emphasizes that in respect to the privacy and sacredness of spiritual information and practices, and to honor and respect Tribal sovereignty, CYFD will not document the underlying purpose, what service is being performed, or the methods that are used within the practices.

[218] CYFD's policy, *Cultural Activities and Traditional Healing Services for Indian Children/Youth* can be accessed here.

Requests for funding or reimbursements can be made to OTA by the case worker for the Native child; the Native child or youth; their family (including extended family and fictive kin); the child's Nation, Pueblo, or Tribe; or the child's resource family, in collaboration with the child's Nation, Pueblo, or Tribe.

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 met the Performance Standard for this TO in 2025.

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 finalized this policy in 2025. This TO will continue to be assessed by the Co-Neutrals in 2026.[219]

[219] TOs are monitored until the Defendants have met the Performance Standard continuously for a period of at least 24 months.

Development of Protocols for 30-Day Review Process (App. C, TO 4.2) [220]

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 2025. Protocols have been developed, however, consistent compliance with the protocols, as required by this TO, did not occur in 2025.

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 describe the legal requirements pursuant to the federal ICWA on the placement of Native children in foster care, and establish 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-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 Native children are in IFPA-preferred placements.[221] 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.[222] This policy articulates the placement preferences pursuant to IFPA and provides a framework for monthly meetings and "OOPP up-staffings" (described below) for Native

[220] 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.
[221] CAP Section II.3.
[222] This policy can be found here.

children not in IFPA-preferred placements. This policy was effective December 1, 2023.[223]

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 family 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 a 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.

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 2025 was not compliant with established protocols and procedures as required by this TO.

[223] The *Kevin S.* 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.

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 2025.

DVP Metrics and Validated Performance Data

CTO4.1(i) – primary metric: Length of time Native American children spent in non-ICWA preferred placements.[224]

Of the 3,083 children in custody at any point during 2025, 342 children (11%) were ICWA-eligible.[225] Of these 342 children, 121 children (35%) spent at least one day in a non-IFPA-preferred placement, including 49 children (14%) who spent more than 180 days in such a placement.[226] This is a decrease (and thus an improvement) from 2024, when 43 percent of ICWA-eligible children spent at least one day in a non-IFPA-preferred placement. Figure 39 shows the number of days spent in non-IFPA-preferred placements for all 342 children.

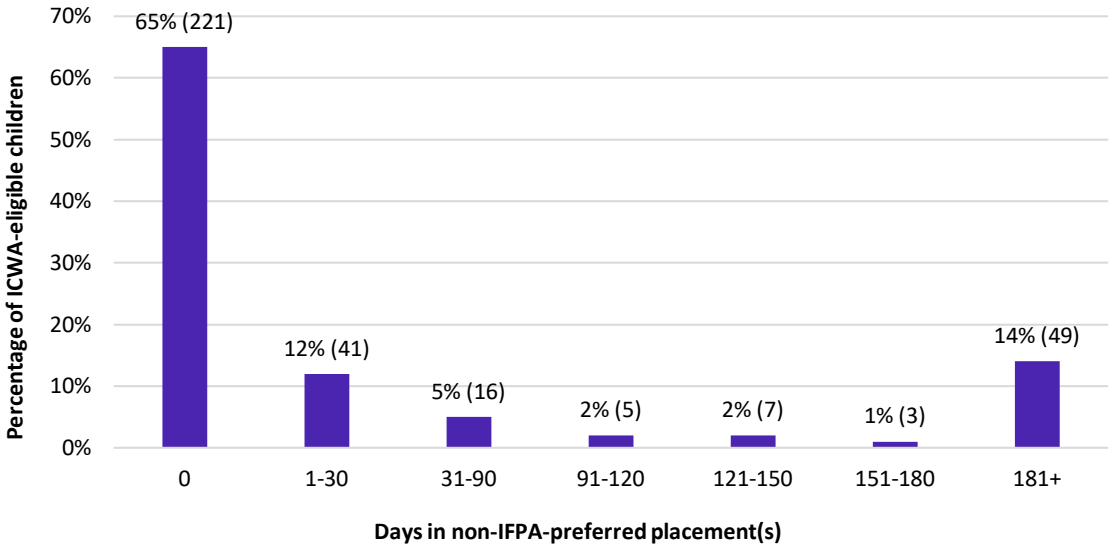
[224] Per the DVP, these calculations (for both primary and secondary metrics) included temporary absences that occurred within or between non-IFPA-preferred placements. For example, if a child was in a non-IFPA-preferred placement, then was in an acute hospitalization, and then either returned to that same placement or moved to a new non-IFPA-preferred placement, the length of that entire spell would count toward the total.

[225] Per the DVP and guidance from the State, 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.

[226] Per the DVP and guidance from the State, 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.

Figure 39: Percentage of ICWA-eligible Children by Total Days Spent in Non-IFPA-Preferred Placements[227,228]

2025; N = 342 ICWA-eligible children



Source: Analysis of Sandbox Placements, Cohort, and CourtDisposition files

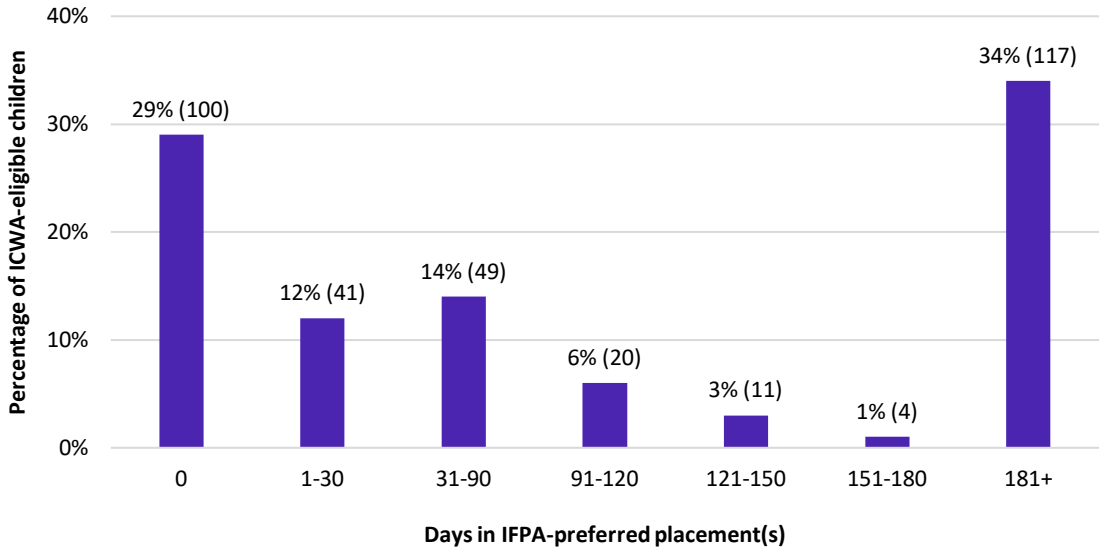
The Co-Neutrals also examined the length of time ICWA-eligible children spent in IFPA-preferred placements, as opposed to non-IFPA-preferred placements. Of the 342 ICWA-eligible children in CYFD custody at any point during 2025, 242 children (71%) spent at least one day in an IFPA-preferred placement in 2025, including 117 (34%) who spent more than 180 days in such a placement. Figure 40 shows the distribution of time spent in IFPA-preferred placements for all 342 children.

[227] Percentages do not sum to 100 due to rounding.

[228] The number of children with zero days in non-IFPA-preferred placements includes 220 children who experienced no non-IFPA-preferred placements and one child who experienced a non-IFPA-preferred placement that began and ended on the same day.

Figure 40: Percentage of ICWA-eligible Children by Total Days Spent in IFPA-Preferred Placements[229,230]

2025; N = 342 ICWA-eligible children



Source: Analysis of Sandbox Placements, Cohort, and CourtDisposition files

CTO4.1(ii) – primary metric: Percentage of 30-day reviews for non-ICWA-preferred placements conducted on time.

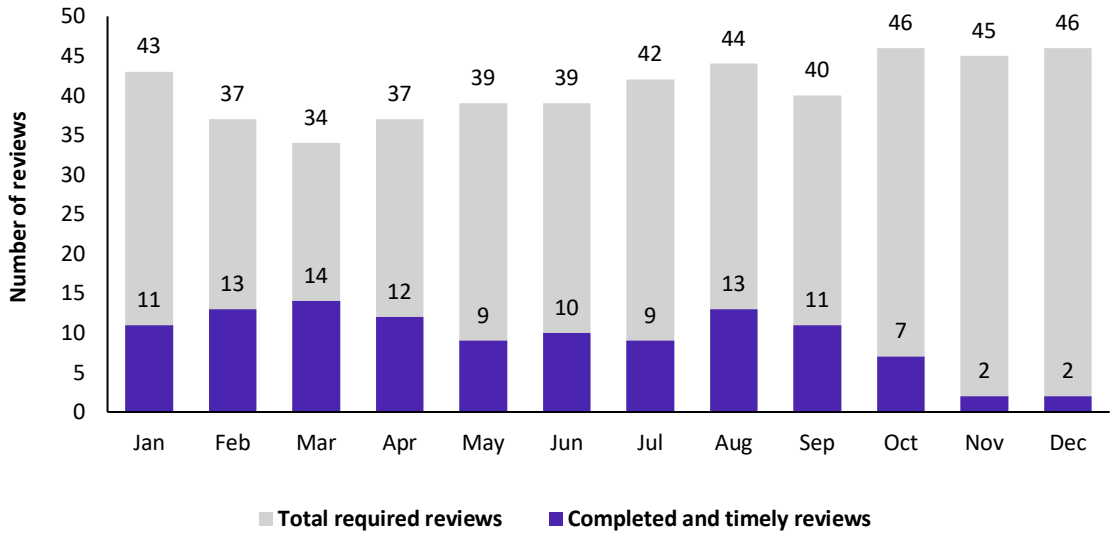
There were 492 required 30-day reviews for children in non-IFPA-preferred placements in 2025, and 113 of them (23%) were conducted on time.[231] This is a decrease from 2024, when 180 of 478 required reviews (38%) were conducted on time. The Co-Neutrals also examined the data by month and found that the percentage of completed and timely reviews decreased over the course of the year (from 30% in the first half of 2025 to 17% in the second half of the year; see Figure 41).

[229] Percentages do not sum to 100 due to rounding.

[230] The number of children with zero days includes 98 children who experienced no IFPA-preferred placements and two children who experienced IFPA-preferred placements that began and ended on the same day.

[231] 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 41: Required and Completed Reviews for Non-IFPA-Preferred Placements, by Month
2025; N = 492 required reviews



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

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 OPA 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.[232]

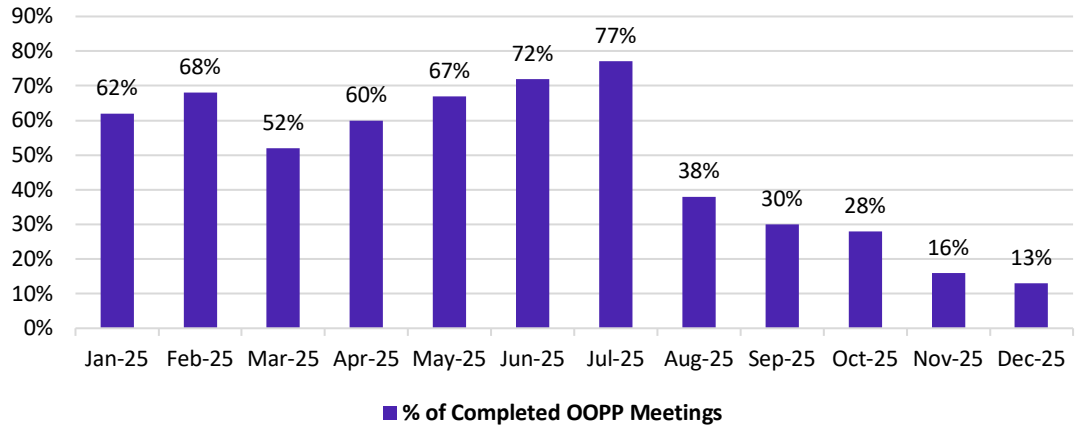
In order to provide current, real-time performance to CYFD and OTA on practice, two separate reviews were conducted covering six-month periods in 2025 – the first was in October 2025 for the period January through June 2025 and included reviewers from CYFD OPA and the Co-Neutral team, and the second was conducted in August 2026 for the period July through December 2025 and included reviewers from the Co-Neutral team. The January through June 2025 sample included 51 children, and the July through December 2025 sample included 36 children; 19 unique children were included in both review samples, thus, a total of 68 unique children's cases were

[232] Reviewers participated in an orientation and training on the FSA standards and the review instrument. CYFD OPA and Co-Neutral staff implemented a quality control process during the reviews, including completing second level reviews of identified surveys.

reviewed.[233,234] The sample of children reviewed experienced a total of 165 placements, of which 152 placements (92%) were not in accordance with IFPA placement preferences.[235] A total of 436 OOPP meetings were required between January and December 2025 for the samples reviewed. Documentation in FACTS showed that only half of the required OOPP meetings were held (50%, 219 OOPP meetings).[236] Monthly performance ranged from 13 to 77 percent, and similar to the quantitative data discussed above, declined substantially later in the year (Figure 42).

Figure 42: Completed OOPP Meetings

January – December 2025



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

[233] The State pulled the universe and sample for the January through June 2025 review. The universe included 109 Native children who were placed in a non-IFPA-preferred placement for at least 30 days during the period under review. The Co-Neutral team pulled the universe and sample for the July through December 2025 review from data provided by the State. The universe included 56 Native children who were placed in a non-IFPA-preferred placement for at least 30 days during the period under review. Sampling for both reviews represents a 95% confidence interval with a 10% margin of error.

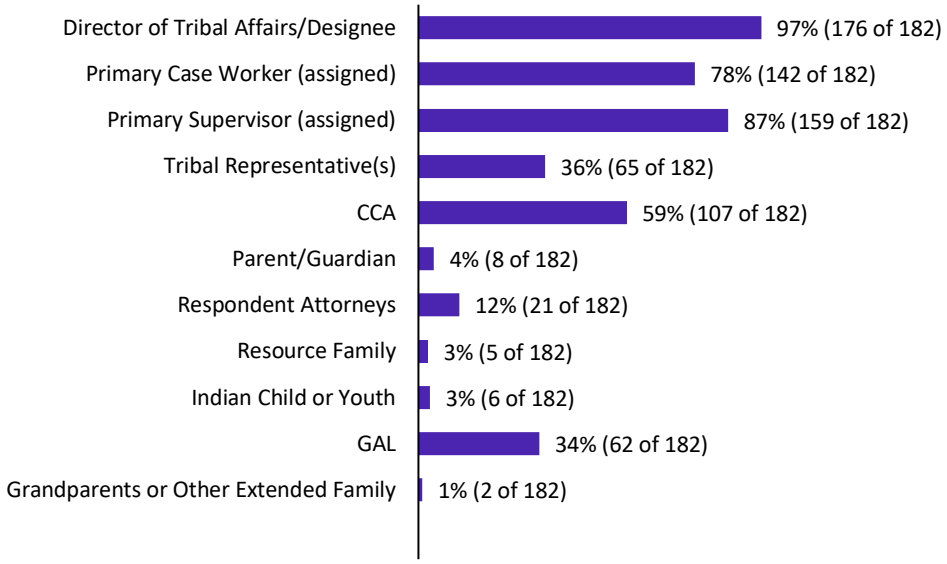
[234] Three children who were originally identified by CYFD as applicable for the January through June 2025 review were removed when reviewers determined that they were placed in IFPA-preferred homes during the period under review but their placements were miscategorized in FACTS. Two children were removed from the July through December 2025 review when based upon what was documented in the record, reviewers determined that ICWA/IFPA did not apply and the cases were mislabeled in FACTS.

[235] 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. Two of the 152 non-IFPA-preferred placements were second order IFPA placements, and 14 were third order IFPA-preferred placements.

[236] 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 counted OOPPs as due or completed based on the calendar month, not 30-day periods.

The team reviewed documentation for all 219 OOPP meetings completed between January and December 2025, and none documented that invitations to attend had been extended to all necessary participants (0%), and that all required discussion topics and issues were addressed within the meeting. [237,238] OTA staff were present in 93 percent of meetings, the child's PC was present in 73 percent of meetings, and the PC's supervisor attended 82 percent of meetings (see Figure 43). A Tribal representative or case worker was present in 38 percent of meetings while the child's parent was present in two percent of meetings.

Figure 43: Documented Participants in Completed OOPP Meetings
January - December 2025



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

Other available preferred placements were documented as discussed in seven percent of completed meetings (16), and of those meetings in which a placement was identified, none had a documented transition calendar which identified specific supports to make the child's placement transition successful. Data collected during the review shows that three of the children moved from a non-IFPA-preferred placement into an IFPA-preferred placement within the period under review, and 11 children achieved permanency with their parents/guardians or a relative during the period under review.

[237] CYFD's procedure requires that OTA facilities the meeting and invites the following individuals to OOPP meetings two weeks in advance: PC, PC supervisor/manager, resource family, GAL (GAL) and/or Youth Attorney (YA), CCA, Tribal representative, Native child's parents if parental rights have not been terminated, parents' attorneys, extended family members, and the child, as appropriate.
[238] 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.

Documentation showed discussion of the following topics in the 219 completed meetings:

- Efforts to locate and identify family members in 41 percent (90),
- Diligent efforts to identify family as possible placement resources in 30 percent (65),
- Barriers that would prevent the child from being placed with family members in 36 percent (78),
- Culturally responsive services and community resources as being requested or provided in 18 percent (40),
- Other preferred placement options in 13 percent (29),
- The Tribe's position as to the current placement in seven percent (15), and
- The Tribe's recommendation(s) for future placement of the child in four percent (9).

Discussion

Quantitative and qualitative data for this TO show that OOPP meetings to review non-IFPA-preferred placements did not consistently occur as required. Of those OOPP meetings that did occur, of the random sample reviewed, none documented inclusion of all necessary team members and discussion topics.

The State's 2025 *Kevin S.* Annual Report states the following regarding the information collected during the CYFD and Co-Neutral teams' qualitative review:

> *The review team evaluated the quality of case document associated with each OOPP staffing that was required for the child in a non-preferred placement. The dominant themes identified centered on OOPP procedural non-compliance and inconsistent meeting quality. Patterns included missed meetings when required, incomplete attendance, lack of timely OTA notifications, minimal documentation of diligent efforts, and repetitive copy-paste narratives that did not provide efforts towards case progress. Tribal engagement and cultural practice were persistently lacking, with Tribal preferences frequently undocumented even when representatives were present. Youth and parent participation were routinely absent, and Upstaffing's were often required but not held or tracked. While some cases reflected steady meeting frequency and occasional relative engagement, overall, the review showed a system where OOPP processes are occurring inconsistently in form and often lacking substance, limiting their effectiveness to secure a preferred placement for Indian Children.*[239]

[239] State's 2025 *Kevin S* Annual Report, p.40. The report is available here.

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 2025. 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 from the child's Nation, Pueblo, or Tribe and family members are invited to attend. The case record review 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. Specifically, a Tribal representative or case worker was present in 38 percent of meetings held, two percent of applicable meetings included the child's parent, and one meeting (<1%) included the child's extended family members. The highest priority IFPA placement preferences are with family and Native resource parents, making these participants essential in identifying relatives and developing a plan to move a Native child into an IFPA-preferred placement. CYFD must make active efforts to invite the required participants, schedule meetings at times and in places where they can participate and support their engagement and participation in decision-making. Further, follow-up on recommendations coming from meetings is essential and CYFD managers must hold workers accountable and actively participate in up-staffings.

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 2025.

On January 12, 2023, the Co-Neutrals approved the State's Indian Child Welfare Act (ICWA) and Indian Family Protection Act (IFPA) 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, 2025, there were 1,786 staff employed at CYFD.[246] According to the ICWA/IFPA Training and Coaching Plan, 121 of these 1,786 staff were required to complete ICWA/IFPA training in 2025.[247,248] Of these 121 staff, 46 (38%) completed all modules of training for Tier 1: *Novice*

[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 indicate that all modules of this training were not available to staff in 2025.
[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 indicate that all modules of this training were not available to staff in 2025.
[246] There was a change in the State's production method for the *StaffPositions* Sandbox file that may affect the reliability of the results calculated for this metric.
[247] In 2025, the State carried out all trainings for Tier 1: *Novice* ICWA/IFPA Certification, but the complete series of Tier 2 trainings and Tier 3 trainings were not yet available to staff. Thus, reporting for this metric only includes all staff who were required to complete Tier 1.
[248] Per the DVP, only employees hired between January 1, 2024, and December 31, 2024, who were required to complete ICWA training during 2025 are included in this metric.

ICWA/IFPA Certification by the due date.[249,250] This is a decrease from 2024, when 106 of 146 required staff (73%) completed all modules of Tier 1 training. Of the 121 staff required to complete Tier 1 training in 2025, 104 (86%) completed at least one course.

All CYFD PSD supervisors, managing attorneys, and ICWA unit staff are required to complete all four modules of training in the Tier 2: Advanced Certification. However, in 2025, only two of the five modules were included in the training completion data provided to the Co-Neutrals (*Supervising Indian Child Welfare Act/IFPA Cases* and *Government-to-Government Relations – Proficient*). Of the 1,786 staff employed in CYFD PSD on December 31, 2025, 205 supervisors and managing attorneys would have been required to complete Tier 2 trainings.[251] Of these 205 staff, 14 staff completed one of the two Tier 2 training modules that appeared in the data and eight completed both.[252] All 22 of these staff also completed all courses in the Tier 1: *Novice* 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 2025.

Discussion

The quantitative data show that 38 percent of required CYFD staff received the ICWA/IFPA Tier 1: training by December 31, 2025, a significant decrease since 2024 when 73 percent of required staff completed the training. Although the ICWA/IFPA Training and Coaching Plan anticipated that the content and curriculum for Tier 2 and Tier 3 would be completed by 2023, data provided to the Co-Neutrals related to training completion shows that all modules of these trainings were not yet available to staff in 2025. OTA reported to the Co-Neutrals in September 2025 that Tier 2 trainings were offered in December 2024, June 2025, and December 2025, and attempts were made to schedule additional opportunities but only one CYFD staff registered to attend.

From January through December 2025, members of the Co-Neutral team conducted interviews with case workers and supervisors across all three case work types throughout the state and asked

[249] As additional information, the Co-Neutrals calculated the number of staff who were not required to be trained but completed at least one Tier 1 training as of December 31, 2025. There were 559 additional staff who completed at least one Tier 1 training. Of these 559 staff, 21 completed *Cultural Humility in Social Services*, 463 completed *Populations of New Mexico*, 397 completed *Indian Child Welfare Act Overview – Best Practice for Best Outcomes (e-learning)*, and 41 completed *ICWA and IFPA In-Depth Training – Applying Best Practices*.

[250] Completion data for each individual module is as follows: *Cultural Humility* – 44 percent of all required staff completed; *ICWA/IFPA Best Practices* – 78 percent of all required staff completed; *Indian Child Welfare Act Overview* – 70 percent of all required staff completed; and *Populations of New Mexico* – 69 percent of all required staff completed.

[251] The State did not identify ICWA unit staff in their *StaffPositions* file, so the Co-Neutrals could not include ICWA unit staff in their count of staff required to complete Tier 2 training.

[252] As additional information, the Co-Neutrals calculated the number of staff who were not required to be trained but completed at least one Tier 2 training as of December 31, 2025. There were 26 staff that completed one Tier 2 training, and five staff that completed both trainings that appeared in the data.

about their experience with ICWA/IFPA trainings, among other topics. Staff were asked to rate how useful the ICWA/IFPA trainings were in preparing them to work with children and families, and staff ratings are listed below in Table 24. In general, those who reflected favorably on the training referenced the importance of gaining a better understanding of the history and background of Native families as well as the specific steps required for working ICWA/IFPA cases. Among the 11 staff who rated the ICWA/IFPA training as "not so useful" or "not at all useful," seven felt the training did not focus enough on ICWA policies and procedures.

Table 24: ICWA/IFPA Training Ratings by Staff Type

N = 193 staff

Rating	Investigations		Licensing and Support		Permanency		All	
	N	%	N	%	N	%	N	%
Extremely useful	37	47%	20	38%	31	51%	88	46%
Very useful	22	28%	20	38%	19	31%	61	32%
Somewhat useful	14	18%	11	21%	8	13%	33	17%
Not so useful	3	4%	2	4%	3	5%	8	4%
Not at all useful	3	4%	0	0%	0	0%	3	2%
Total	**79**	**100%**	**53**	**100%**	**61**	**100%**	**193**	**100%**

Source: Co-Neutral Team Interviews with CYFD Case Workers and Supervisors, January – December 2025

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."[253] 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.

In prior reports, the Co-Neutrals assessed that the State met the Performance Standard for many of the FSA Appendix D ITs.[254] There are two ITs and six TOs in Appendix D that have not yet been achieved by the State and are discussed in this section of the report. These include requirements for HCA to monitor implementation of care coordination delivered by MCOs; developing a joint process between CYFD and HCA to ensure seamless access to services and supports for all children in custody; and the implementation of the Behavioral Health Workforce Development Review, including ensuring there are sufficient HCA staff to effectively monitor Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services overseen by MCOs and building out an adequate behavioral health provider network to meet the needs of children in custody. Additionally, the State is required to provide incentives for providers to become trained in evidence-based practices (EBPs); to ensure medically necessary behavioral health services are immediately available to children in custody; and to provide well-child visits (WCVs) to all children within 30 days of entering custody.

In 2025, HCA found deficiencies in PHP's performance as the MCO for children in custody, leading to the creation of a Corrective Action Plan (CAP) to improve performance in care coordination and network adequacy such that children receive timely and appropriate access to services. HCA and PHP continued to refine the CAP into 2026. Consistent with issues identified in the CAP, case record reviews completed by CYFD and the Co-Neutral team identified weakness with care coordination. Reviewers found that care coordinators were not consistently in attendance at meetings relevant to children's treatment planning – including for children placed in facilities who were awaiting discharge – and that there were instances where children's FACTS and MCO case records documented different diagnoses, services, and even discharge plans for children.[255]

In 2025, the State began implementing the Behavioral Health Workforce Development Review. PHP's performance is a key factor that determines implementation of the Review, as PHP is

[253] FSA, pg. 12a

[254] 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.*

[255] Specific findings for these reviews can be found in App. B, TO 2.1 – *Joint Clinical Reviews of Out-of-State Placements*, App. B, TO 2.3 – *Out-of-State IPP Meeting and Development of Discharge Plans*, and App. B, TO 3.2 – *30-Day IPP Meetings for Clinical Congregate Care*.

responsible for hiring and contracting with behavioral health providers to ensure that children have access to specific evidence-based services necessary to meet their needs in the counties where they live. While there was some progress in 2025 by the State and PHP to build out the provider network – such as the roll out of Certified Community Behavioral Health Clinics (CCBHCs) and the training and certification of providers in evidence-based services – the State ultimately struggled to make progress in building out services to meet the needs of children.[256] Specifically, the State only met the target for certifying providers in MST and EMDR in 2025, and did not for certifying providers in the other identified modalities (FFT, DBT, and TF-CBT). Similarly, despite the increase in MST and EMDR providers, and the partnership with NMSU COI for free training and certification and enhanced EBP modifier billing rates, the State's data show that 121 children received specific EBP services within the identified age range for the EBP modality (HFW and MST).[257] The number of children who received these services was far below the utilization targets for 2025.

Additionally, role confusion over responsibility for children's behavioral health services among CYFD, HCA, and PHP – and by extension their staff – continued to inhibit progress as the State's approach often appeared disjointed and without effective collaboration between Departments. This lack of unity and clarity in roles is exacerbated by the continued lack of a complete joint process between CYFD and HCA.[258]

The State's performance for ensuring completion of children's WCVs within 30 days of entering custody improved in 2025, with significant improvements made in the last quarter of 2025. HCA, CYFD, and PHP developed a joint process to monitor and problem solve barriers to children receiving their WCVs, leading to performance as high as 93 percent of children (71 of 81 who entered and remained in custody 30 days or longer) in November 2025.

[256] Additional information about CCBHCs in New Mexico can be found here.
[257] Data for metric App. D, TO 1.2 only include services provided to children within the age range specified for each EBP modality; thus, EBP services provided to children outside of the relevant age range were not included in this metric. Performance data for metrics App. A, TO 2 and App. D, TO 3 include EBP services provided to children regardless of age, thus those metrics include five additional children not included within App. D, TO 1.2.
[258] The State provided a proposal for developing the joint process deliverable to the Co-Neutrals in September 2026 that is currently under review.

a. Implementation Targets

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 2025.

Discussion

Section 4.4 of the PHP Turquoise Care contract for children in custody requires care coordination to be provided in collaboration with a child's treatment team and through direct contact with the child and family.[259] Children in 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 such as CYFD case workers and other staff, family members, physicians, specialists, and other health care professionals as needed to meet the child's needs. 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.

HCA administers and manages PHP's contract for serving children in custody. In July 2024, HCA added a Population Health Unit to increase management and oversight of outcomes for children in custody. As part of their contract, PHP is required to submit regular quarterly reports to HCA demonstrating outcomes, including a report specifically focused on member engagement and care coordination. In 2025, HCA required PHP to submit a Corrective Action Plan (CAP) to remedy deficiencies found in their performance, including care coordination. As part of PHP's CAP, HCA required PHP to improve their care coordination processes to ensure children in custody are receiving timely and appropriate access to services.

In 2025 as part of RO#1, the State was required to explore the co-location of PHP care coordinators in CYFD county offices to increase collaboration among CYFD and PHP staff to determine if it was an effective strategy for helping children receive their well-child visits within 30 days of entering custody. By the end of 2025, co-location was occurring in 13 CYFD county offices for a limited number of hours every other week. Bernalillo (including the ICWA unit), Chaves, Dona

[259] The Turquoise Care contracts replaced the Centennial Care contracts as of July 1, 2024. The PHP Turquoise Care contract for serving children in custody can be found here. Additional information about PHP can be found here.

Ana, Lea, Otero, and San Miguel counties were all receiving on-site care coordinator visits between two to four hours per week, while Cibola, McKinley, Rio Arriba, San Juan, Sandoval, Torrence, and Valencia counties were all receiving two to three hours of care coordinator visits every other week. Ultimately, HCA concluded that co-location was not an effective intervention for increasing completion of well-child visits and the practice was discontinued in 2026.

As part of the qualitative reviews completed by CYFD OPA staff and the Co-Neutral team to assess outcomes for children placed at in-state and OOS congregate settings in 2025, documentation was reviewed from PHP utilization review records and FACTS case records, including team meetings. Frequently, there was different information included in the FACTS case record than in the MCO records, including different diagnoses and medications, discharge planning and services. Additionally, lists of meeting participants showed a lack of consistent attendance and participation by MCO care coordinators.[260]

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 2025.

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 custody. As of December 31, 2025, the State did not develop a joint process for offering services and supports and had not provided an updated draft joint process proposal to the Co-Neutrals since September 2022.[261]

The joint process is foundational to the implementation of the FSA, and the lack of the joint

[260] Specific findings of these reviews are discussed earlier in this report in App. B, TO 2.1 – *Joint Clinical Reviews* and App. B, TO 3.2 – *30-Day IPP Meetings for Clinical Congregate Care.*

[261] The State provided a proposal for developing the joint process deliverable to the Co-Neutrals in September 2026 that is currently under review.

process continued to impact the State's performance throughout 2025. For example, a complete joint process would clearly delineate the roles and responsibilities for CYFD and HCA pertaining to: completing, collecting, and sharing information for well-child visits (WCVs); completing and using the CAT and CANS screening tools; referring, assessing, and placing children into TFC and FC+ placements; connecting children to behavioral health services and ensuring on-going treatment plan updates; identifying and responding to critical incidents; and for various other additional processes that impact a child and family as they navigate involvement with CYFD and HCA. While the State has identified processes to complete some of these tasks, these policies are often standalone and not connected or accessible, leading to confusion in the field over which Department – and by extension their staff – are responsible for helping a child meet specific needs.

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 2025.

The Co-Neutrals approved the State's App. D, IT 1 Behavioral Health Workforce Development Review (Review) on March 12, 2025, contingent on the development of metrics and iterative performance targets to be used to assess implementation under App. D, TO 1. The metrics were finalized and the Review was fully approved on November 13, 2025.[262]

The 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 custody specific to the services identified in the FSA, including HFW, intensive case management, intensive home-based services, and evidence-based, well-supported, or promising trauma-responsive therapies such as DBT, MST, TF-CBT, FFT, and EMDR. As the sole MCO serving most children in 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.[263]

[262] The approved Behavioral Health Workforce Development Review can be found here.
[263] The *Turquoise Care - Children in State Custody* contract went into effect on July 1, 2024, and named PHP as the MCO serving children in custody. Most children in custody eligible for Medicaid are served by PHP, however Native children in custody can choose which MCO they want to enroll in, or they can remain Fee-For-Service.

The State's performance for implementing the Behavioral Health Workforce Development Review is measured within three commitments: App. D, TO 1 – *Workforce Development*; App. D, TO 1a – *Employing Sufficient Staff*; and App. D, TO 1b – *Sufficient Provider Network*. An analysis of the State's overall performance on implementing the Review is included in the discussion after App. D, TO 1b.

DVP Metrics and Validated Performance Data

*DTO1.*2*(i) – Based on the service utilization estimates identified in the Review, 30% of the children expected to need for High-Fidelity Wraparound services, DBT, MST, Trauma-Informed CBT, FFT, EMDR, intensive case management, and mobile crisis response will receive the services by December 31, 2025.*[264]

The State determined and agreed that 30 percent of children expected to receive the specific services identified in the Review would receive them by December 31, 2025. Out of all the specific services identified in the Review (HFW, DBT, MST, TF-CBT, FFT, EMDR, intensive case management, and mobile crisis response), the State's data show children received billable services for only two services – HFW and MST. Specifically, 99 children received HFW (compared to 159 expected to use the service) and 24 children received MST (compared to 68 expected to use the service). The remaining services were not provided to children in custody, were not billed using the appropriate codes, or were not provided within the appropriate age range designated for the service.[265]

[264] This metric is new as of 2025, and the Co-Neutrals and State have not yet finalized the DVP metric language.

[265] The Review identifies the age ranges specified by the certifying organization for each EBP. Children's ages were calculated based on their age at the end of the year. EBPs provided to children outside of the relevant age range were not included (for example, a two-year-old child who had a service billed for EMDR). Performance data for metrics App. A, TO 2 and App. D, TO 3 include EBP services provided to children regardless of age, thus those metrics include five additional children not included within this metric.

Table 25: Total Number of Children who Received an EBP Service as of December 31, 2025, by EBP

2025; N = 121 children who received an EBP service

Modality (age range)	Total number of children expected to receive the service[266]	Number of children expected to receive service by December 31, 2025 (30% of total # expected)	Number of children who received service in 2025, per billing data[267]	2025 Target met
TF-CBT (3-18 years)	1,124	338	0	No
Intensive case management (0-18 years)	1,082	325	0	No
Mobile crisis response (0-18 years)	633	190	0	No
HFW (0-18 years)	528	159	99	No
FFT (10-18 years)	371	112	0	No
MST (11-18 years)	225	68	24	No
EMDR (12-18 years)	198	60	0	No
DBT (13-18 years)	172	52	0	No

Source: Analysis of Sandbox Encounters and Cohort files

> *DTO1.3(vi) – By August 1, 2025, the State will complete a current clinical review of all medications prescribed to children in state custody who are prescribed psychotropic medication. The clinical review will be consistent with NMAC 8.10.8.17, paragraph F, and the timeframes and processes outlined in CYFD's PRI 7 Medical and Behavioral Health, paragraph 9 Psychotropic Medication. Thereafter, the State will ensure on an ongoing basis that all such clinical reviews for children in state custody occur consistent with the regulations, timeframes, and processes developed pursuant to DIT4.*

To validate this metric, the Co-Neutrals requested the State provide the results, methodology, and process for completing their clinical reviews, including children's FACTS IDs and information on how the reviews were being tracked and documented. HCA provided aggregate population-level not child-specific) data and information regarding clinical reviews completed by PHP in 2025 for children whose prescribed medications were considered "red flags," including children prescribed multiple medications to treat mental health conditions, inconsistent use of specific medication types (i.e., stimulants), gaps in recommended laboratory monitoring for children on specific medications (i.e., antipsychotics), specific medications prescribed for children of certain ages (i.e.,

[266] The Co-Neutrals and State agreed to apply the utilization estimates identified in the approved App. D, IT 1 Review. In future years, the utilization estimates will be updated to reflect a more current cohort of children in custody, as identified in the Review.

[267] 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 total number of children who received an EBP service.

children under 12 prescribed antipsychotic medications), and instances where a child was prescribed multiple medications to treat symptoms before adequate trials with one medication. The aggregate information provided by the State ultimately showed that medication reviews took place and may have included outreach by PHP to prescribing providers to discuss cases. However, it is unclear whether this process included efforts to modify or influence prescribing practices based on the reviews or assure routine monitoring for children in custody. Child-specific documentation of these consultations, reviews, and outreach was not found by the Co-Neutral team in FACTS, thus, could not be validated.

Additionally, CYFD's procedure (NMAC 8.10.8.17) requires a heightened level of monitoring by the child's PC, with staffings scheduled at least every 60 days to review the child's medication use when specific criteria are met (see Table 26).[268] This metric requires the clinical reviews completed by the State to be consistent with this procedure, and that reviews will continue on an on-going basis. The information provided by the State, and 15 children's FACTS case records subsequently reviewed by the Co-Neutral team, contained no documentation regarding collaboration between PHP's psychiatrist and CYFD staff. This lack of collaboration between CYFD and PHP (and subsequently, HCA) regarding children's psychotropic medications further highlights the urgency for the State to create a unified joint process deliverable as required by App. D, IT 8 – *Developing a Joint Process for Offering Services and Supports*.

[268] NMAC 8.10.8.17 regarding psychotropic medication monitoring can be found here.

Table 26: NMAC Criteria for Higher Level of Monitoring for Children Prescribed Psychotropic Medications

CRITERIA INDICATING NEED FOR FURTHER REVIEW & MONTHLY STAFFINGS If a child or youth in PSD foster care has one or more of the six criteria below, a referral for "Medication Consultation" must be submitted and 60-day staffings must occur to monitor medication use until the child no longer meets the criteria.	
Criteria One	The child/youth is taking medications and does not have an assessment, including a DSM-5 diagnosis, in the child's case file.
Criteria Two	The child/youth has been on psychotropic medications for a period of 3-6 weeks and their symptoms are worsening or not improving.
Criteria Three	The child/youth is prescribed three or more psychotropic medications at the same time (excluding over the counter medications or vitamins/supplements).
Criteria Four	The child/youth is prescribed of any of the following at the same time: - Two or more stimulants - Two or more alpha agonists/antihypertensives - More than two antidepressants - One or more antipsychotics - One or more mood stabilizers (including Lithium and anticonvulsants)
Criteria Five	The prescribed psychotropic medication is not consistent with appropriate care for the child or youth's diagnosed mental disorder or with documented targeted symptoms usually associated with a therapeutic response to the medication prescribed.
Criteria Six	Psychotropic medications are prescribed for children of very young ages, including children receiving the following medications with an age of: - Stimulants: Less than four years of age - Alpha Agonists: Less than five years of age - Antidepressants: Less than five years of age - Mood Stabilizers: Less than 12 years of age - Antipsychotics: Less than 12 years of age

Source: NMAC 8.10.8.17

DTO1.3(vii) – By December 31, 2025, CYFD CBHC's will provide consultation on 90% of all children's cases where:

- *The child has not received a referred EBP within 30 days of referral;*
- *The child if experiencing inappropriate placements*
- *The child has been denied acceptance for TFC.*

To validate this metric, the Co-Neutrals requested a list containing the FACTS IDs for 228 children who were referred for CBHC consultation in 2025, including the reasons for the consultation. Data for children eligible for a CBHC consultation based on the first criteria – lack of receipt of a referred EBP – was not provided as the State's current data collection regarding referral sources for EBP services relies on recommendations by either a completed CANS screening or recommendations made in a child's IPP meeting. Neither the CANS screenings nor IPP meetings

occurred regularly in 2025, thus, it was not possible to identify the full universe of children applicable for this metric to determine if consultation was provided in 90 percent of cases as required by the App. D, TO 1. Because of this, the Co-Neutrals could not identify a statistically significant sample to assess performance toward this requirement.

The Co-Neutrals identified 25 cases where CBHCs provided consultation in 2025 to better understand the role of CBHCs in PSD cases, the impact of CBHC involvement on the child's placement and treatment, and whether a CBHC's involvement resulted in increased access to treatment services.[269]

Of the 25 cases reviewed, over half (15 of 25) were referred to a CBHC due to either "high behavioral health needs" or as part of the CYFD/CBHC Pilot Project, which CYFD launched in September 2025 in Lea, Sandoval, and Valencia counties. The Pilot project required referrals to CBHCs to enable an early assessment and collaboration to identify mental health needs for children placed on a 72-hour custody hold. In nine of the 25 cases reviewed, the CBHC had direct contact with the child by either attending a team meeting, providing de-escalation while the child was in a CYFD office or Receiving Center, or attending a home visit alongside the child's PC. In most cases reviewed (20 of 25), CBHCs made recommendations for mental health assessments, services, or supports the child needed; in 19 of the 20 cases, referrals for services were documented as completed. and in eight cases, services were provided to the child. Ultimately, the Co-Neutral team's review of this sample of cases identified that CBHCs frequently made recommendations for specific mental and physical health assessments or treatments, or for other supports needed to help stabilize the child and their placement. However, there was inconsistent case involvement and consultation and it could not be determined whether the recommendations were followed.

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 2025.

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventative health care services for children enrolled in Medicaid.[270] It requires states to provide regular, age-appropriate screenings and evaluations. When concerns or

[269] Of the original sample of 25 cases selected, 16 cases had to be replaced with alternates as case reviews identified issues such as: the CBHC did not actually consult on the child's case in 2025; the child never entered PSD custody in 2025 or was in the custody of CYFD's Juvenile Justice Services (JJS); or the child's case was listed twice in the data provided by the State.
[270] Additional information about EPSDT can be found here.

problems are identified, EPSDT requires that all necessary health care services are made available to treat any physical and mental illnesses or conditions. This FSA commitment requires HCA to employ sufficient staff to effectively manage the MCO contracts to ensure children's needs are adequately identified and treated appropriately.

In 2025, as part of its oversight of PHP as the single MCO for most children in custody, HCA required PHP to submit a Corrective Action Plan (CAP) focused on improving the care children receive and expanding the provider network (especially for children with high acuity needs). HCA reports that PHP is required to submit monthly reports to monitor whether effective engagement and services are being provided to children in custody, including completion of required care coordination assessments, completion of timely well-child visits, increasing TFC capacity, and increasing and ensuring referrals to behavioral health providers who provide EBPs.

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 2025.

This commitment requires HCA to require PHP to have a sufficient provider network to meet the needs of children in custody identified in the State's Behavioral Health Workforce Development Review. In the context of the FSA, this means that services identified as medically necessary to meet a child's mental health needs are accessible within 10 days of the need being identified. To accomplish this goal, the Review identifies the number of providers certified in each the EBP modalities specified in the FSA that are necessary to meet the needs of the number of children expected to utilize each service. As part of the App. D, TO 1 metrics, the State agreed to certify 60 percent of the estimated number of needed providers for each service specified in the FSA by December 31, 2025.

DVP Metrics and Validated Performance Data

DTO1.1(i) – The number of providers trained in 2025; the number of providers in training in 2025; and the number of providers certified in 2025 for Dialectical Behavior Therapy (DBT), Multi-Systemic Therapy (MST), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Functional Family Therapy (FFT), and Eye Movement Desensitization and Reprocessing therapy (EMDR).

The State reports that in 2025, 183 providers completed training in MST, FFT, DBT, TF-CBT, or EMDR, and 386 providers were in training during the year.[271] There were 239 providers certified to bill the EBP modifier rates, mostly EMDR (208 certified providers).

Table 27: Total Number of Providers Trained, in Training, and Certified, by EBP[272]
As of December 31, 2025

	Total as of December 31, 2025
MST	
Number of providers fully trained	0
Number of providers in training	4
Numbers of providers certified	20
FFT	
Number of providers fully trained	0
Number of providers in training (Phase 1)	4
Number of providers in training (Phase 2)	1
Number of providers in training (Phase 3)	0
Number of providers certified	2
DBT	
Number of providers fully trained (teams)	0
Number of providers in training (teams)	6
Number of providers certified (teams)	2
Number of providers certified (Individual)	5
TF-CBT	
Number of providers fully trained (and consultation)	22
Number of providers in training	51
Number of individual clinicians approved for specialty rate	4
EMDR	
Number of providers fully trained (and consultation)	161
Number of providers in training	320
Number of providers certified	208
Total number of providers trained across all EBPs	**183**
Total number of providers in training across all EBPs[273]	**386**
Total number of providers certified to bill modifier rates across all EBPs	**239**

Source: State's 2025 Annual Report on Kevin S.

[271] The State has shared that DBT and TF-CBT providers can start serving clients as soon as they receive initial training and before certification, as certification is a requirement for billing a specialty rate for those EBPs, not a requirement for providing services. For DBT, FFT, and MST, providers are trained and/or certified as teams and not as individuals in accordance with the relevant practice models; a team may include multiple individuals trained and/or certified to provide those services.
[272] The underlying data was provided by the State and not validated independently by the Co-Neutrals.
[273] Includes providers in all phases of training for FFT.

DTO1.2(ii) – Description of outreach to providers (including number attended, number of contacts that led to providers beginning training/certification) (from NMSU COI)

The State reports holding 11 information and outreach sessions regarding the EBPs with community behavioral health providers, child welfare professionals, Magellan Health providers, and other community stakeholders. In total, the State reports that 856 stakeholders and providers attended the sessions, and there were 403 inquiries, applications, or interest forms submitted to NMSU COI from providers regarding DBT, MST, TF-CBT, FFT, and EMDR.

DTO1.2(iii) – Based on the needed provider estimates in the Review for each EBP, the State will certify 60% of the needed providers in each modality by December 31, 2025.

The State reports 239 providers were certified to use DBT, MST, TF-CBT, FFT, or EMDR in 2025. Of those, 20 were MST providers and 208 were EMDR providers, which are both greater than the 2025 60 percent target and the overall number of total providers needed to meet the needs of children in custody per the Review. The State also certified providers in FFT, DBT, and TF-CBT, however, the number of providers within each modality did not meet the 2025 targets for these EBPs.

Table 28: Total Number of Providers Certified as of December 31, 2025, by EBP[274]
As of December 31, 2025

	Total needed providers per Review	Providers needed by December 31, 2025 (60% of total)	Actual providers as of December 31, 2025	2025 Target met
MST				
Numbers of providers certified	10	6	20	Yes
FFT				
Number of providers certified	15	9	2	No
DBT				
Number of providers certified (Individual)	23	14	5	No
TF-CBT				
Number of individual clinicians approved for specialty rate[275]	94	57	4	No
EMDR				
Number of providers certified	11	7	208	Yes
Total number of providers across all EBPs	**153**	**93**	**239**	**Yes**

Source: State's 2025 Annual Report on Kevin S.

For HFW, the State reports 11 providers across 19 unique sites/teams in 2025. The Review identifies total workforce capacity needs for HFW as five HFW coaches and 36 HFW facilitators. It

[274] These data were provided by the State and not validated independently by the Co-Neutrals.
[275] The State has shared that full certification for TF-CBT takes 18 months, but that providers are able to begin implementing the service and be certified to use the modifier rate prior to full TF-CBT certification.

is not clear from the State's information whether they have met or are close to meeting the number of HFW coaches and facilitators needed to meet the needs of children in custody.

Discussion

In 2025, at the recommendation of the Co-Neutrals, the State began implementing the Behavioral Health Workforce Development Review prior to its final approval. While many different behavioral health initiatives began or continued in 2025 – such as the roll out of Certified Community Behavioral Health Clinics (CCBHCs), HCA's oversight of PHP, and the continued partnership between CYFD and NMSU COI – the State's approach in 2025 was disjointed, without a clear, unified approach.[276] The responsibility for building out the children's behavioral health service array and workforce in New Mexico is shared between CYFD BHS and HCA (with PHP as the single MCO serving children in custody), but there was often in 2025 a lack of clarity regarding the roles and responsibilities of each agency, exacerbated by the lack of a joint process to guide interagency collaboration. This bifurcation was observed in the clinical review of children on psychotropic medications, as there was no documentation ensuring communication and collaboration between PHP's medication reviews with children's CYFD case workers pursuant to the NMAC 8.10.8.17 procedure.

HCA engaged in increased oversight of PHP in 2025 with the establishment of PHP's CAP, which remained in negotiation as of the end of 2025, as HCA reports additional remedial actions were necessary to remedy the issues identified through their oversight. PHP's performance is integral to the implementation of the Review, as HCA required PHP to create a hiring and contracting plan that identifies, by county, the number of staff and credentials required to meet the Review's identified objectives as outlined by the FSA. However, as CYFD BHS also had responsibility for children's behavioral health, coordination between HCA, CYFD BHS, PHP, and NMSU COI is crucial to the success of building behavioral health capacity to meet the needs of children in custody.[277]

Although some progress was made in training providers in MST, FFT, DBT, and TF-CBT, the State only met the target for certifying providers in MST and EMDR in 2025, and no other identified modalities. Despite the increase in MST and EMDR providers, the State's data show that only 121 children received specific EBP services within the identified age range for the EBP modality (HFW and MST).[278] The number of children who received these services was far below the utilization targets for 2025.

Additionally, in 2025, some behavioral health providers began operating in New Mexico as CCBHCs. CCBHCs are community-based behavioral health clinics certified to provide a wide array of services, including drug and alcohol treatment, outpatient therapy, peer and family support services, targeted case management, and crisis intervention services. Crisis intervention services, including mobile crisis response, must be available 24 hours per day, seven days per week either directly through the CCBHC or through an approved licensed contractor. CCBHCs are required to

[276] Additional information about CCBHCs in New Mexico can be found here.
[277] The State reports launching a "DIT1 Activation Plan" with a collaborative workgroup of staff from HCA, PHP, and CYFD in April 2026 focused on implementing the full Review, with an early focus on increasing EBPs and service utilization.
[278] There were 126 children of any age who received a specific EBP service (HFW, MST, and EMDR).

provide services to anyone, regardless of ability to pay, and must be able to provide services to children and adults of all ages. In 2025, New Mexico had five CCBHCs operating in the state, with a plan to have 10 total CCBHCs serving 10 counties across the state in 2026. CCBHCs can participate in the EBP trainings offered through NMSU COI and are also able to provide the specific EBP services named in the FSA once certified.

The State also began offering crisis services for children aged 14 years and older and to adults through Crisis Triage Centers (CTCs). In 2025, there were four CTCs operating in New Mexico, with plans to expand these centers in future years. In 2025, CYFD BHS also continued its partnership with NMSU COI in building capacity for Mobile Response and Stabilization Services (MRSS), although the NMSU contract ended in 2026.

The case reviews for CBHC consultation showed that CBHCs can be a valuable resource to children in custody, however, the lack of clarity on roles and responsibilities for working with children in PSD custody is a barrier to providing comprehensive and effective services to children on a consistent basis.

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 2025.

Discussion

The State developed enhanced billing rates for providing specific EBP services as of July 1, 2023, which has been the primary incentive available to providers willing to be trained in evidence-based, well-supported, and promising trauma-responsive services. The enhanced rates are connected to specific modifier codes to be used by providers when billing Medicaid for intensive case management, HFW, DBT, MST, TF-CBT, FFT, and EMDR. To bill the enhanced modifier rates, providers must be trained and certified to provide the specific service, and must be approved by NMSU COI as meeting requirements to bill and receive the enhanced rates. As another incentive

for providers, the State partners with NMSU COI to offer free training in the named EBP modalities in the FSA.[279]

As discussed in App. D, TO 1b – *Sufficient Provider Network,* the State reports 569 providers either completed or were in the process of completing training with NMSU COI and expects the majority of these providers to be fully certified in 2026.

In discussions the Co-Neutral team had with behavioral health providers during site visits to New Mexico in 2025 and 2026, providers reported varying levels of awareness of the available training offered through NMSU COI, with some providers completing the training and successfully billing using the enhanced modifier rates, and others who were unaware that the free training was being offered.

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.[280] 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 2025.

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, and that services are provided within 10 days of identification.

[279] NMSU COI accomplishes this by hosting training and certification by national credentialing organizations. For example, NMSU COI offers training and certification in EMDR by hosting staff from the EMDR International Association (EMDRIA).

[280] App. D, TO 3 defines these services as: HFW services; intensive case management; intensive home-based services; and evidence-based, well-supported, or promising trauma-responsive therapies such as DBT, MST, TF-CBT, FFT, and EMDR.

DVP Metrics and Validated Performance Data

This commitment is measured using the same metrics as App. A, TO 2.

> *ATO2.2(i) – primary metric: The sum number of children in the cohort who received either HFW services, MCR, DBT, MST, TF-CBT, FFT, or EMDR during the reporting year.*
>
> *ATO2.2(i*) – secondary metric: The sum number of children in the cohort who received either HFW services, MST, MCR or FFT during the reporting year.*
>
> *ATO2.3(i) – primary metric: Of all children in state custody who received screenings or assessments that indicated a need for HFW, MCR, DBT, MST, TF-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.*

As discussed in App. A, TO 2 – *Expansion and Availability of Services*, the State's data show that 126 children (4% of children in custody at any point in 2025) received at least one session of HFW, MCR, DBT, MST, TF-CBT, FFT, or EMDR in 2025.[281] The Co-Neutrals were unable to validate the timeliness of services as the State did not have an adequate data collection process in 2025.

Discussion

Consistent with prior years, a small number of children received an EBP service specified in the FSA in 2025 according to the Medicaid billing data. However, it is possible that additional children received specific EBP services in 2025 that were not captured in the billing data, as the Co-Neutrals identified 39 percent of all children in custody at any point in 2025 received a non-specific mental health service, such as a psychiatric diagnostic evaluation; individual, group, or family therapy; and crisis intervention services.[282]

[281] These data include EBP services provided to children regardless of age. Data presented in App. D, TO 1.2 (121 children) limits utilization data to applicable age ranges per EBP modality.

[282] See App. A, TO 2 for further discussion of these data.

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 2025.

The FSA requires all children in custody to have a comprehensive well-child checkup (well-child visit, or WCV) within 30 days of entering care. The requirements for WCVs for children in custody are outlined in Procedure 17 of CYFD's *Permanency Planning Procedures* (8.10.8 NMAC). The procedure states that children in custody should have a comprehensive WCV including a physical examination within 30 days of entering custody, as well as annual well-child checks, dental exams, and eye exams.

HCA issued LOD #21 on October 8, 2024, which outlines the responsibilities and reporting requirements of MCOs to ensure all children in custody have a WCV within 30 days of entering care.[283] 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.[284]

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 WCV, and are also required to provide communication, education, and training to providers to ensure that these visits take place within 30 days after the child enters custody and that they include all required components.

HCA's Keeping Kids Healthy website defines WCVs as follows:[285]

> 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

[283] LOD #21 can be found here.
[284] LOD #21, paragraph two.
[285] HCA's Keeping Kids Healthy webpage can be found here.

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 nine months and 13 years;
- Lead screening at 12 months and 24 months;
- Immunizations;
- Selective screenings necessary according to risk factors;[286] and
- Anticipatory Guidance.[287]

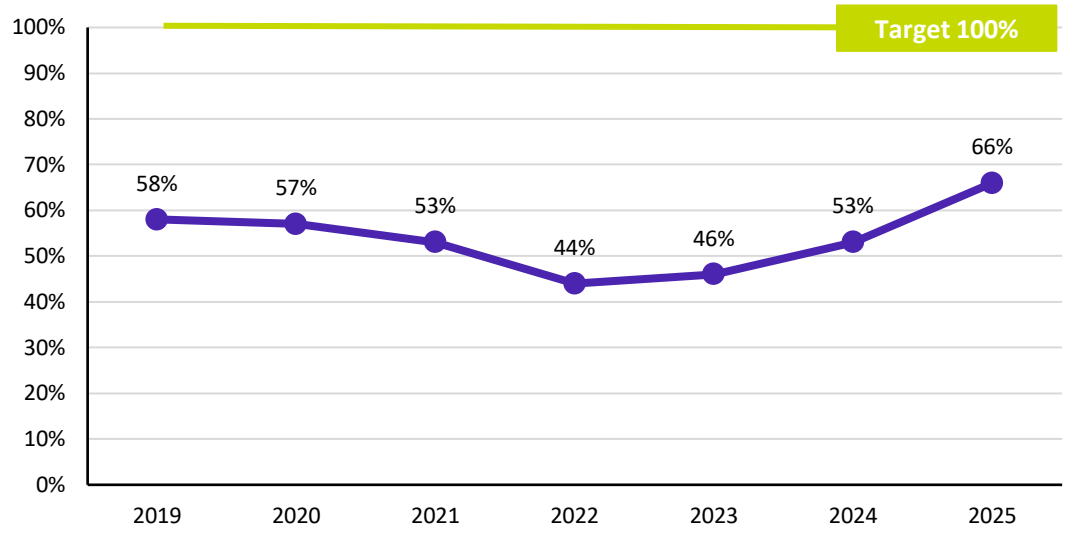
DVP Metrics and Validated Performance Data

DTO4.1(i) – primary metric: Of all episodes of custody 30 days or longer that began during the reporting year, the percentage 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 744 episodes of children's custody that began in 2025 and lasted at least 30 days before the end of the year, 491 (66%) included a WCV within 30 days of the child entering custody.[288] This is the highest performance since baseline data were collected in 2019, but significantly below the target of all children as defined in the FSA (see Figure 44).

[286] This may include a Tobacco, Alcohol, or Drug Use Assessment, or STI testing due to sexual behavior.
[287] 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.
[288] These results differ from the results published in the Co-Neutrals' January 30, 2026 Arbitration Report, because they are based on different data sources. The findings presented here are based on data from the State that went through the State's quality-assurance process for annual data submissions.

Figure 44: Percent of Children in Custody Who Received a WCV Within 30 Days of Entry[289,290]
2019 – 2025



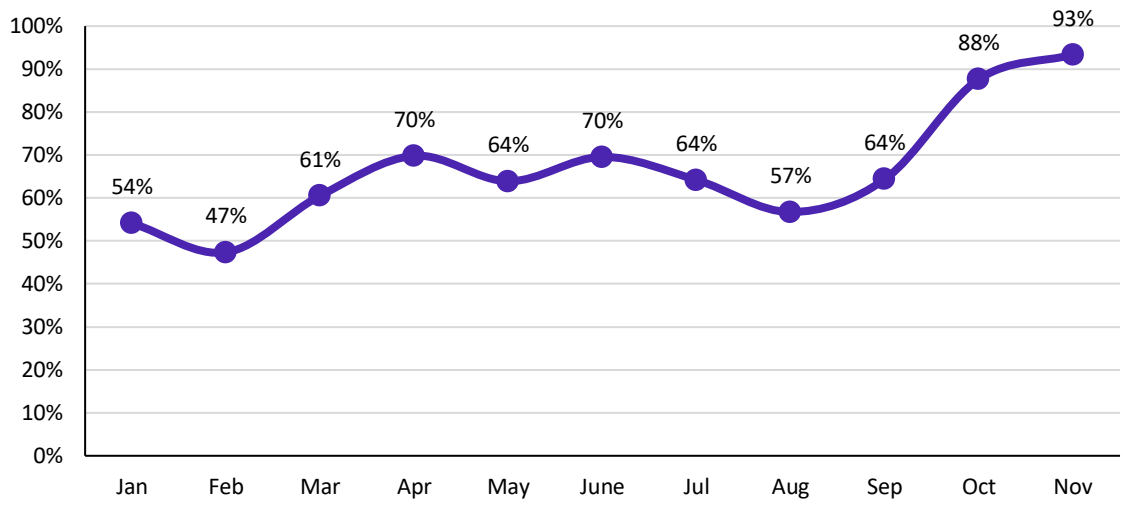
Source: Analysis of Sandbox Encounters and Entries files and supplemental well-child checkup data

As shown in Figure 45, the percentage of children who received timely WCVs varied throughout the year, with a noticeable increase in the final quarter of 2025. Monthly performance during the first three quarters of the year ranged from 47 to 70 percent, while monthly performance in quarter four was 88 percent in October and 93 percent in November.[291] In March, September, and October 2025, the State's performance increased while eligible entries remained relatively high. Figure 46 shows a more specific breakdown of the timeliness and completion of WCVs by month.

[289] Children may enter custody more than once during the year, and each episode that lasted longer than 30 days during the period under review is counted as an episode.
[290] In 2024, this metric included only children with episodes lasting *longer than* 30 days. In all other reporting periods it includes children with episodes that lasted *at least* 30 days.
[291] December performance was not included in the monthly data analyses, as only children who enter on December 1 are counted since children who enter later would have a WCV due in 2026.

Figure 45: Percentage of Required WCVs Completed on Time, by Month[292]

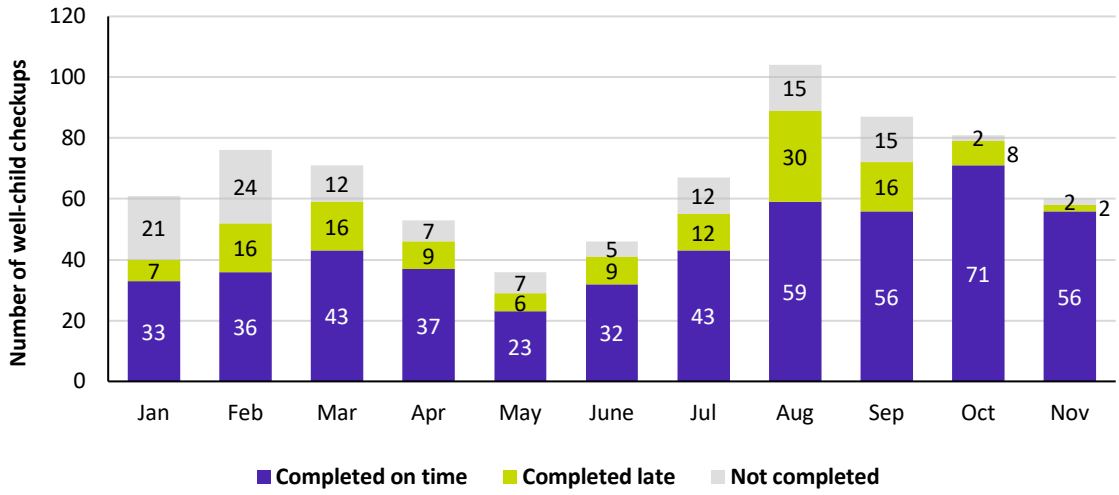
2025; N = 742 eligible episodes of children's custody, 491 timely well-child checkups



Source: Analysis of Sandbox Encounters and Entries files, and supplemental well-child checkup data

Figure 46: Number of Timely, Late, and Required WCVs, by Month

2025; N = 742 eligible episodes of children's custody, 491 timely well-child checkups



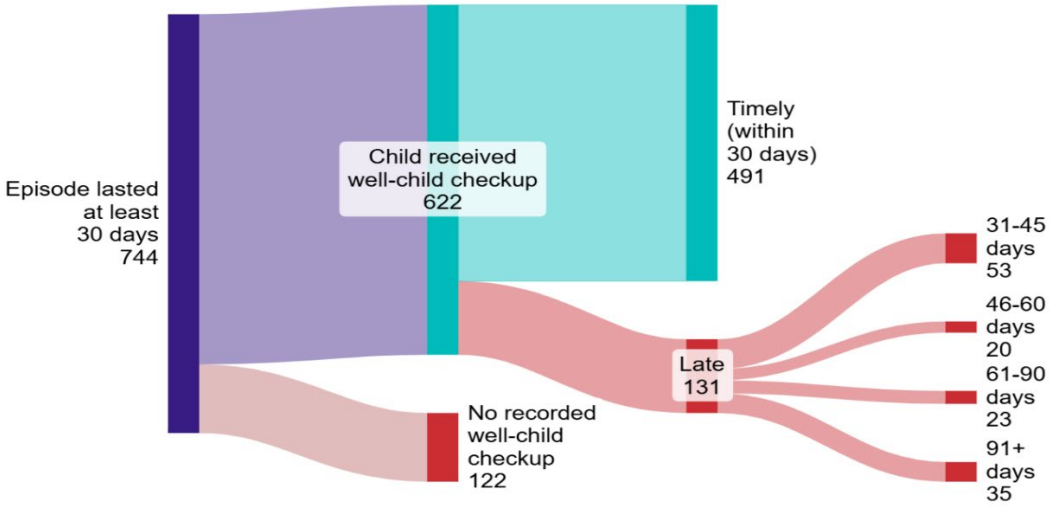
Source: Analysis of Sandbox Encounters and Entries files and supplemental well-child checkup data

[292] To account for the possibility that claims for WCVs in the final quarter of 2025 had not been fully processed when the State submitted its billing data, the State also submitted a supplemental file listing WCVs that the State confirmed had occurred by reviewing provider notes. There were 50 WCVs confirmed only via provider notes (and did not appear in the submitted billing data), which is 10 percent of the 491 timely WCVs in 2025 and 39 percent of the 129 timely WCVs in the final quarter of 2025.

The Co-Neutrals analyzed all episodes of children's custody during which children did not receive the required WCV within 30 days of entering custody (see Figure 47). For 131 episodes of children's custody, a WCV was completed late (more than 30 days after the child entered custody): specifically, 53 were completed 31 to 45 days after entry, 20 were completed 46 to 60 days after entry, 23 were completed 61 to 90 days after entry, and 35 were completed more than 90 days after entry. For the remaining 122 episodes (16%), there was no recorded WCV. This is an improvement from prior performance, when there was no recorded WCV for 24 percent of episodes in 2024, 19 percent in 2023, and 29 percent in 2022.

Figure 47: Time to WCVs

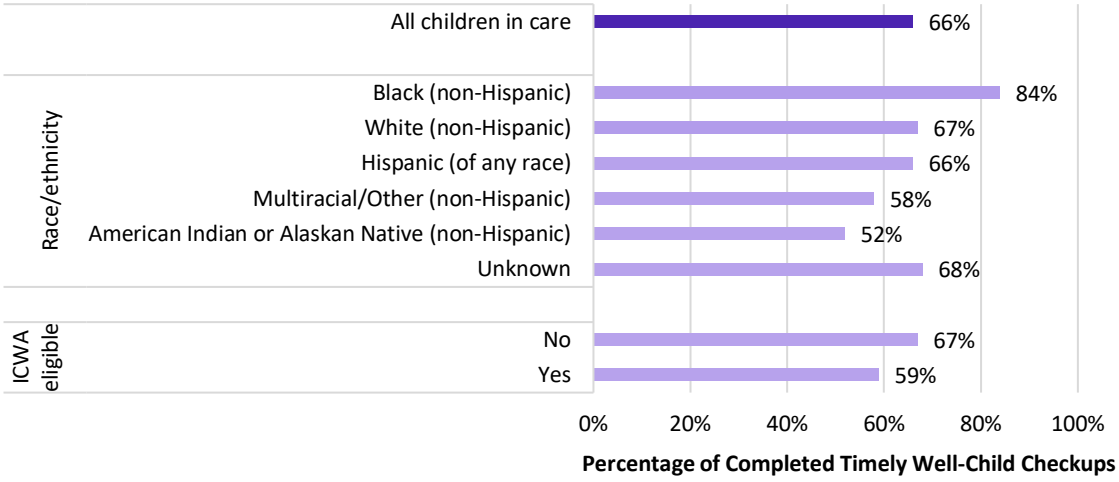
N = 744 episodes of children's custody that began in 2025 and lasted 30 days or longer



Source: Analysis of Sandbox Encounters and Entries files and supplemental well-child checkup data

The Co-Neutrals also analyzed rates of timely WCVs by race, ethnicity, and ICWA-eligibility (see Figure 48). American Indian or Alaskan Native (non-Hispanic) children received a disproportionately low rate of timely WCVs (52%), while Black (non-Hispanic) children received a disproportionately high rate (84%). Children identified as ICWA-eligible also received a lower rate of timely WCVs (59%) compared to non-ICWA-eligible children (67%).

Figure 48: Percentage of Completed Timely WCVs, by Race/Ethnicity and ICWA-Eligibility
2025



Source: Analysis of Sandbox Encounters, Cohort, and Entries files and supplemental WCV data

DTO4.1 – validation strategies.

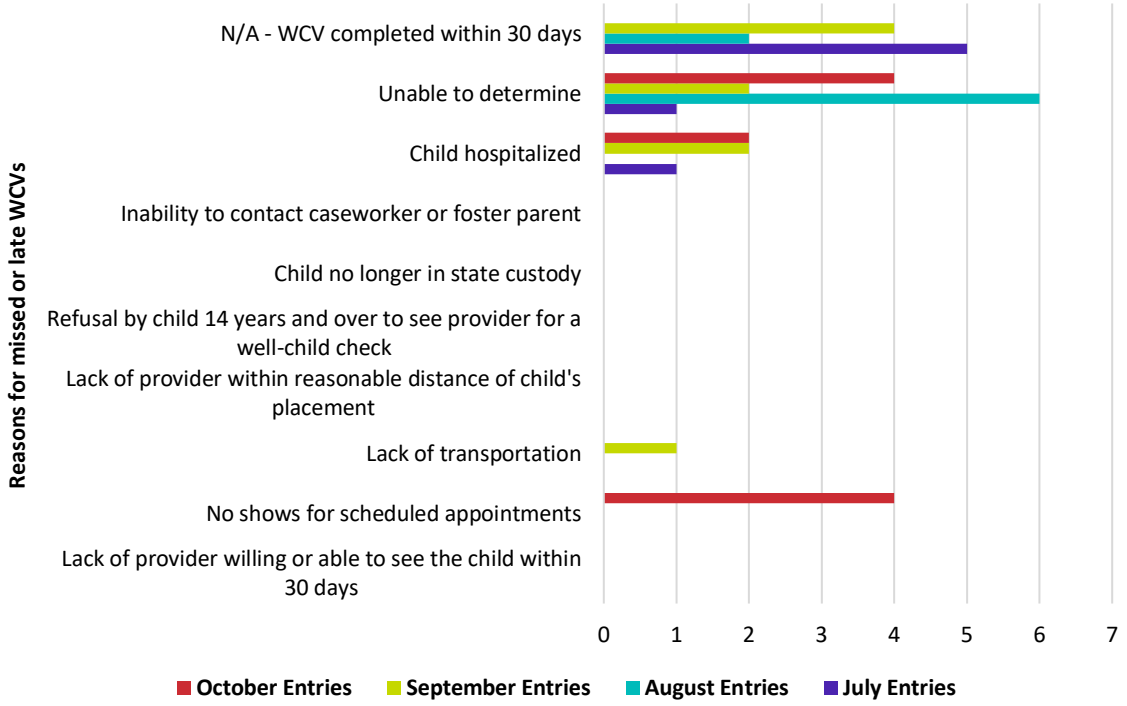
In accordance with RO#2, the Co-Neutrals requested monthly child-specific data for all children who entered custody during the month and had a completed WCV, as well as information to identify the reason for missed or late WCVs for children who did not receive a timely WCV. The State also provided relevant MCO care coordination notes which were reviewed by the Co-Neutral team. To validate reasons for missed and late WCVs, the Co-Neutral team completed case reviews for children identified by the State as having WCVs that were completed late or were not completed for children who entered custody between July through October 2025.[293] In total, the Co-Neutral team reviewed 34 case records – 24 case records of children who entered custody between July through September 2025 who did not receive a well-child visit, and 10 case records of children who entered custody in October 2025 and experienced a late or missed well-child visits.

The Co-Neutral team found documentation of a completed WCV for 14 of 24 children who entered custody between July through September 2025 initially identified by the State as not receiving a well-child visit. Of the 10 cases reviewed for children who experienced late or missed well-child visits who entered custody in October 2025, the Co-Neutral team's review confirmed the reasons initially identified by the State for the missed or late WCVs, which include missed appointments and children being hospitalized after coming into custody. The reasons identified by the State and in the Co-Neutral team's review are identified in Figure 49.

[293] The State identified reasons for missed WCVs for children who entered custody between July through September 2025, and provided reasons for missed and late well-child visits for children who entered in October 2025.

Figure 49: Identified Reasons for Missed and Late WCVs

July – October 2025; N = 34 children with missed or late WCVs



Source: WCV data provided by the State, CYFD FACTS case records and care coordinator notes

Discussion

As required in ROs #1 and #2, the State worked in 2025 to identify barriers that were preventing children from receiving comprehensive WCVs within 30 days of entering custody. The State also implemented a project in which PHP care coordinators were co-located across 13 CYFD county offices for two to three hours at least every other week.[294] Ultimately, the State concluded that co-location was not an effective intervention for increasing completion of well-child visits and the practice was discontinued in 2026.

In the last quarter of 2025, the State began implementing daily staffings to monitor completion of well-child visits, and to identify and solve any identified barriers. Staff from CYFD, HCA, PHP, and CYFD's *Kevin S.* team attend these meetings, and WCV performance improved significantly in the last quarter of 2025.

As the State struggled to achieve adequate and consistent WCV completion for most months during the year, the Performance Standard was not met in 2025. However, there was a significant improvement in performance in the last quarter of 2025.

[294] This was a requirement of RO#1 and RO#2.

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
CCBHC – Certified Community Behavioral Health Clinics
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
CTC – Crisis Triage Centers
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
RFPTU – Resource/Foster Parent Training Unit
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
THB – Traditional Healing Benefits
TO – Target Outcome
WCV – Well-Child Visit
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 D[295]		
IT 1.1	Behavioral Health Workforce Development Review	Report Assessing 2024
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

[295] 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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