HUMAN SERVICES DEPARTMENT

HSD FY22 BUDGET REQUEST

DECEMBER 4, 2020

SECRETARY DAVID R. SCRASE, M.D.

INVESTING FOR TOMORROW, DELIVERING TODAY.

HUMAN SERVICES DEPARTMENT

MISSION

To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

GOALS

We help NEW MEXICANS

1. Improve the value and range of services we provide to ensure that every qualified New Mexican receives timely and accurate benefits.

We communicate EFFECTIVELY

2. Create effective, transparent communication to enhance the public trust.

We make access EASIER

3. Successfully implement technology to give customers and staff the best and most convenient access to services and information.

We support EACH OTHER

4. Promote an environment of mutual respect, trust and open communication to grow and reach our professional goals.

HSD LEADERSHIP TEAM

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HSD LEADERSHIP TEAM

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MEET THE HARRIS-MAEZ FAMILY

- Family of 6 living in SE NM.
- Father is unemployed due to COVID-19 and has a history of depression.
- Mother is school teacher, teaching virtually, and is facilitating her own children's' virtual education.
- Teenage daughter struggling with disconnection from peers, work, and recreation. She has started using alcohol.
- Two younger children (ages 5 and 8)- youngest is experiencing some anxiety.
- Grandmother diagnosed with dementia, recently moved home from long term care facility due to concerns regarding COVID-19.

HSD SFY 2022 BASE BUDGET REQUEST

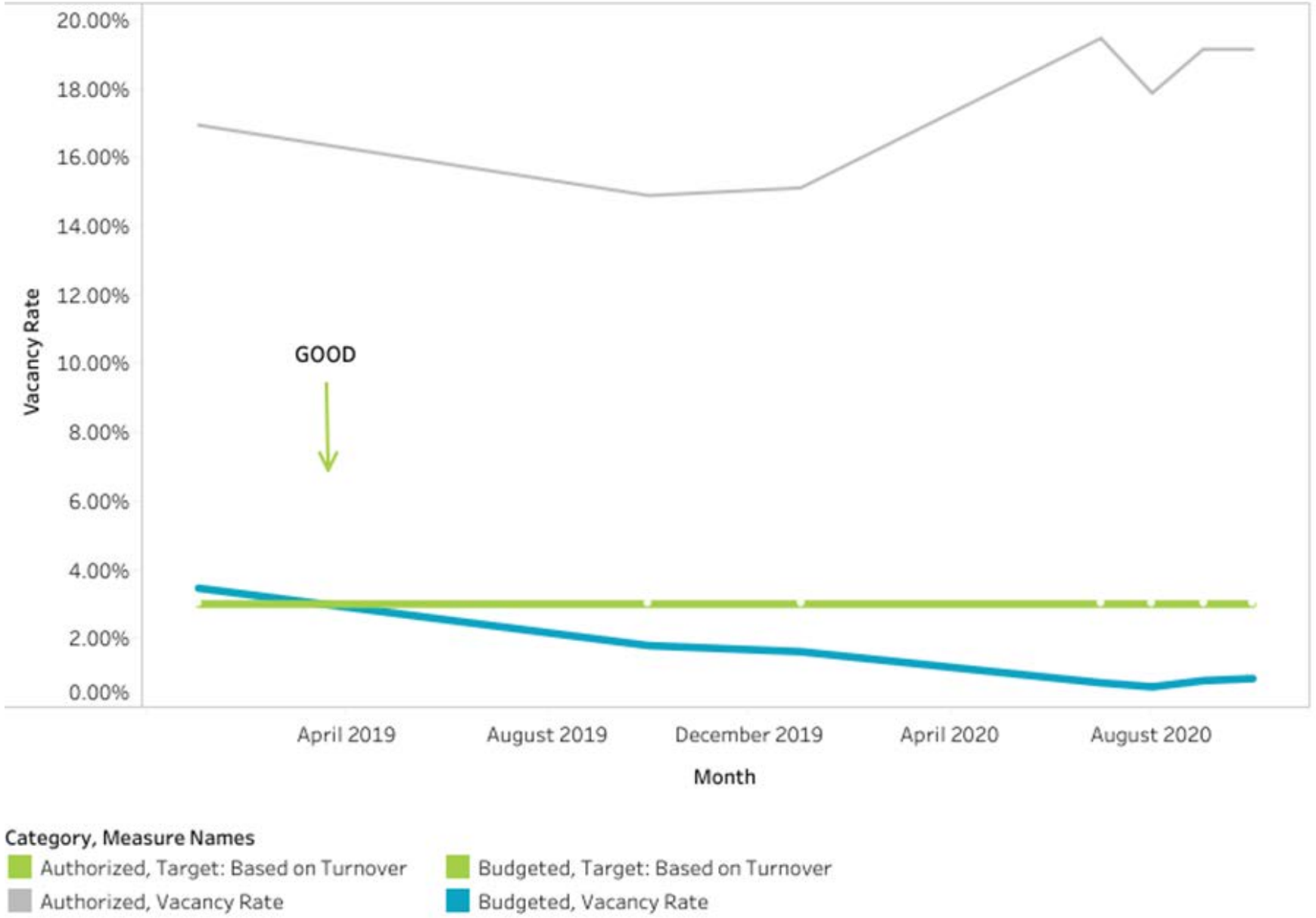
Program	New Mexicans Served as of 11/20	FY22 Request General Fund *(000)*	% of GF Budget	FY22 Request GF + Fed *(000)*	% of Total Budget
Medicaid (managed care + FFS)	915,939	$996,353.0	88.20%	$6,528,735.0	82.99%
SNAP	491,705	$0.0	0.00%	$778,156.8	9.89%
TANF	34,592	$87.1	0.01%	$142,563.4	1.81%
CSED	269,027	$7,702.4	0.68%	$31,158.9	0.40%
BHSD	11,268	$45,636.5	4.04%	$65,496.9	0.83%
LIHEAP	134,821	$79,880.9	7.07%	$320,754.1	4.08%
TOTAL (*unduplicated)	**1,002,194***	**$1,129,659.9**	**100.00%**	**$7,866,865.1**	**100.00%**

HSD FY22 BASE REQUEST

	HSD FY22 Base Request (thousands)			
Program	**General Fund**	**Federal Fund**	**Total Funds**	**General Fund Increase/Decrease**
Program Support (P522)	$2,212.1	$12,183.5	$14,395.6	($131.8)
Information Technology Division (P522)	$15,528.8	$30,842.3	$46,371.1	$0.0
Child Support (P523)	$7,702.4	$23,456.5	$31,158.9	($458.9)
Medical Assistance (P524)	$15,311.3	$81,036.8	$96,348.1	($912.1)
Medicaid and Medicaid BH (P524 & P766)	$996,353.0	$5,532,382.0	$6,528,735.0	$44,185.3*
Income Support Admin (P525)	$30,566.0	$58,166.7	$88,732.7	($1,820.8)
Income Support Program (P525)	$16,349.8	$979,277.0	$995,626.8	($974.0)
Behavioral Health Services Division (P767)	$45,636.5	$19,860.4	$65,496.9	($2,717.5)
Total	**$1,129,659.9**	**$6,737,205.2**	**$7,866,865.1**	**$37,170.2**

* Medicaid Projection 9/1/2020	$1,164,235.0	$6,140,590.0	$7,304,825.0	($167,882.0)
** Medicaid Projection 10/30/2020	$1,158,151.0	$6,073,968.0	$7,232,119.0	($161,798.0)
*** Total Computable: 9/1 ($776,090.0); 10/30 ($703,384.0)				

What is the rate of open positions at HSD?



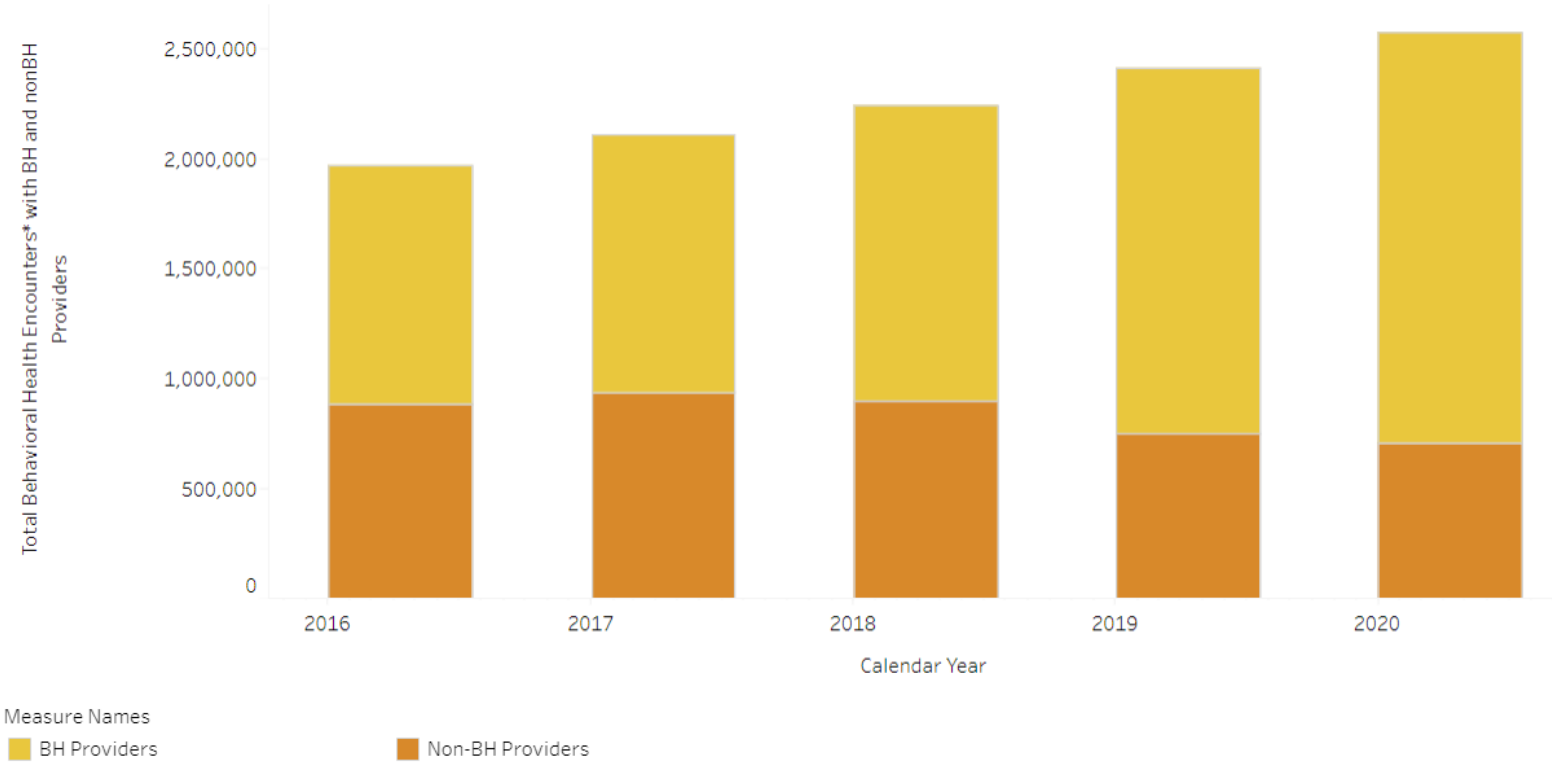
Source: https://sites.google.com/view/nmhsdscorecard/goal-4

HSD FY21 ACCOMPLISHMENTS

Legislature entrusted $7.56B to HSD and we strive to demonstrate a return on that investment:

- Significant program enrollment expansion, 20 additional waivers.
- Promotion of telehealth statewide.
- Transformed business model to safely meet customer needs during pandemic.
- IT advancements such as real time eligibility enroll 22% of online Medicaid applicants without human intervention, at 100% accuracy.
- Supporting sister agencies in ESF-6 coordination of pandemic-related services and supports.

How good is my Managed Care Organization (MCO) at working with providers to ensure I have a behavioral health (BH) visit with a BH or non-BH provider?



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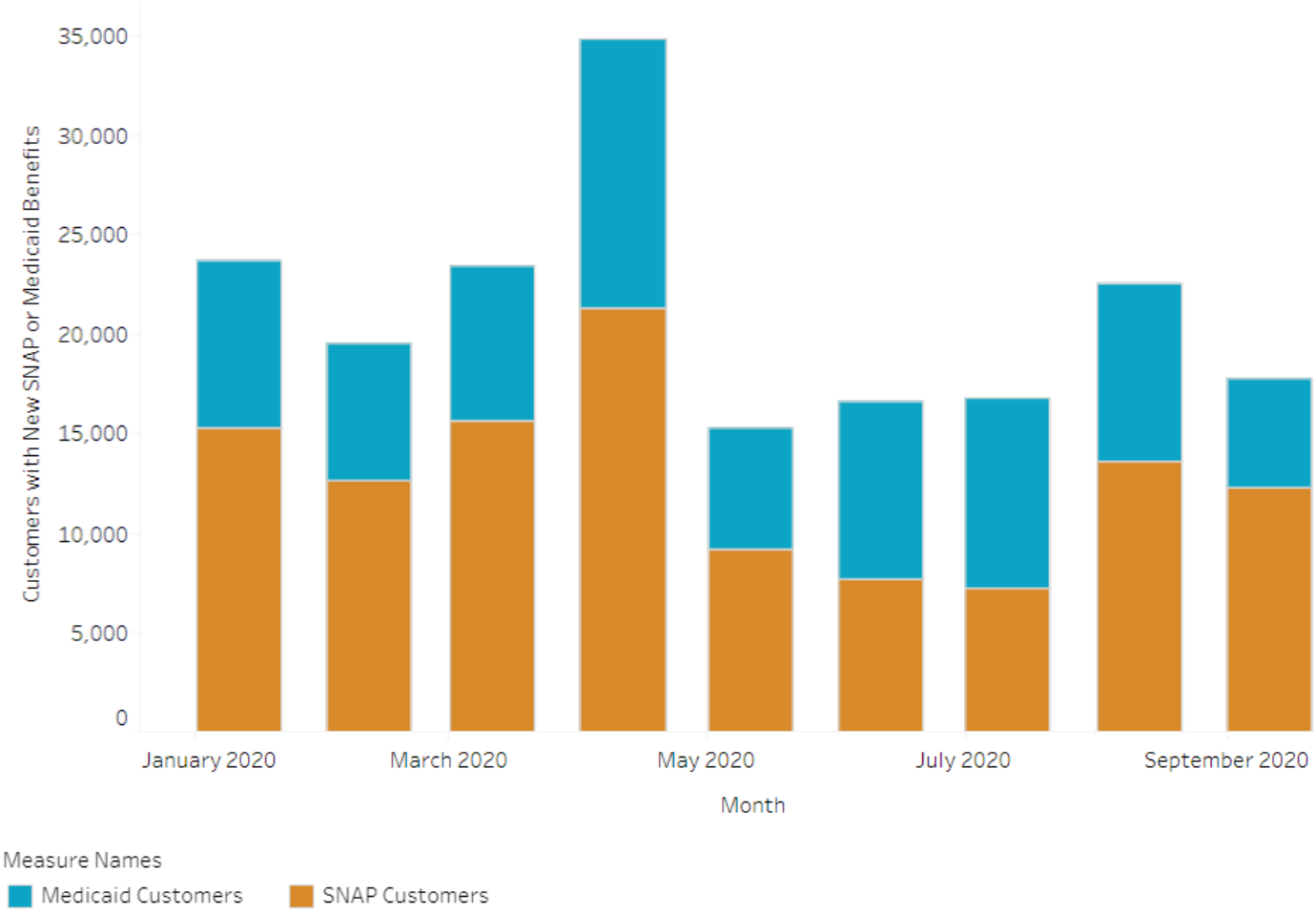
COVID-19-RELATED PROGRAM WAIVERS MEANS MORE NEW MEXICANS BENEFIT FROM SERVICES

Waiver	Impact
Medicaid retainment	87,000 individuals since 4/25/20
Cash assistance extended enrollment	2,627 households
SNAP extended enrollment	53,552 households
SNAP one-time statewide supplement	463,000 individuals
SNAP Pandemic-EBT	~513,000 students

Compared to pre-COVID-19, how many people like me were able to receive NEW benefits each month during the pandemic?



HIGHER ENROLLMENT AND PANDEMIC RESPONSE HAVE CREATED NEW CHALLENGES FOR HSD

- Consolidated Customer Support Center – triple call volume resulting in high abandonment rate
- Schedule and resource challenges for critical IT projects:
  - HHS 2020
  - Health Information Exchange
  - Integration with NMHIX
  - ASPEN enhancements
- Delay of new programs/initiatives
  - BHSD satellite office in Las Cruces
  - Provider payment strategies and innovations

Calls Received: Comparison Against Historical Calls Received

	2018 Monthly Avg.	2019 Monthly Avg.	2020 Monthly Avg.	SEPT	OCT
CSED	19,145	17,914	19,036	15,716	15,657
ISD/MAD	43,585	41,607	45,995	109,547	133,401

Oct 2020 calls received:
- **2.9x more than 2020 average (prior to CCSC launch)**
- **3.1x more than 2018**

MEDICAID COST CONTAINMENT OPTIONS

Without additional federal support and based on our current projection, Medicaid will have to reduce costs by 16% or $162M in GF.

This equates to almost $800M in reductions to the program (includes federal match).

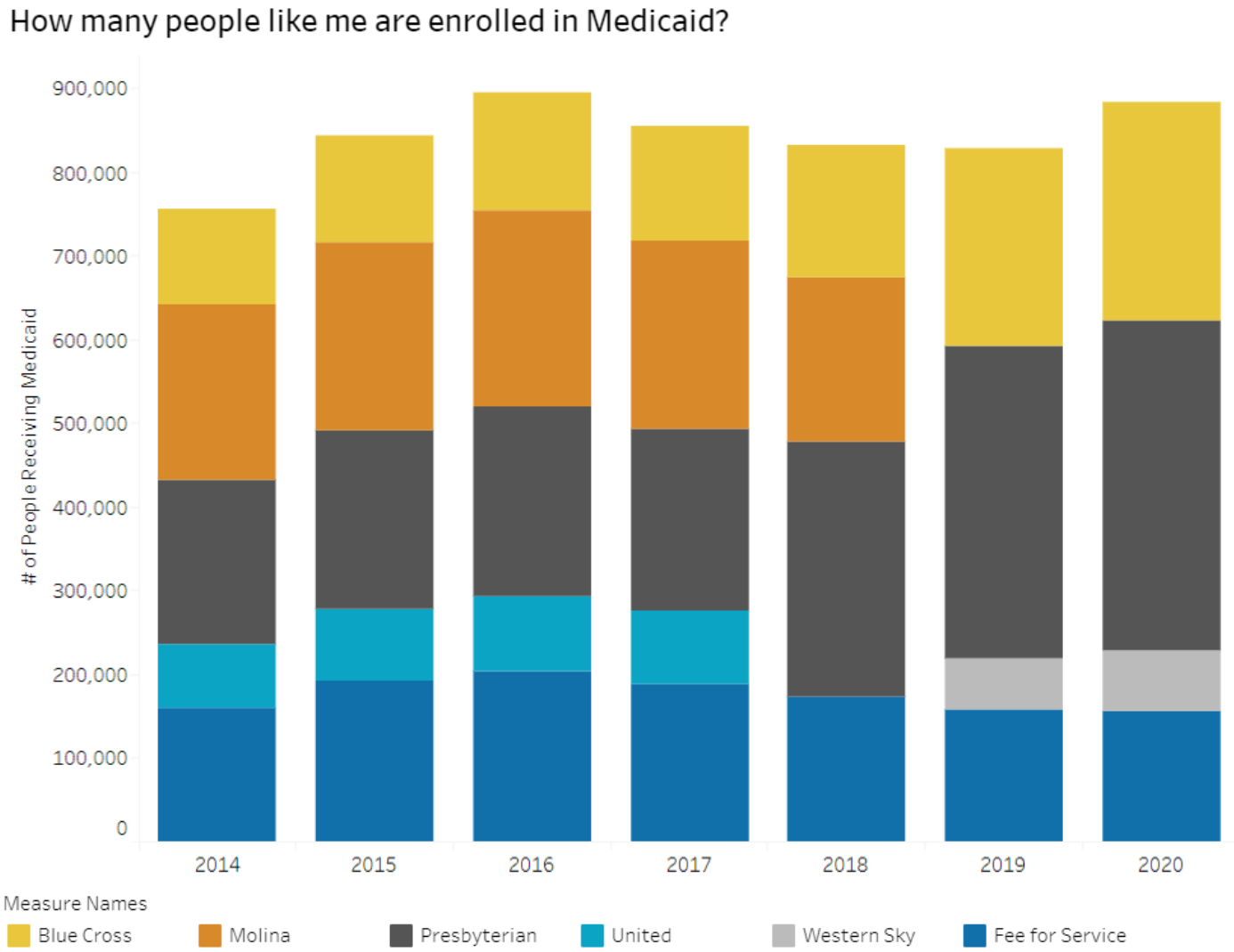
- Cut hospital, nursing facility, and all other provider rates.
- Transition the required Hospital Access Payment and Targeted Access Payments immediately rather than over three years.
- Reduce MCO capitation rates within actuarial limits.
- Reduce MCO care coordination staffing levels.
- Eliminate Centennial Rewards program (incentivizes healthy behaviors for members).
- Eliminate Health Home program.
- Suspend Behavior Management Skills pilot.
- Eliminate Home Visiting program expansion.
- Implement co-pays and premiums.
- Reduce or eliminate adult dental and vision benefits.

GUIDING MEDICAID PRINCIPLES

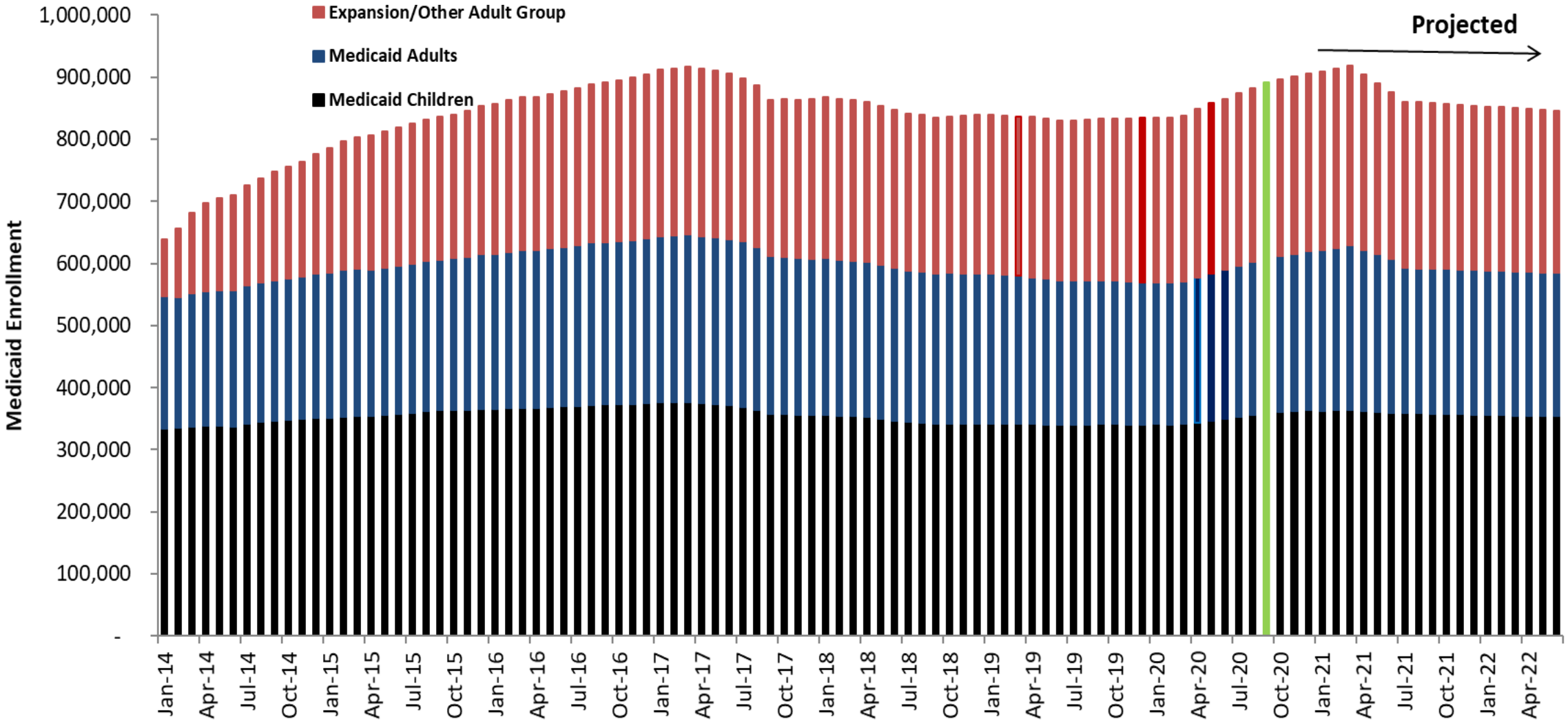
- New Mexico has the highest population percentage covered by Medicaid, which creates a greater New Mexico HSD responsibility to our healthcare market and to fair payments.
- The overwhelming majority of federal Medicaid dollars must be spent on providing direct services to Medicaid beneficiaries.
- HSD aims to optimally leverage federal funds to improve the health of New Mexicans, while maintaining strict compliance with the law.

MEDICAID ENROLLMENT

- Total beneficiaries:
  - 835,457 in February 2020.
  - 901,000 in November 2020.
  - ~917,000+ by March 2021.
  - ~875,000 by June 2021 if Maintenance of Effort ends 3/31/21.
- 82% are enrolled in managed care.
- 43% (up from 40%) of all New Mexicans are enrolled in Medicaid.
- 43% of beneficiaries are children.
  - 58% (up from 56%) of NM children are enrolled in Medicaid.
  - 72% of all births in NM are covered by Medicaid.



NEW MEXICO MEDICAID ENROLLMENT



June 2022 Projected Enrollment

Expansion/OAG:
262,100

Medicaid Adults:
230,810

Medicaid Children:
353,633

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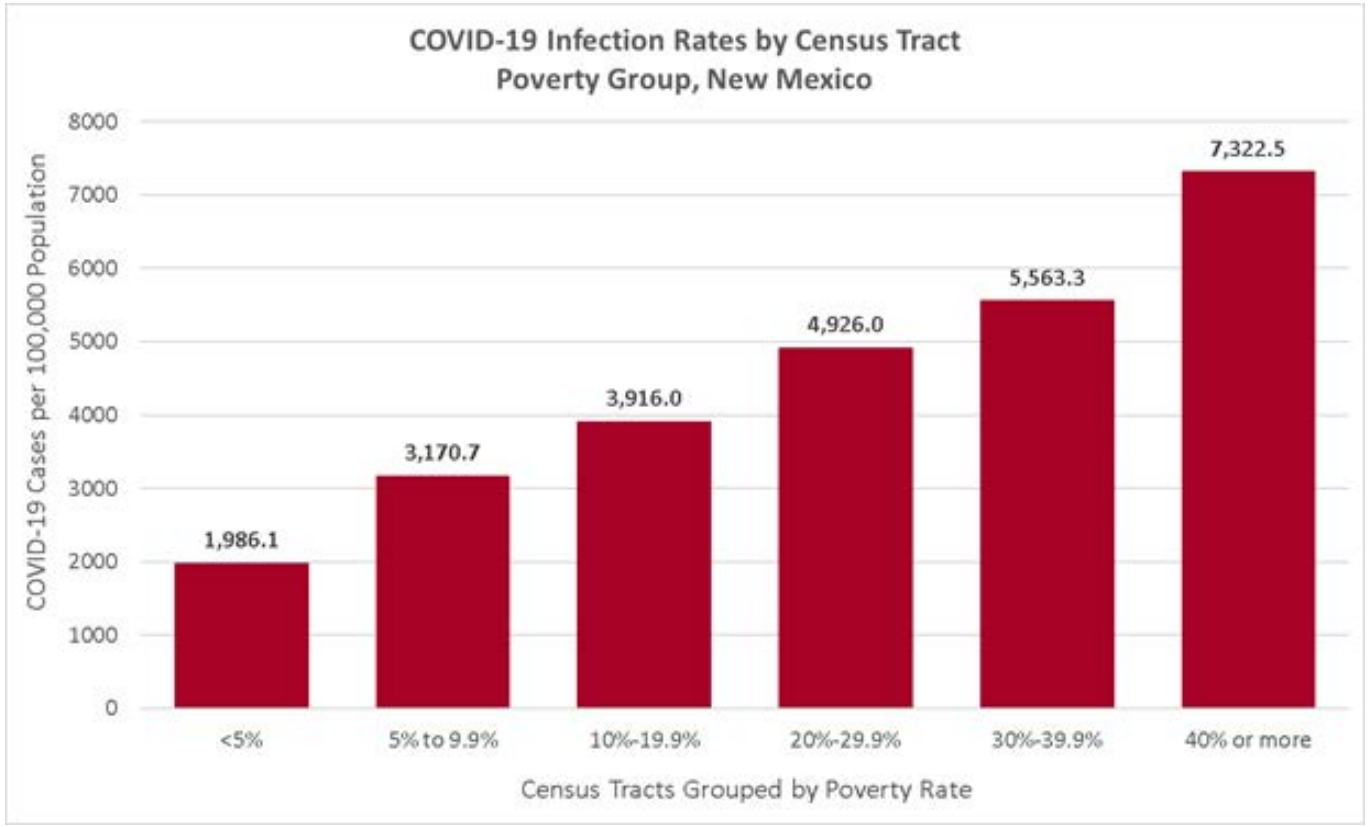
COVID-19 PANDEMIC HAS CREATED A PUBLIC HEALTH CRISIS THAT IS INCREASING SOCIAL AND ECONOMIC INEQUALITY

INSTITUTE FOR RESEARCH ON POVERTY

- Lower-income workers considerably less likely to have paid sick leave, so may face lost wages/employment if they miss work.
- Workers in lower-paying jobs less likely to work at home and more likely to interact with others, thus at greater risk of contracting the virus.
- Lack of in-person school and childcare may limit options for parents and widen achievement gaps in the longer term.
- CDC: longstanding inequality resulted in increased risk of contracting COVID-19 and severe illness for African Americans, Hispanics/Latinos, and Native Americans.
- People with lower socioeconomic status more likely to have chronic health conditions that exacerbate effects of COVID-19, and to develop them at an earlier age.



Sources: COVID-19 Cases, NMDOH, Epidemiology and Response Division, NM Electronic Disease Surveillance System, 11/30/2020. Poverty Rates, U.S. Census Bureau, American Community Survey (ACS), 2018 5-yr. estimates. A data issue caused U.S. Census Bureau to omit data for Rio Arriba County census tracts in ACS 2018 5-yr. estimates. Data from 2017 5-yr. estimates used in this analysis as proxy poverty data for those census tracts.

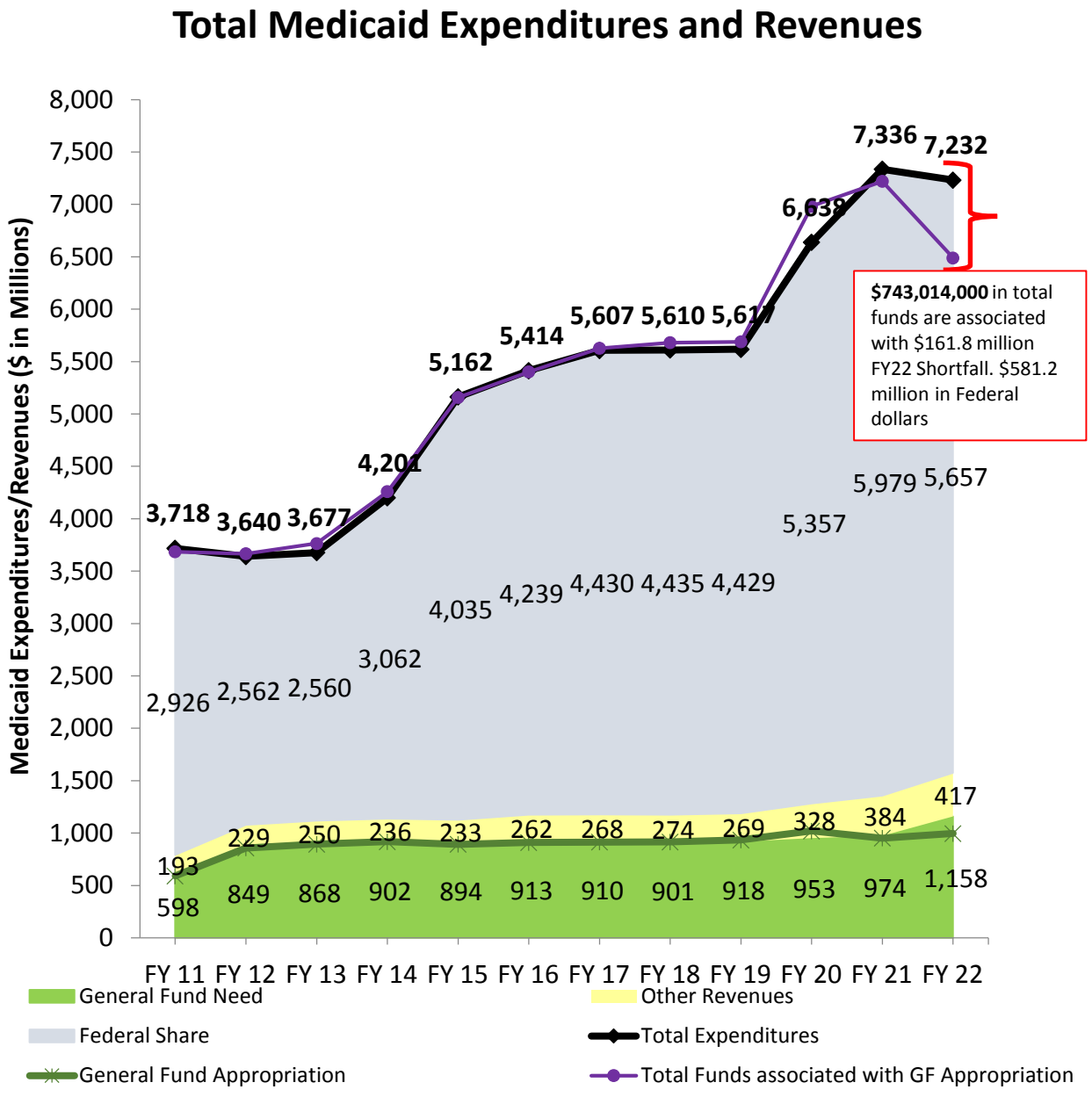
HSD FY22 BUDGET RISKS

Duration of 6.2% FMAP for Medicaid remains uncertain.

- Recurring GF amount of $75 million should be restored, because 6.2% additional FMAP is slated to expire January 2021 (barring federal action).
- Even with additional federal support, estimated $180M GF deficit in Medicaid SFY 2022 budget remains; this would require an $800M reduction to program costs overall with Federal Match included.
- HSD has a finalized blueprint of cost containment strategies and will implement when needed.
- Additional COVID-19-related expenses such as vaccine administration will require additional GF support.

Current and future IT investments are critical.

- IT budget preserved without 5% GF cut.
- IT investments support 1,000 employees managing benefits for over 1M+ customers, with 60+ benefit plans regulated by both State and Federal law.
- Uncertainty related to pandemic could apply pressures that could impact IT improvements/innovations



MEDICAID BUDGET UPDATE: EXPENDITURES

- Estimated expenditures in FY20 are $6.6 billion.
- Estimated expenditures in FY21 are $7.3 billion.
- Estimated expenditures in FY22 are $7.2 billion.

Budget Projection – Expenditures ($000s)	FY2020	FY2021	FY2022
Fee-For-Service	$743,568	$747,111	$734,767
DD & MF Traditional, and Mi Via Waivers	$441,399	$536,177	$550,490
Centennial Care MCO	$5,159,706	$5,753,152	$5,696,623
Medicare	$195,519	$206,817	$231,968
Other	$98,237	$92,870	$18,272
Total Projection	**$6,638,429**	**$7,336,127**	**$7,232,119**
Prior Projection	$6,671,404	$7,313,020	$7,304,825
Change from Prior	-$32,974	$23,107	-$72,706
*The current quarterly budget projection is updated with data through September 2020.			

MEDICAID BUDGET UPDATE: REVENUES

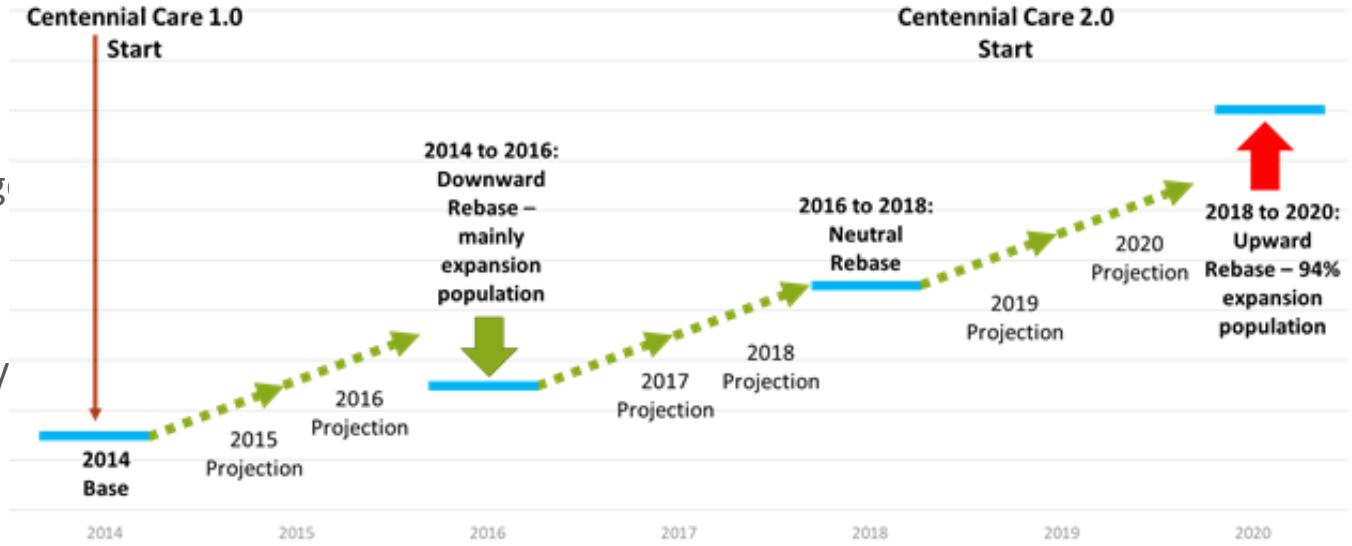
- Estimated state revenue surplus in FY20 is $66,566.0 ($14 million after a $52.5 million reversion).
- Estimated state revenue shortfall in FY21 is $21.5 million.
- Projected state revenue shortfall in FY22 is $161.8 million.

Budget Projection – Revenues ($000s)	FY2020	FY2021	FY2022
Federal Revenues	$5,357,379	$5,978,501	$5,657,253
All State Revenues	$1,269,202	$1,343,483	$1,558,216
Operating Transfers In	$243,799	$303,793	$334,627
Other Revenues	$72,272	$66,027	$65,437
General Fund Need	$953,131	$973,662	$1,158,151
Appropriation	$1,019,697	$952,168	$996,353
State Revenue Surplus/(Shortfall)	**$66,566**	**-$21,494**	**-$161,799**
Change from Prior	$5,126	$50,196	$6,133
Reversion	**-$52,548**	-	-
Surplus/(Shortfall) after reversion	**$14,018**		

HOW THE MEDICAID PROJECTION PROCESS WORKS

- Formal quarterly projections (January, April, July, October).
  - Next Medicaid Projection is Friday, January 8, 2021.
  - *Process improvement:* projection timeline moved to first week of January (previously end of January) to better align with session timeframe and will include actuals through November 2020.
- In the past, each managed care population underwent a "rebase" that incorporated all prior data every two years.
  - When rebasing has occurred in the past there have been larg shifts (tens of millions of dollars).
  - *Process Improvement:* To avoid these significant impacts to the budget, MAD is now rebasing for all populations annually
- Here's what will happen between this hearing and January projections meeting - analysis of factors driving budget:
  - Enrollment growth growing above current projection from continued MOE requirement.
  - Potential variations in initial valuation of CY21 MCO rates compared to current projection.
  - Review of medical service utilization trends..

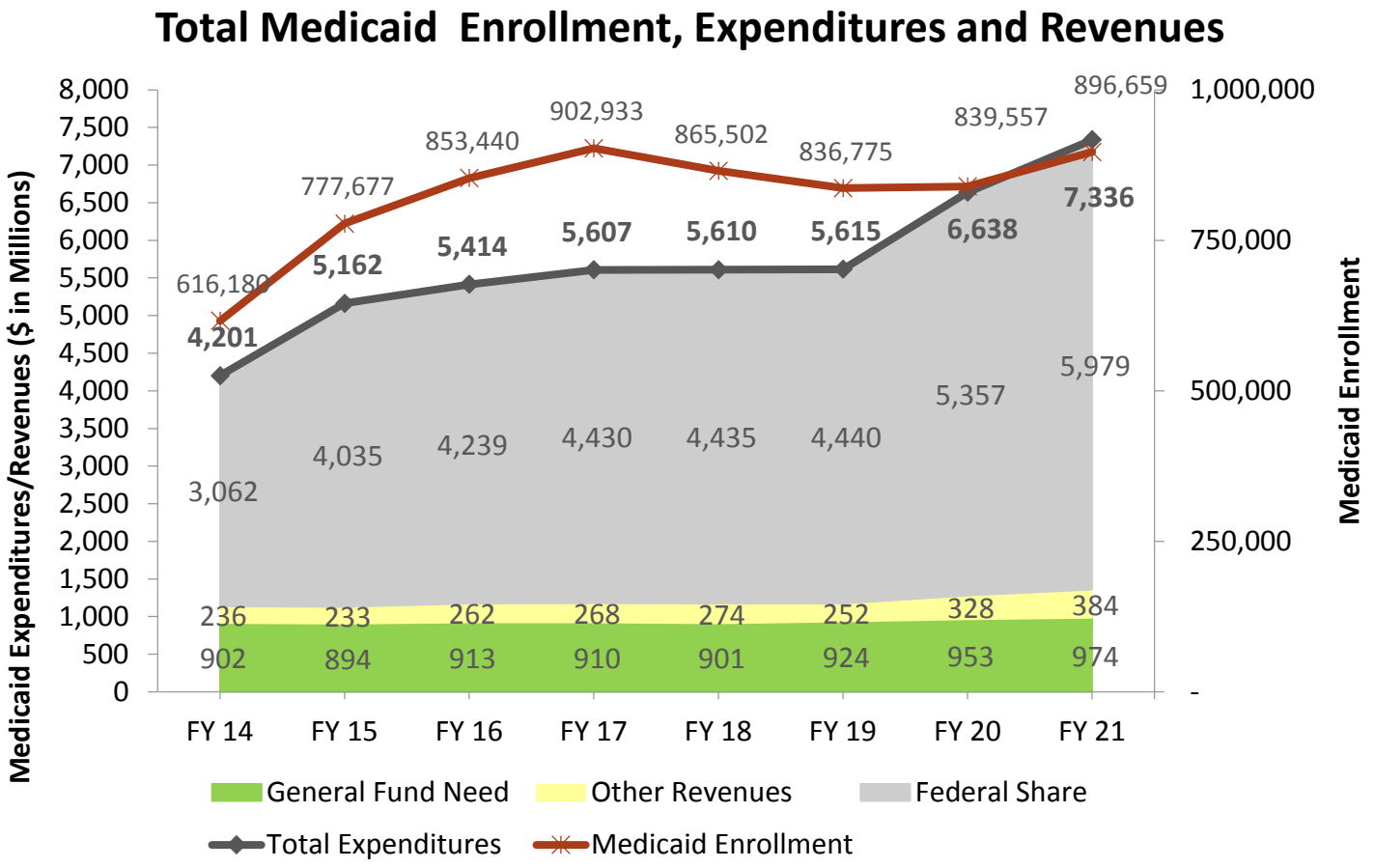
Timeline of HSD Projection and Rebasing process



There are a variety of other factors that may impact the budget given the uncertainty and volatility surrounding the pandemic and our economic conditions.

SPENDING AND REVENUE: THE REAL STORY

- Centennial Care 2.0 costs are increasing at a rate that is slower than national trends
- FY19 to FY21:
  - Δ GF Change = $50 M (+5.1%)
  - Δ Other Revenues = $132 M (+52.4%)
  - Δ Federal Revenue = $1721 M (+30.7%)



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FY22 ADDITIONAL HSD BUDGET INITIATIVES

IT, COVERAGE INITIATIVES, CHILD SUPPORT

HSD IT Investments

What are the HSD IT investments?
HSD makes IT investments in three critical areas: IT infrastructure, IT applications, and new projects to deliver new capabilities and services to the department's customers and workforce.

Although other parts of the department are cutting budgets, department leadership is not reducing its investment in IT for FY 2022. For FY 2022, HSD has prioritized continued investment in the ASPEN integrated eligibility system to improve delivery of services to New Mexicans at the same level as FY 2021.

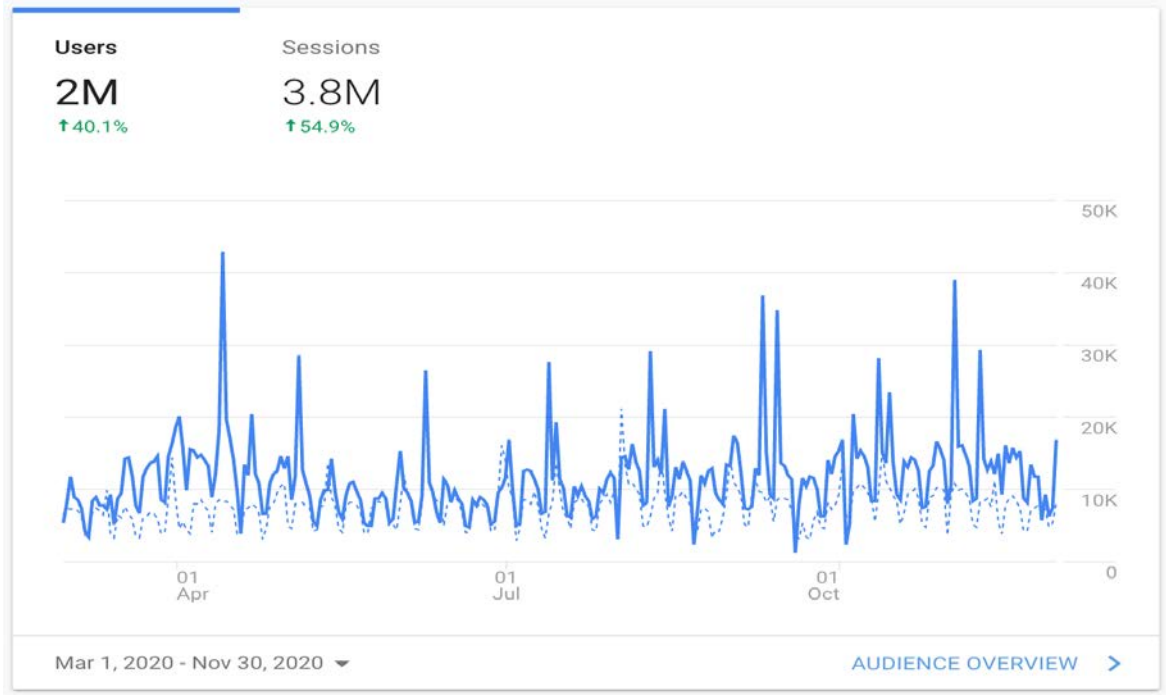
General Fund and Federal Fund (FY 2021, 2022, Difference)

	FY 2021	FY 2022	Difference
General Fund	$ 15,549,500.0	$ 15,549,500.0	$ 0.0
Federal Fund	$ 30,881,600.0	$ 30,881,600.0	$ 0.0
Total	**$46,431,100.0**	**$46,431,100.0**	**$0.0**

Financial Benefits to New Mexico
Investments in ASPEN lower operating costs for HSD. An example of this return on investment is the implementation of real time eligibility for Medicaid applications. Medicaid real time eligibility resulted in 29,673 applications being processed without worker action from January 1, 2020 through August 2, 2020.

Utilizing the average time of data entry for processing of Medicaid applications, Medicaid real time eligibility saved an estimated 41,794 hours of staff time during the same period. This savings equates to $2,032,864 and is equivalent to 38 staff positions.

Benefits to New Mexicans
Investments in the ASPEN system provide direct support to New Mexicans during the COVID-19 pandemic. For example, current investments resulted in HSD issuing $124,442,274 of supplemental SNAP benefits for 182,316 SNAP households. Pandemic Electronic Benefits totaled $151,448,366, supporting 285,471 children.



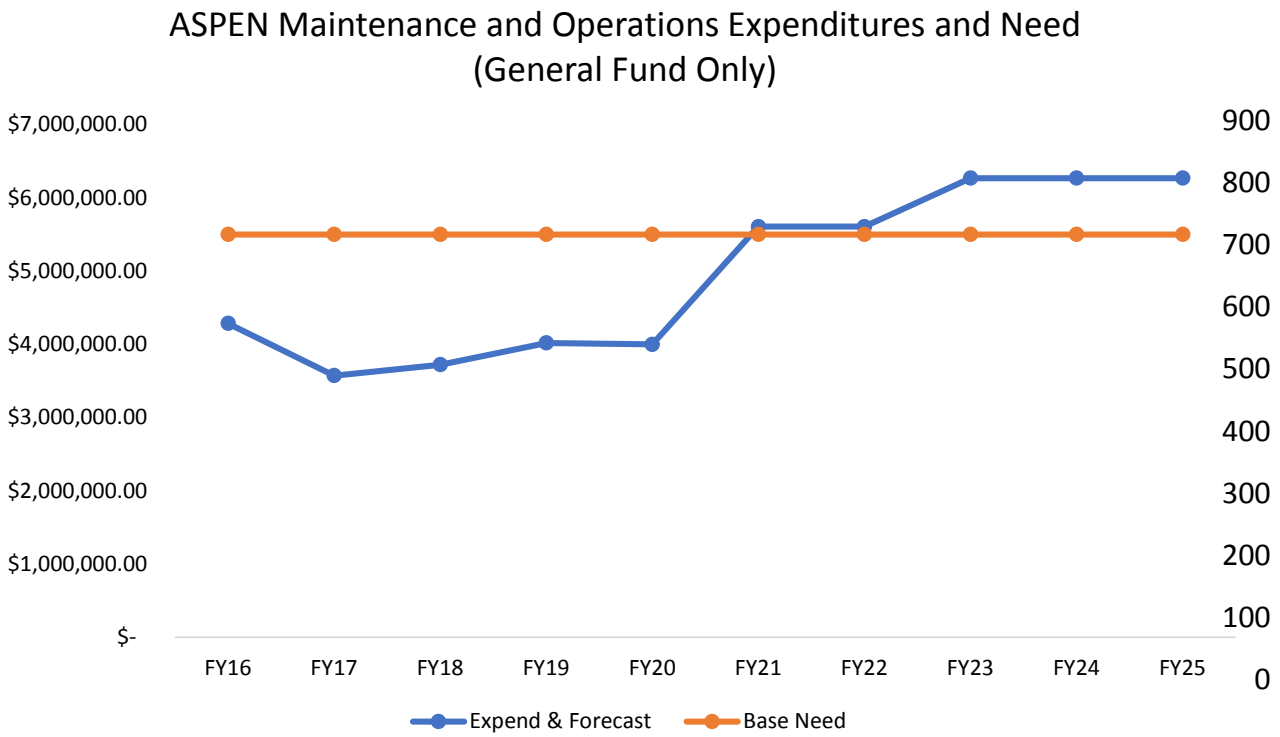
YES NM Usage, March 1 – November 30, 2020.

Frequently Asked Questions
Q. What does IT cost per customer served by HSD's programs in New Mexico?
A. The total cost per customer served by HSD is about $44. This is derived by taking the total amount of the ITD's operating budget and dividing it by the number of customers served by HSD in a given state fiscal year.

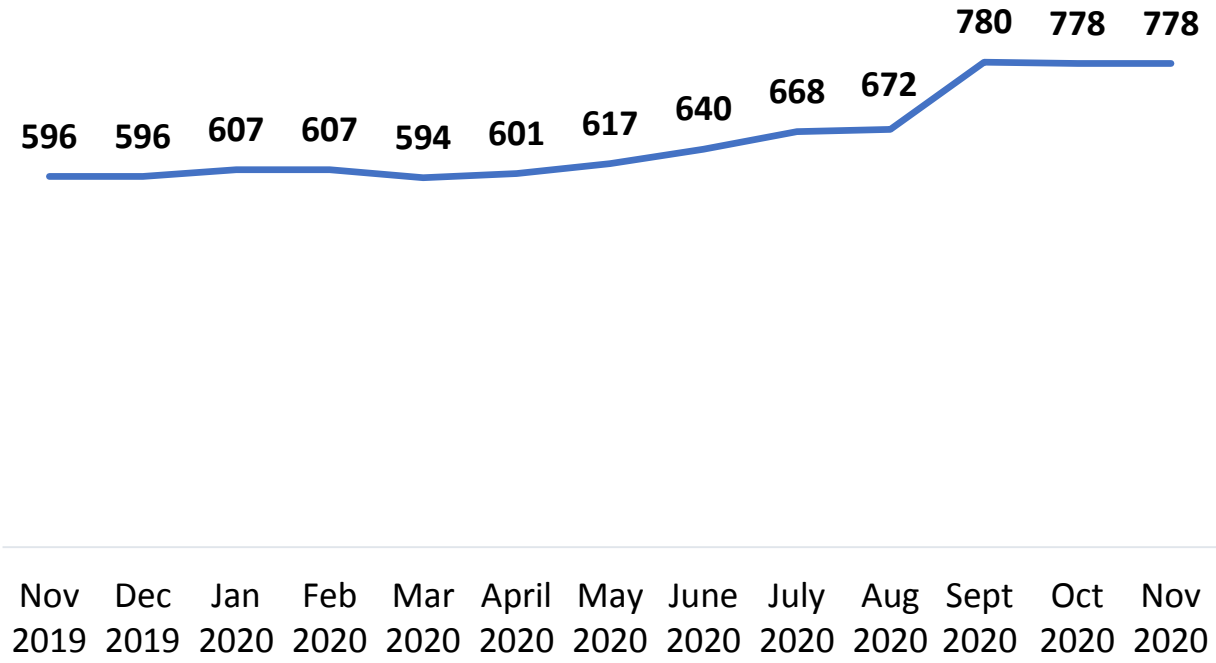
Q. For every dollar spent on IT, how much is covered by federal funds?
A. HSD receives a federal match for most IT investments. For every dollar spent within the IT operating budget, 66.5 cents is covered by federal funds. Federal match varies based on the program or system. For example, the ASPEN system has a federal match rate of 67.2%.

HSD IT Investments

ASPEN Funding Need



IT Security Risk Score



HHS 2020

What is the HHS 2020?
HHS 2020 is an initiative that contains multiple projects designed to achieve the vision to create a highly responsive and effective health and human services system to improve the health and well-being of all New Mexicans.

The Medicaid Management Information System Replacement (MMISR) project, funded with a combination of federal and state funds, provides the technical foundation. MMISR removes barriers to sharing information across public-facing departments (the "enterprise") and improves the quality of service for those receiving public assistance, their health care providers, and health and human services workers.

General Fund and Federal Fund (FY 2021, 2022, Difference)

	FY 2021	FY 2022	Difference
General Fund	$4,104,100.0	$1,208,900.0	($2,895,200.0)
Federal Fund	$36,146,300.0	$10,812,800.0	($25,333,500.0)
Total	**$40,250,400.0**	**$12,021,700.0**	**($28,228,700.0)**

Benefits to New Mexicans

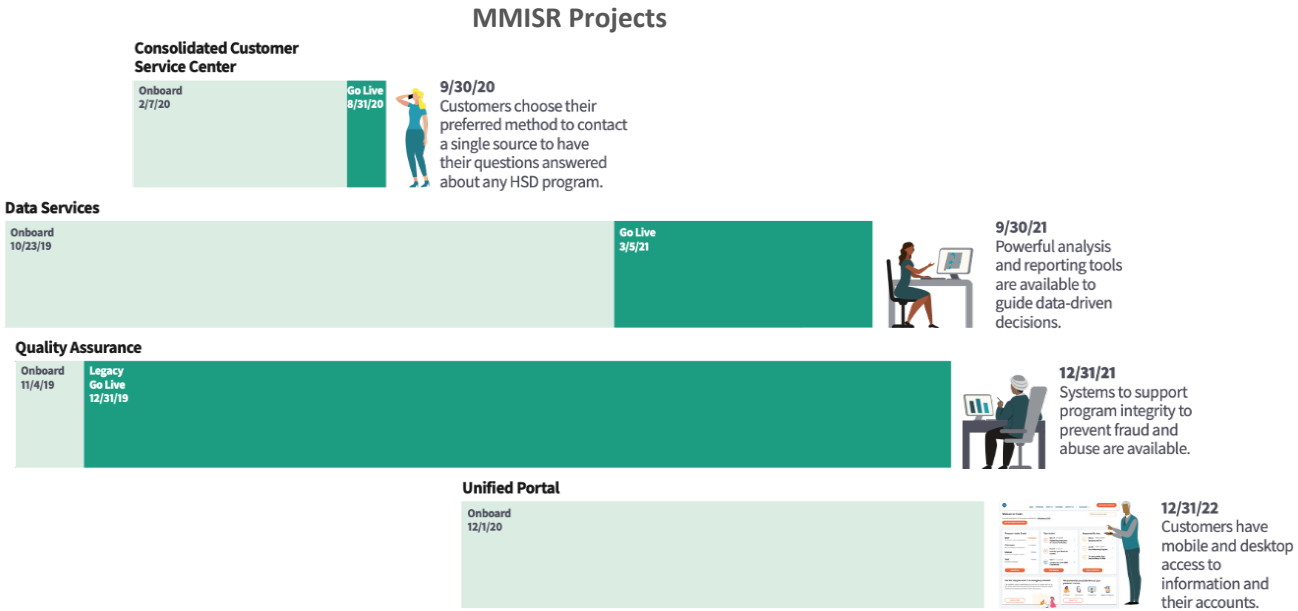
- "One-stop shop" — whether online, on the phone, or in an office, the public will have a single point of contact to access resources and services for any health and human services agency or program.
- Improved efficiency for providers through more streamlined approval, contract, and payment processes.
- Removal of silos around information about customers via a "unified portal," providing workers across health and human services departments a single resource.
- Improved population health and well-being for New Mexicans by moving from a system centered around discrete transactions to one addressing the whole needs of an individual.

Frequently Asked Questions

Q. How much of the project is funded by the federal government?
A. The federal government provides 90% enhanced funding for the MMISR project.

Q. What benefit does this project have to policy makers?
A. MMISR increases access to data for multiple stakeholders and allows for a 360-degree view of members, providers, and other entities. It will enable data-driven decision making and provide automated dashboards of key information. Oversight of managed care performance and ability to forecast Medicaid expenditures also will be provided.

Q. What other agencies are participating in the HHS 2020 MMISR project?
A. In addition to HSD, Aging and Long Term Services Department, Children, Youth, and Families Department, Department of Health, and the Early Childhood Education and Care Department are all participating in the HHS 2020 MMISR project.



Benefits of the Consolidated Customer Service Center

CUSTOMER

A New Mexico resident with a question about her family's TANF benefits calls the number for the **Consolidated Customer Service Center**. Once she provides her information, the agent realizes that her issue overlaps another program administered by a different department — and answers her question related to that program without transferring the call.

COMMUNITY PARTNER

A case worker who travels around northeastern New Mexico is preparing to help a client with an application late at night. He has a question about a program and uses the chat function at the **Consolidated Customer Service Center** to get an immediate answer, even though it's after business hours.

PROVIDER

A billing specialist at a hospital in Roswell has a question about how to process some claims she needs to submit. She's able to call one phone number at the **Consolidated Customer Service Center** to get answers, even though the claims involve several different state programs and departments.

EMPLOYEE

An employee at CSED who handles inquiries often used to have to ask customers to call another number at another department. Because of the automated functions of the **Consolidated Customer Service Center**, they often don't even need to speak to her, but when they do, she handles all their questions at one time with access to all programs.

Health Care Affordability Fund

What is the Health Care Affordability Fund Act?

The Act would establish a new fund dedicated to reducing the cost of health insurance and medical expenses for working families – up to 23,000 New Mexicans by:

- Updating State's existing health insurance premium surtax to simply replace a fee that has been in place during most of the Affordable Care Act's implementation.
- Collecting a fee via the State's existing health insurance premium surtax gives NM the opportunity to invest in health care affordability initiatives. The fund will reduce premiums and out-of-pocket costs for low- and middle-income New Mexicans who purchase coverage on the State Health Insurance Exchange.

General Fund and Federal Fund (FY 2021, 2022, Difference)

	FY 2021	FY 2022	Difference
General Fund	$56,000,000.0	$182,000,000.0	$126,000,000.0
Federal Fund	$0.0	$0.0	$0.0
TOTAL	**$56,000,000.0**	**$182,000,000.0**	**$126,000,000.0**

Benefits to New Mexicans

- The fund maintains stability of the Health Insurance Exchange and promotes a competitive marketplace by expanding enrollment in healthcare coverage.
- Coverage expansion is an essential factor to achieve health equity. Healthcare affordability will drive down cost in the long-run for everyone.
- Affordability is the number one barrier to health care. The fund is an opportunity to make health insurance more affordable. Increases in health insurance coverage is associated with better access to care, a healthier and more economically secure workforce, and improved health outcomes.

Frequently Asked Questions

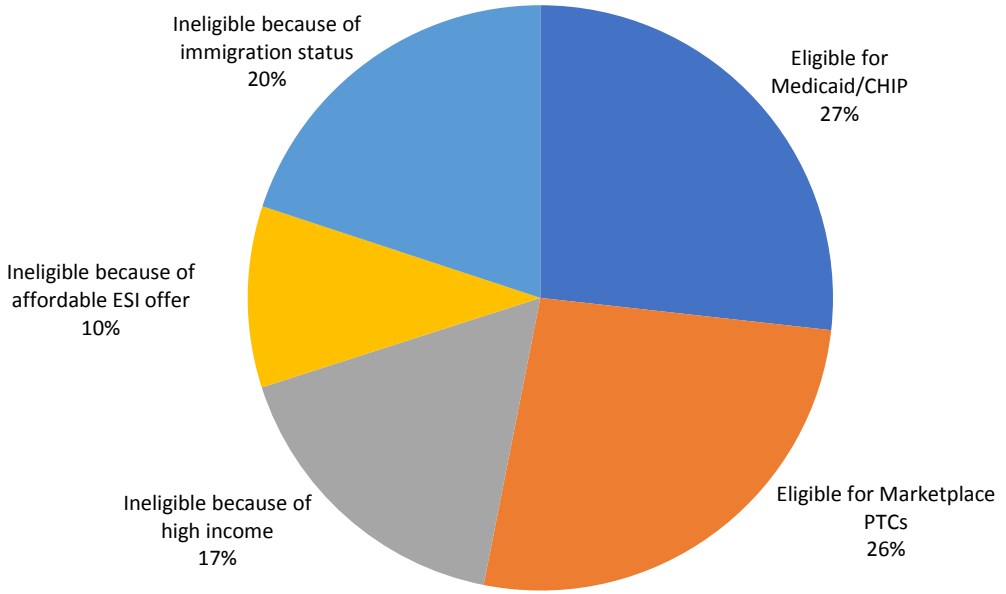
Q. Will the Fund increase health insurance rates on individuals and businesses?

A. Most businesses are self-insured and are not subject the state's surtax (77% of small businesses in NM do not offer insurance to their employees). New Mexicans who purchase insurance in the individual market will be shielded from federal financial assistance and those who do not qualify for assistance are projected to experience a premium decrease of up to 18% due to improvements in the risk pool that result from the state's affordability initiatives.

Q. Will the Fund create new administrative burdens for the NM Tax and Revenue Department?

A. No, and in fact, this bill is the simplest way to collect this type of fee. Because the surtax already exists, the department will only need to change the rate to capture the revenue from the federal fee that is no longer being assessed.

Characteristics of 214,000 uninsured in New Mexico (under age 65), 2020



Child Support Modernization

What is the Child Support Modernization?
Child Support Modernization is the implementation of national best practices to ensure that more money is available for New Mexican children, so they can have the childhood they deserve.

General Fund and Federal Fund (FY 2021, 2022, Difference)

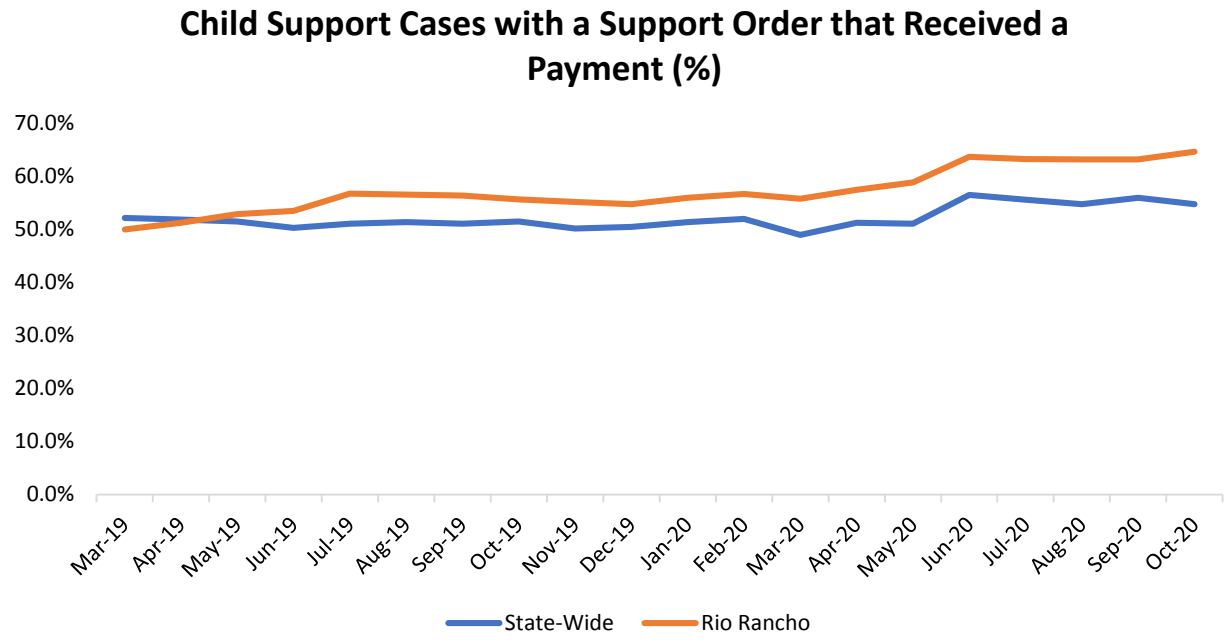
	FY 2021	FY 2022	Difference
General Fund	$8,161.30	$7,753.2	($408.1)
Federal Fund	$19,130.9	$18,338.70	($792.2)
Total	**$27,292.2**	**$26,091.9**	**($1200.3)**

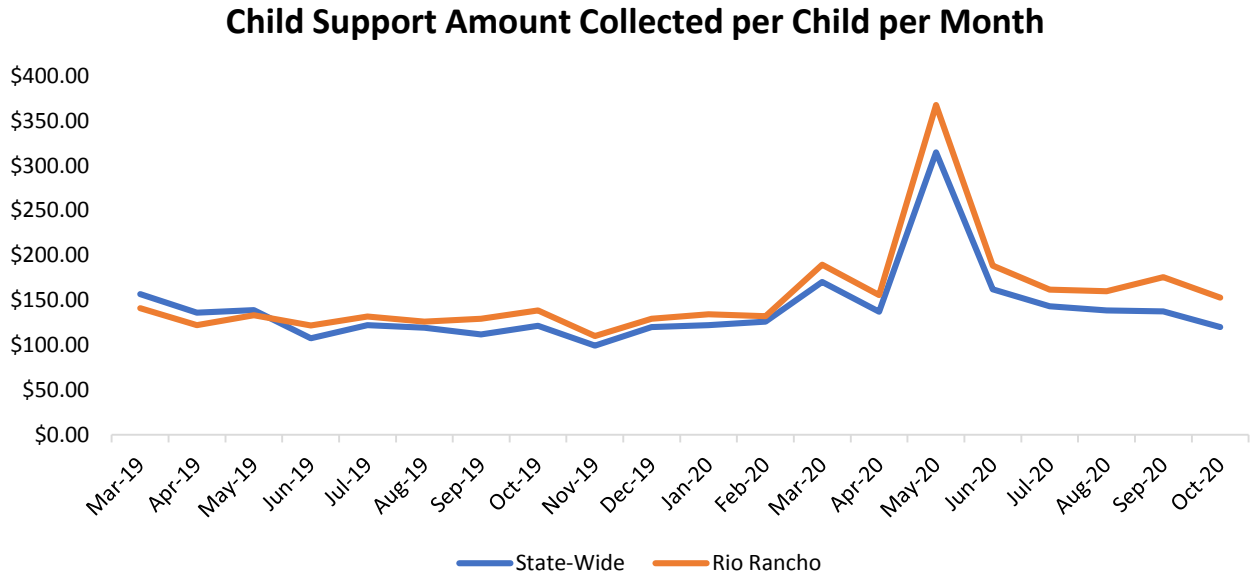
Benefits to New Mexicans
In New Mexico, for a family with one parent and two children, the living wage is approximately $4,676 per month. Child support is an important source of income that provides stability as families continue to improve their children's lives. The Rio Rancho office deployed many child support modernization tools and strategies, increasing its amount of child support collected per child by 8.2%. If all offices experience the same increase, the amount of child support collected per child would increase by almost $11 per child, per month.

Frequently Asked Questions

Q. Will shifting the focus from legal enforcement to employment let non-paying child support payors off the hook?
A. No, there are work requirements in child support orders that if not complied with will lead to further legal enforcement.

Q. Will Child Support Modernization reduce the amount of child support that I am currently receiving?
A. Under the new Federal regulations, child support must use the actual income of both parties, which means that in calculating the monthly support amount, child support staff will no longer be able to impute income, which may reduce the monthly support amount that is in the court order.





ADDITIONAL FY22 BUDGET FACTSHEETS

EXCERPT FROM FORTHCOMING 2021 DATA BOOK

New Mexico Medicaid Program Budget

What is the New Mexico Medicaid Program Budget?

Medicaid is a jointly-administered federal and state health insurance program for eligible lower-income individuals and certain people with disabilities. The projected FY22 budget for NM Medicaid is $7,232 billion. Factors that increase Medicaid program costs include:

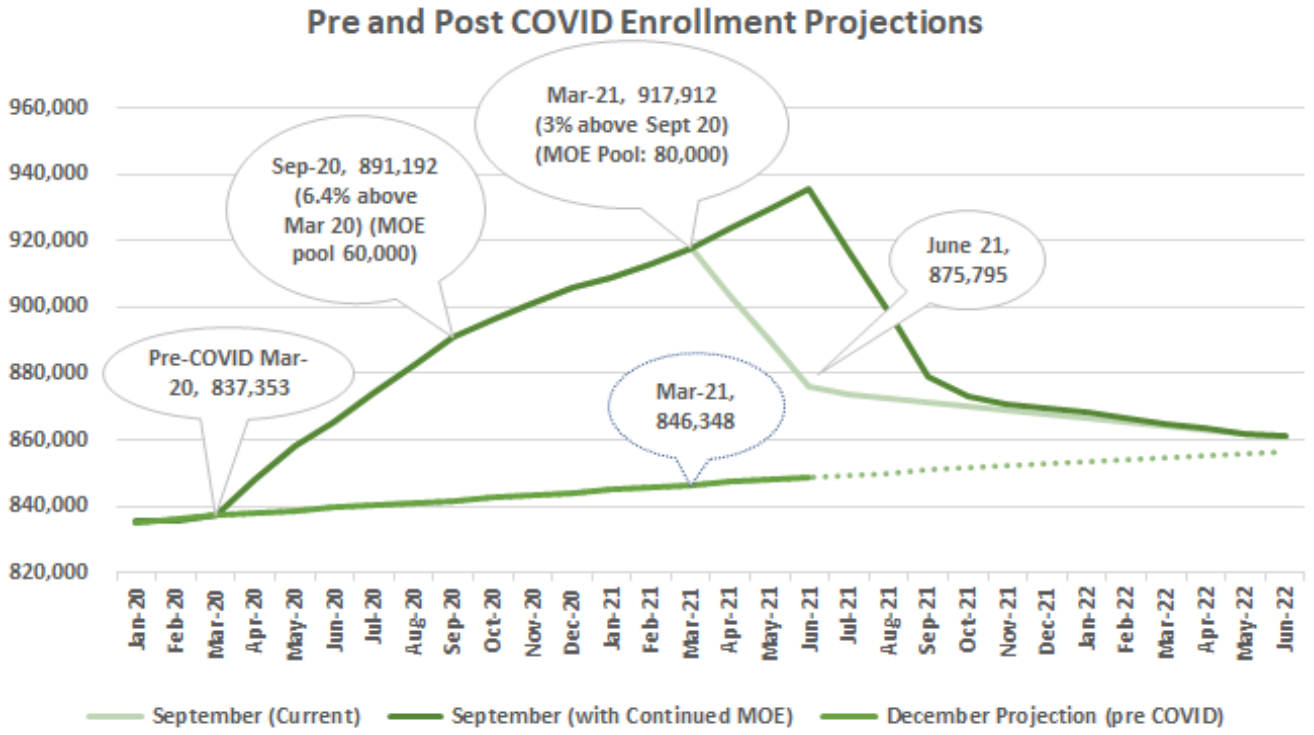
- Increased Medicaid and Children Health Insurance Program (CHIP) enrollment: Baseline projection assumes federal government ends its Public Health Emergency (PHE) January 2021. (Alternatively, if PHE remained through March 2021 enrollment is projected to surpass 900,000 individuals in first-quarter of CY 2021.
- Increased medical service unit costs and increased utilization of services in the wake of the COVID-19 public health emergency.
- Gradual disenrollment resulting from removal of maintenance-of-effort requirements.
- Modest economic recovery from the public health emergency, resulting in some disenrollment.
- Legislature enabled changes to align provider rates with costs after years of inadequate payment.

Financial Benefits to New Mexicans and New Mexico

- Medicaid currently provides medical insurance coverage to 43% of the State's population (including 58% of the State's children).
- Medicaid reduces uncompensated care costs experienced by healthcare providers.
- Medicaid is a primary source of revenue to healthcare providers in NM.
- Taxes and assessments paid through Medicaid provide revenues to:
  - New Mexico's health insurance exchange;
  - New Mexico's high-risk insurance pool; and,
  - Access-to-care through programs such as PACE and Project ECHO.

How has the COVID-19 pandemic impacted the Medicaid and CHIP programs?

- Increased medical expenses associated with acute and long-term care of Medicaid populations. Specifically, additional personal protective equipment needs, additional cleaning and protection needs, and significant staffing challenges.
- Testing, treatment, and vaccine administration are unanticipated expenses significantly impacting the Medicaid budget.
- Delayed costs from pent-up demand as a result of necessary public health orders and fear of exposure.
- Increased unemployment has resulted in significant Medicaid enrollment. Medicaid enrollment typically grows at a rate of .1% per month but since April 2020 has grown on average by 1.5% per month.



Telehealth

What is telehealth?
Telehealth provides physical and/or behavioral healthcare services remotely (e.g. telephone, online, video). Telehealth:

- Complements in-person healthcare, helping to improve healthcare outcomes.
- Is a critical component of the State's response during the COVID-19 pandemic, promoting an alternative to healthcare when in-person visits are not recommended.
- Supports providers as they maintain service delivery.

Benefits to New Mexicans

- Centers for Medicare and Medicaid expanded virtual services clarifying the value of telemedicine options during the COVID-19 pandemic and in the future.
- Positive outcomes for both providers and their clients:
  - Providers report fewer appointment no-shows and cancellations;
  - Many providers work safely from home or scaled-down office settings;
  - Many clients appear more relaxed and able to engage when they are in their own homes; and,
  - Clients avoided the cost and inconvenience of driving potentially long distances.

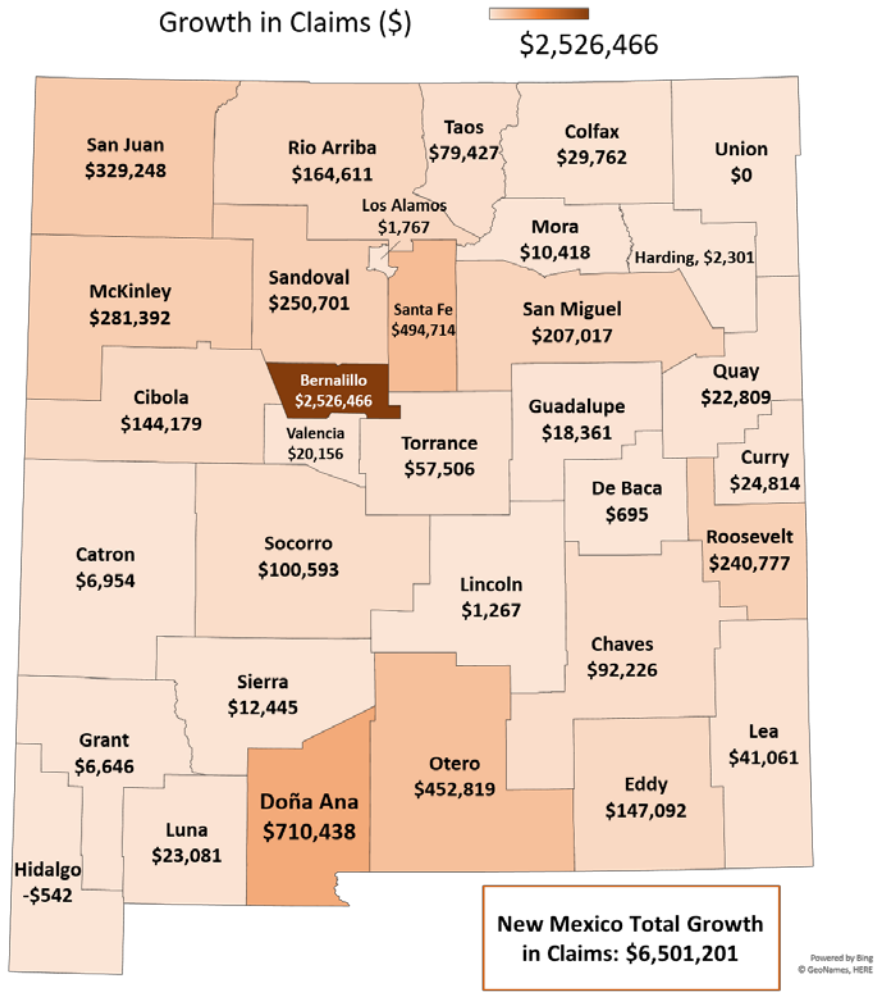
Frequently Asked Questions

Q. What Services are well-suited for telehealth?
A. Telehealth services are an appropriate means of care for various types of healthcare, including new patient visits, behavioral health, and follow-up visits for chronic medical conditions.

Q. How has telehealth helped maintain healthcare services during the COVID-19 pandemic?

A. A preliminary review examined the change in telehealth between the first and second quarters of calendar year 2020. Results illustrate HSD observed an increase of 61,492 telehealth claims, reflecting a 300% increase. Synchronously, the average volume of total healthcare claims dropped 275,000 per month. Thus, telehealth was instrumental in maintaining service delivery.

Growth in Telehealth Claims: CY20 Q1 to CY20 Q2 (Increased Amount Paid)



Source: New Mexico Human Services Department, Medicaid data analysis.

Primary Care Graduate Medical Education Expansion

What is Primary Care Graduate Medical Education Expansion?
HSD, through its Graduate Medical Education (GME) Expansion Program, funds new and expanding primary care GME programs and provides technical assistance to the program network. GME is the physician training period after medical school and before independent practice; and research demonstrates 55% of medical residents will stay within 100 miles of their residency program. Building on the 2019 GME Expansion in NM Five-Year Strategic Plan, it is anticipated primary care programs will grow from 8 to 13 (63% increase) by 2025.

General Fund and Federal Fund (FY 2020, 2021, 2022, Difference)

	FY 2021	FY 2022	Difference
General Fund	$500,000.0 ($150,000.0 appropriated; $350,000.0 special appropriation request)		$143,000
Federal Fund	$0.0	$0.0	$0.0
Total	**$500,000.0**	**$500,000.0**	**$143,000.0**

Frequently Asked Questions

Q. Have any programs received funding for GME expansion support?

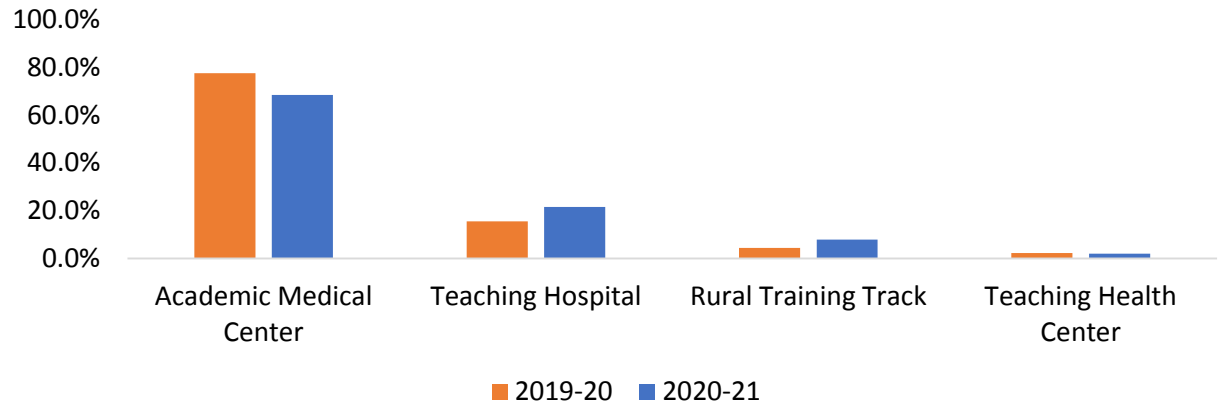
A. Yes, in FY20 three programs were selected to receive funding, totaling $1,000,035:

- Burrell College of Osteopathic Medicine (Las Cruces) to add a total of 12 new Family Medicine residency positions. Anticipated date of arrival of first resident: Summer 2021.
- Memorial Medical Center (Las Cruces) to add a total of 12 new General Psychiatry residency positions. Anticipated date of arrival of first resident: Summer 2022.
- Rehoboth McKinley Christian Health Care Services (Gallup) to add a total of 12 new General Psychiatry residency positions. Anticipated date of arrival of first resident: Summer 2024.

5-year timeline of New or Expanded Primary Care GME Programs in New Mexico

	Number of New First-Year Residents							
Program	**FY20**	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**Total new Residents**	**New Graduating Resident per Year**
Family Medicine	3	17	17	24	10	10	71	27
General Psychiatry	0	5	11	11	11	6	54	11
General Pediatrics	-	5	5	5	-	-	15	5
General Internal Medicine	-	5	5	5	-	-	15	5
Total Residents per Year	**3**	**32**	**38**	**45**	**21**	**16**	**155**	**48**

NM Distribution of First-Year Primary Care Residents by Specialty, 2019-20 & 2020-21 Years (%)

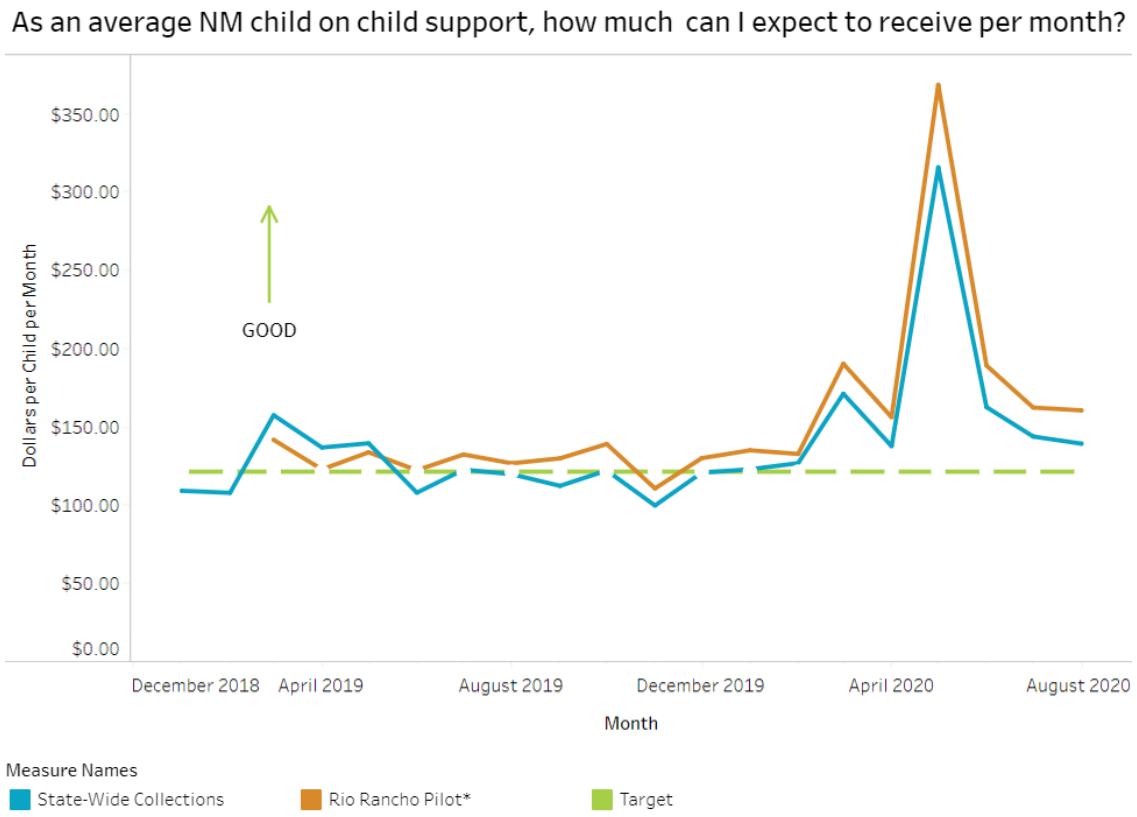


APPENDIX

MEASURING PERFORMANCE:
HSD PERFORMANCE SCORECARD

HSD places a high priority on using data to identify key priorities, track progress, and prove effectiveness of public investments.

- HSD Performance Scorecard aligns with HSD Strategic Plan, promotes transparency and oversight, and tells HSD's story more accurately and from customers' perspective.
- Scorecard is a visual representation of the work we do each and everyday and how it connects to mission and vision.
- 31 measures cover areas related to finance, growth, quality, employees, and consumer/beneficiary satisfaction.



As an average NM child on child support, how much can I expect to receive per month?

Description	Reports	Numerator	Denominator	Target	Data Source	Comments
Amount of child support collected per child in the Child Support caseload *Child Support is piloting new tools and processes in the Rio Rancho Office, which has realized a 170% increase in this measure since Aug 2018.	Monthly	Sum of support ($) given to each child on child support	Total number of active dependents in the Child Support caseload	$121 based on improvements seen in primary pilot office	Structured Query Language (SQL) query Child Support Enforcement System (CSES) extract of Federal Child Support Office Quarterly Report of Collections	March-July 2020 skewed by the intercept of COVID-19 Stimulus Payments.

HUMAN SERVICES DEPARTMENT

Investing for tomorrow, delivering today.

INDIAN MANAGED CARE ENTITY (IMCE)

- HSD continues to meet with Navajo Nation, Naat'áanii Development Corporation, and Molina Healthcare to support development and implementation of first IMCE in the country.
- Anticipated go live, open enrollment: June 2021.
- IMCE provides NM Native Americans:
  - Increased access to care via network inclusive of Indian Health Services, Tribal 638s, and statewide/neighboring providers.
  - Care coordination unique to tribal members.
  - Mechanism to address social determinants of health (e.g. food insecurity and transportation).
  - Workforce of qualified, NM tribal members.
  - Unique Value-Added Services:
    - Enhanced behavioral health benefits/services.
    - Traditional Healing reimbursement for outpatient and inpatient services, with flexibility to pay provider, healer, and/or member.

NM Medicaid Native American Enrollment, October 2019-October 2020		
	Enrolled Members	Year Over Year Increase
Blue Cross Blue Shield	21, 084	9% Increase
Presbyterian	42,513	12% Increase
Western Skies Community Care	4,138	9% Increase
Total Managed Care Enrollment	67, 735	9% Increase
Medicaid Fee For Service	71, 863	10% Increase
Total	**134, 737**	**10% Increase**

MEDICAID INCREASED MATCH: MAINTENANCE OF EFFORT REQUIREMENT

- States must attest compliance with the statutory requirements below to receive this increase and if they violate these terms, they will be required to return all additional federal funds:
  - **No new eligibility and enrollment requirements** that are more restrictive than were in place prior to the Public Health Emergency (PHE);
  - No cost-sharing for testing;
  - No increases in premiums; and,
  - **No disenrollment** during PHE declaration.
    - Prior to the emergency, NM averaged 7,000 disenrollment per month = 0.84% of membership. Over 60,000 not disenrolled to date.

MEDICAID 6.2% FMAP EXTENSION TIMELINE

January 31, 2020

- Secretary Azar first declared COVID-19 a nationwide public health emergency (PHE) since January 27, 2020 utilizing his authority under Sec. 319 of the Public Health Service Act.
- Under Sec. 319, the Secretary may extend the PHE declaration for subsequent 90-day periods for as long **as the PHE continues to exist.**

April 21, 2020

- Secretary Azar issued a renewal of the determination which was scheduled to expire on July 25, 2020.

July 23, 2020

- Secretary Azar issued a renewal of the determination which was scheduled to expire on October 23, 2020.

October 2, 2020

- The most recent renewal will be effective through January 21, 2021, UNLESS the Secretary determines that it no longer exists prior to that date.

https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx

DURATION OF MEDICAID FMAP INCREASES

	FFY 2019	FFY 2020	FFY 2020 6.2% increase	FFY 2021	FFY 2021 6.2% increase	FFY 2022
FMAP	72.26%	72.71%	**78.91%**	73.46%	**79.66%**	73.71%
E-FMAP	80.58%	80.90%	**85.24%**	81.42%	**85.00%**	81.60%
CHIP E-FMAP	100%	92.40%	**96.74%**	81.42%	**85.00%**	81.60%

- Expansion FMAP steps down again on January 1, 2019, to 93% and on January 1, 2020 to 90%.
- CHIP Reauthorization:
  - 100% expired in September 30, 2019.
  - Phase-out increased to states' E-FMAP by 11.5% through September 30, 2020.
  - E-FMAP reverts back on October 1, 2020.
- As a result of the Families First Coronavirus Response Act (FFCRA), NM receives a 6.2% FMAP increase for the months of January 2020 through March 2021.
  - This will last until the end of the quarter in which the public health emergency ends.
  - COVID-19 testing and related services for uninsured are 100% FFP.

MEDICAID FMAP AND 6.2% INCREASE IMPACT

Federal Fiscal Year 20 FMAP with 6.2% Increase							
	Pre-PHE Federal and State FFP			Policy Adjusted Federal and State FFP			
	Federal Match %	State Match %	Ratio (Federal: State)	Federal Match with 6.2%	State Match w/ 6.2%	Ratio (Federal: State)	**Percent Change from 6.2%**
Traditional (PH & LTSS)	72.71%	27.29%	2.66	78.91%	21.09%	3.74	**40%**
Chip EFMAP	92.40%	7.60%	12.16	96.74%	3.26%	29.67	**144%**
Other Adult Group (CY20)	90.00%	10.00%	9.00	90.00%	10.00%	9.00	**0%**
State FY Blended FFP	78.75%	21.25%	**3.71**	80.60%	19.40%	**4.15**	**19%**

GENERAL FUND IMPACT FROM MEDICAID 6.2% FMAP INCREASE

FY2020

FY20 6.2% FMAP Impact by Program ($000s)	
Fee for Service	14,933.8
DOH Waivers	*15,301.9*
CC - Physical Health	49,877.5
CC - LTSS	38,090.9
CC - Behavioral Health	11,428.5
CC- Health Insurance Providers Fee	2,945.0
Medicare	3,953.6
Others	2,082.1
Total Medicaid	**138,612.8**

FY2021

FY21 6.2% FMAP Impact by Program ($000s)	
Fee for Service	20,575.3
DOH Waivers	*21,576.6*
CC - Physical Health	85,957.7
CC - LTSS	63,207.4
CC - Behavioral Health	19,763.6
CC- Health Insurance Providers Fee	-
Medicare	6,407.3
Others	3,497.7
Total Medicaid	**217,487.9**

The 6.2% FMAP increase is included from January 2020 – March 2021.

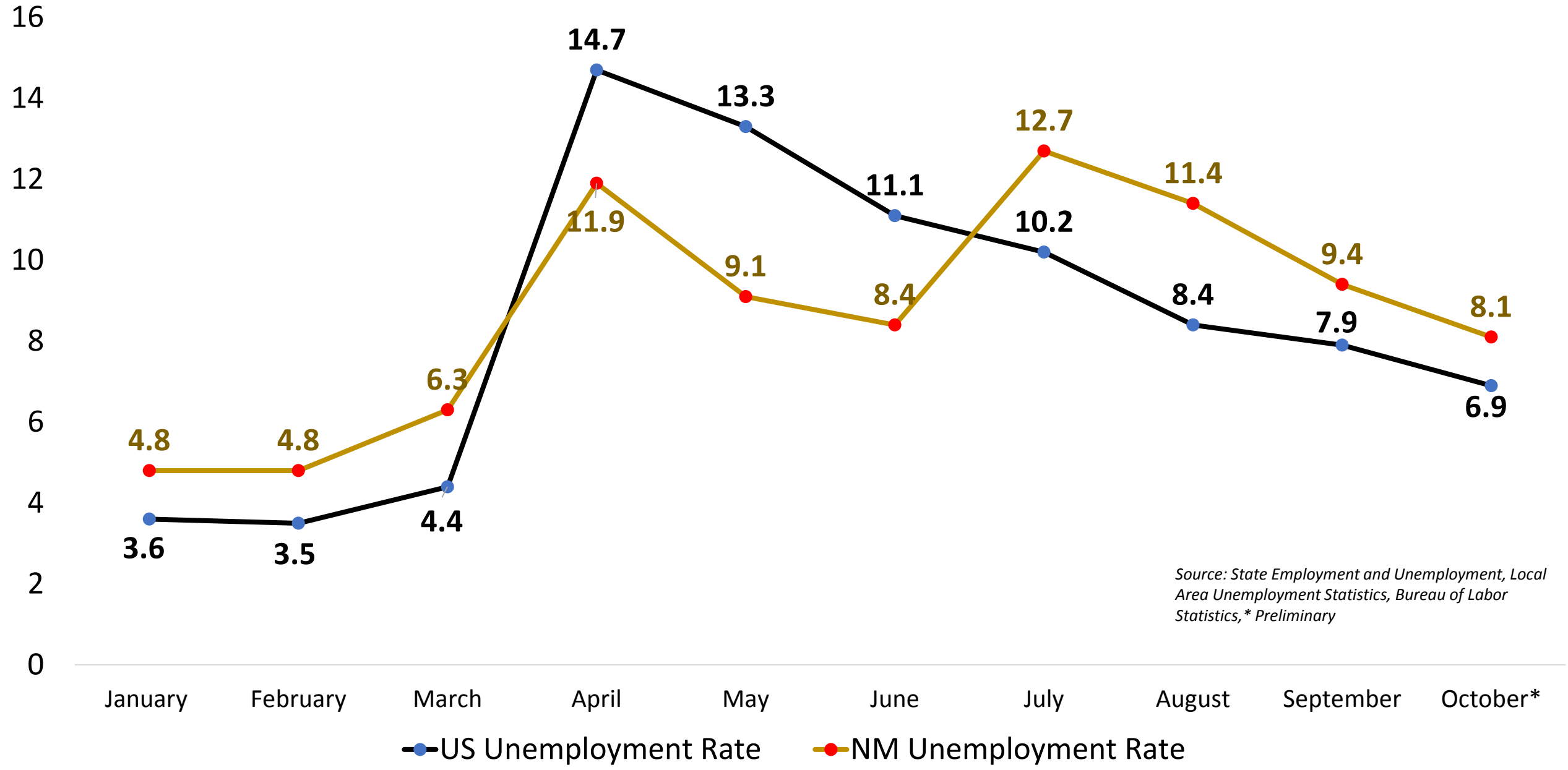
ISSUES WITH REPORTING ACCURATE MEDICAID UTILIZATION DATA

- **Providers**: delays in claims submission due to disruption of pandemic.
- **MCOs**: delays in processing due to emergency programming for COVID related rate increases.
- **HSD**: less complete data to compare current data to last year.

MEDICAID PROVIDER RATE INCREASES RELATED TO COVID-19

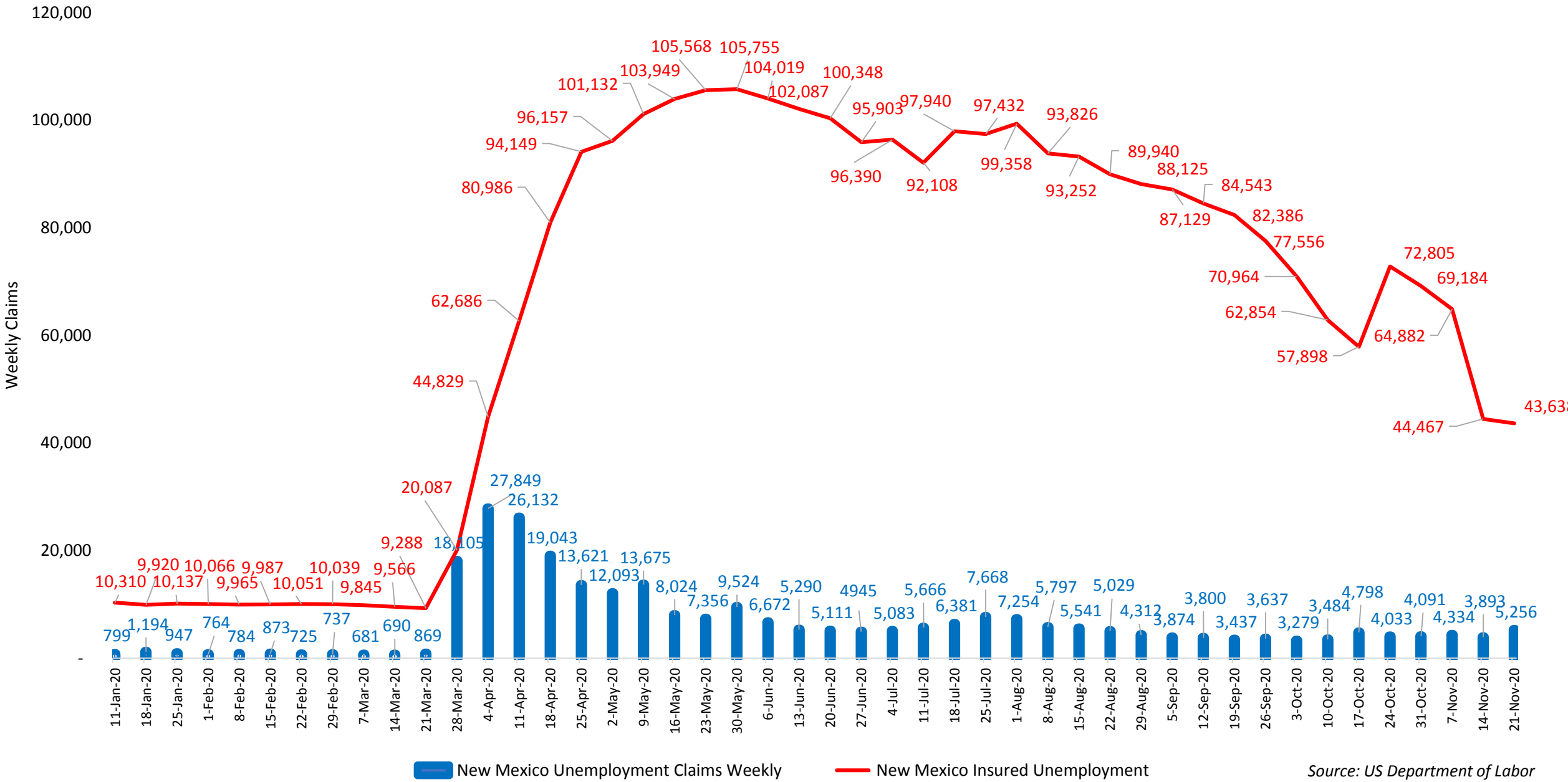
Waiver Type	Policy Change	Reflected in the Budget Projection	Estimated Total Cost (millions)	Estimated GF Cost (millions)
Appendix K for HCBS	Retainer Payments for PCS services (1 quarter)	NO	$0.0	$0.0
Appendix K for Mi Via, Med Frag & DD Waiver	Increase assistive technology budget from $250.00 to $500.00 (1 quarter)	NO	$0.03	$0.01
	Support waiver participants (personal care) in an acute care hospital or short-term institutional stay (DD waiver, Med Frag waiver, and Mi Via Waiver) (1 quarter)	NO	-	-
	Increase rates for supported living, intensive medical living, family living (DD waiver) (1 quarter)	YES	$9.1	$1.9
Disaster SPA	Delayed reconciliation of SBHC cost reports for FFY18	YES	$0.0	$0.0
	EMSA – to cover COVID-19 testing	YES	$1.9	$0.5
	COVID-19 testing uninsured group for uninsured beginning 3/18	YES	$1.3	$0.0
	Targeted Access Payments (Disaster SPA)	YES	$16.8	$3.5
	Hospital Access Payments	YES	$57.6	$12.1
	Advance payment of DSH for first 2 quarters of 2020	YES	$16.4	$3.5
	DRG ICU 50% rate increase (1 quarter) for 201 Acute Care Hospitals	YES	$50.6	$7.1
	DRG inpatient stays 12.4% rate increase (1 quarter) for 201 Acute Care Hospitals	YES	$16.2	$2.3
	12.4% rate increase (1 quarter) for providers 202-205	YES	$3.5	$0.6
	30% rate increase to short term skilled & custodial nursing facility services for COVID-19 + patients (1Q)	YES	$6.7	$1.4
	30% rate increase for Assisted Living Facilities (ALFs) for COVID-19 positive patients (1 quarter)	YES	$0.06	$0.01
	$1 rate increase to pharmacies for curbside pickup (1 quarter)	YES	$1.9	$0.3
	Other Provider Rate Increases (1 quarter)	YES	$13.1	$2.4
Managed Care	Increase non-emergency ground transportation (NEMT) rates (1 quarter)	YES	$1.6	$0.4
	E&M/Non-E&M/Medicaid only rate increase (1 quarter)	YES	$36.6	$6.3
	Targeted Access Payments (Regular SPA)	YES	$7.2	$1.5
	TOTAL Medicaid Costs		**$240.5**	**$43.8**

Unemployment Rate in New Mexico and US, Seasonally Adjusted
January 2020 - October 2020



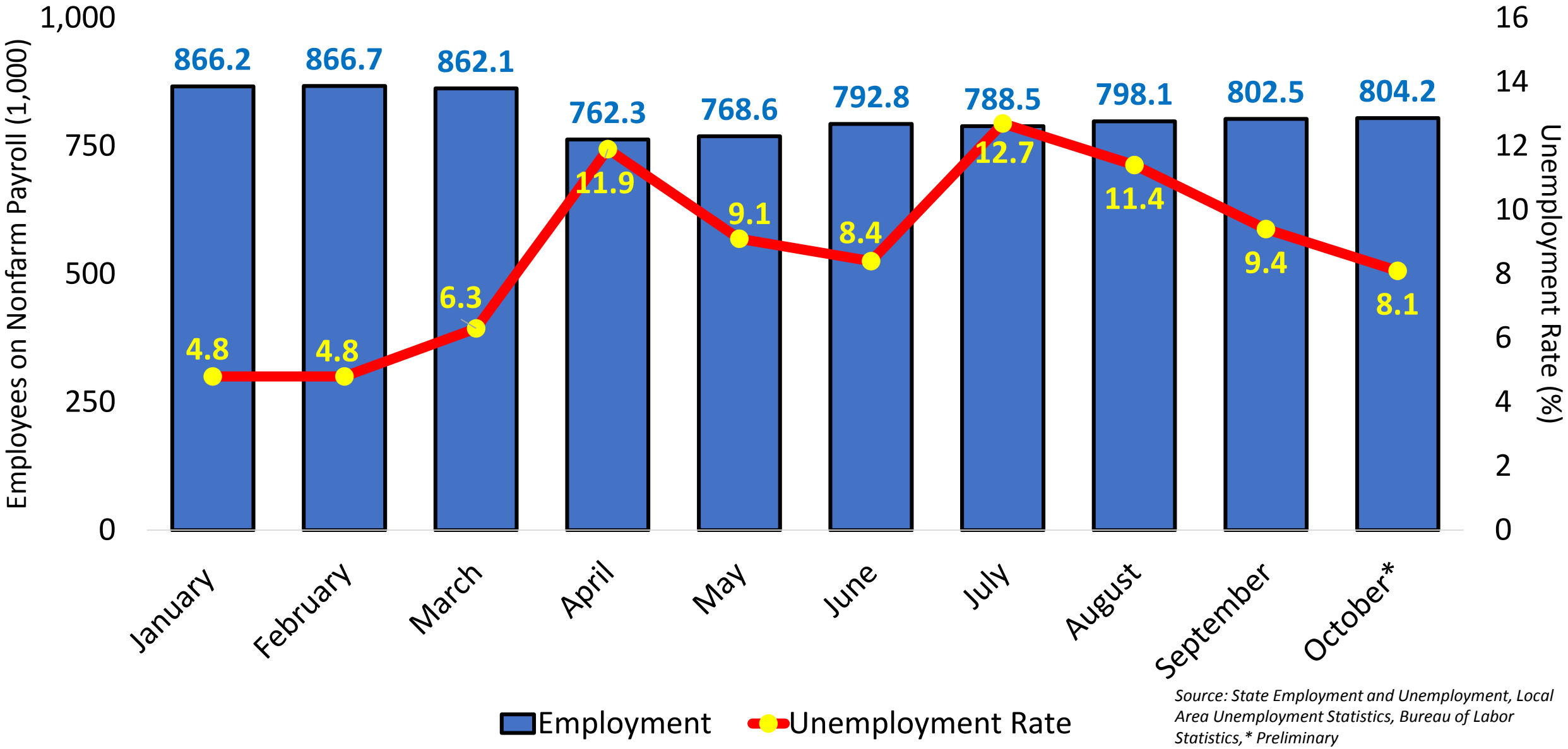
Source: State Employment and Unemployment, Local Area Unemployment Statistics, Bureau of Labor Statistics, Preliminary*

New Mexico Unemployment Initial Claims & Insured Unemployment



Source: US Department of Labor

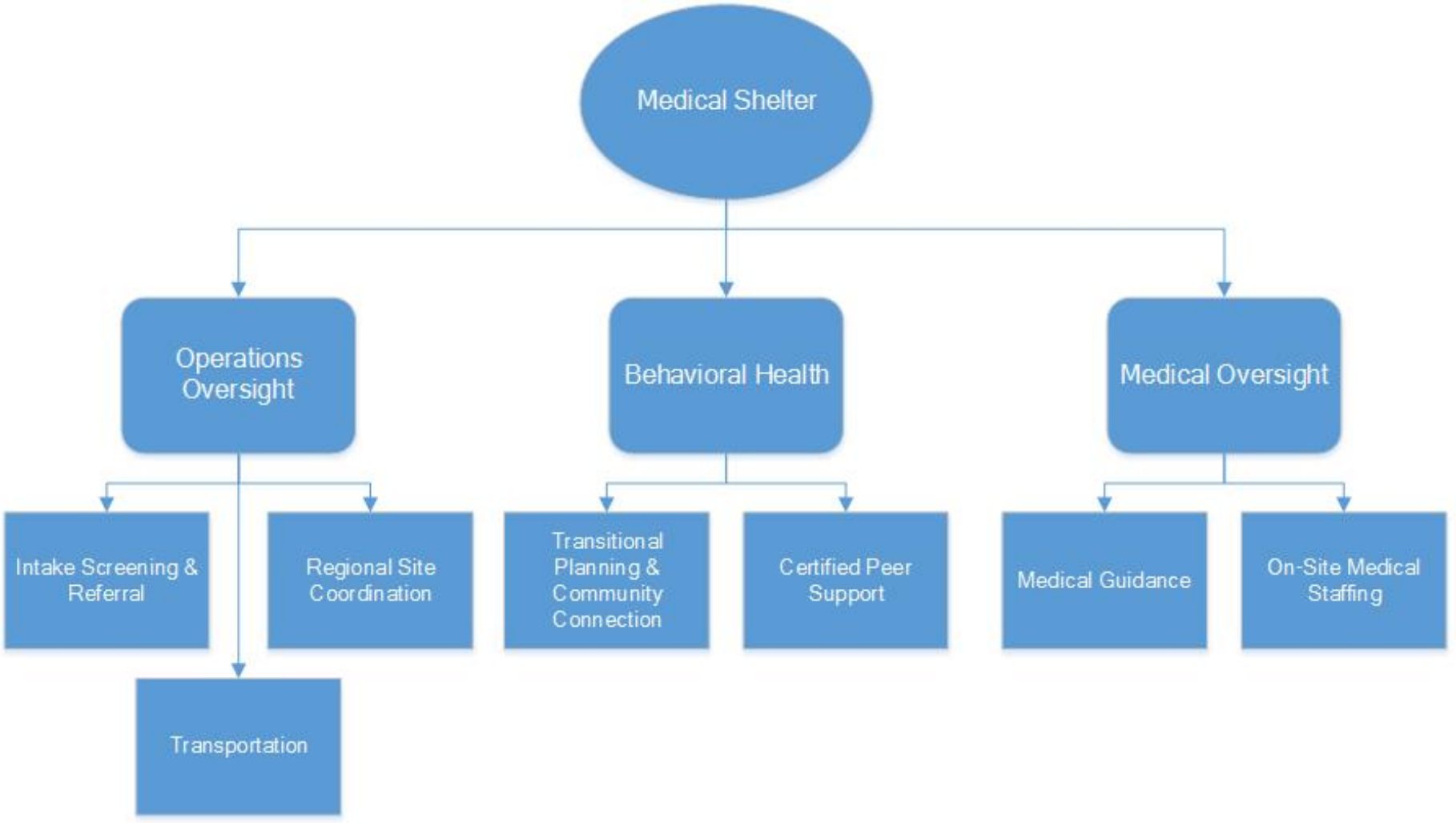
New Mexico Nonfarm Payroll Employment and Unemployment Rate
Seasonally Adjusted
January 2020 - October 2020



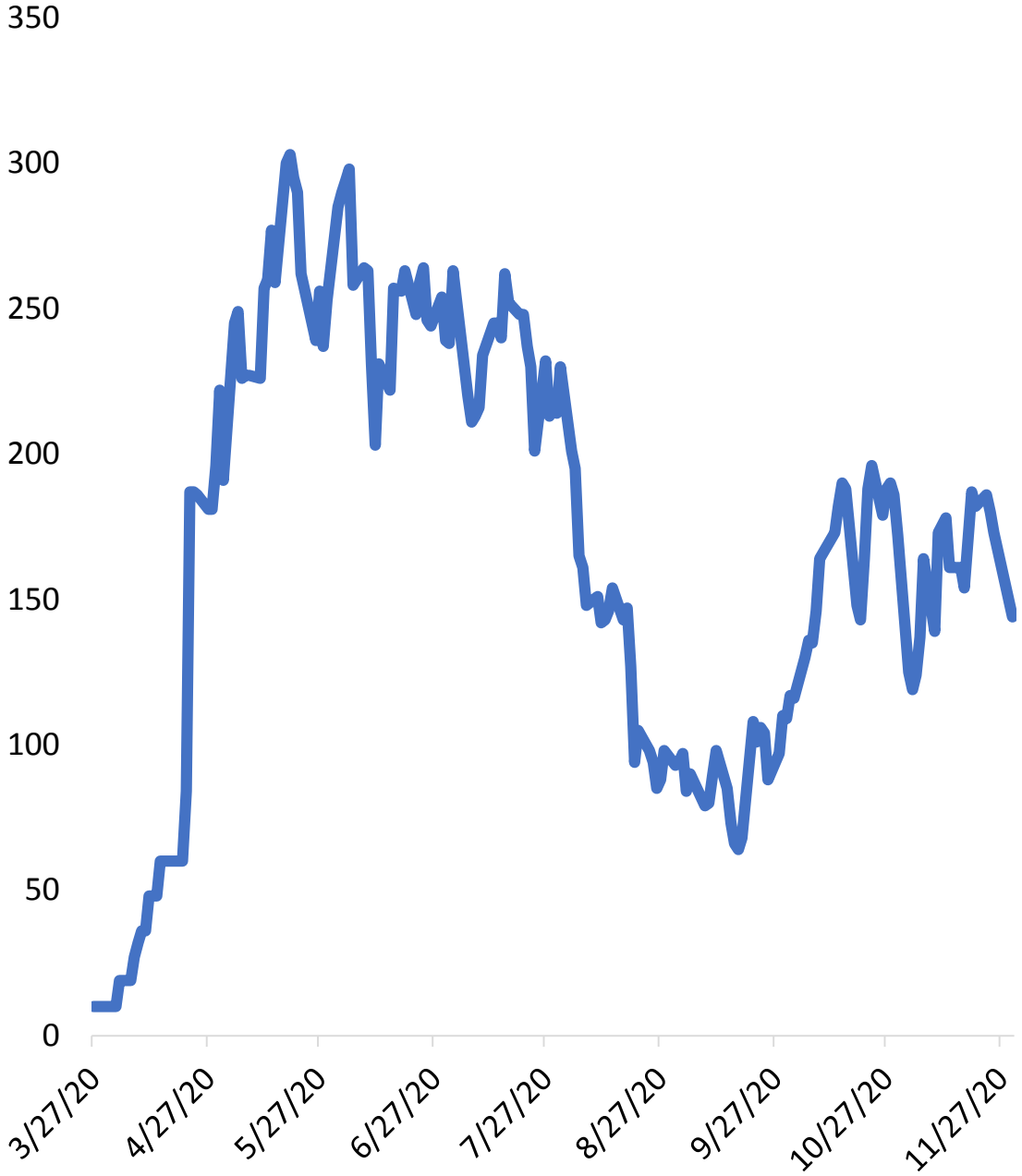
Source: State Employment and Unemployment, Local Area Unemployment Statistics, Bureau of Labor Statistics, Preliminary*

HSD is Responsible for EMERGENCY SUPPORT FUNCTION (ESF) 6 – FOOD & SHELTER

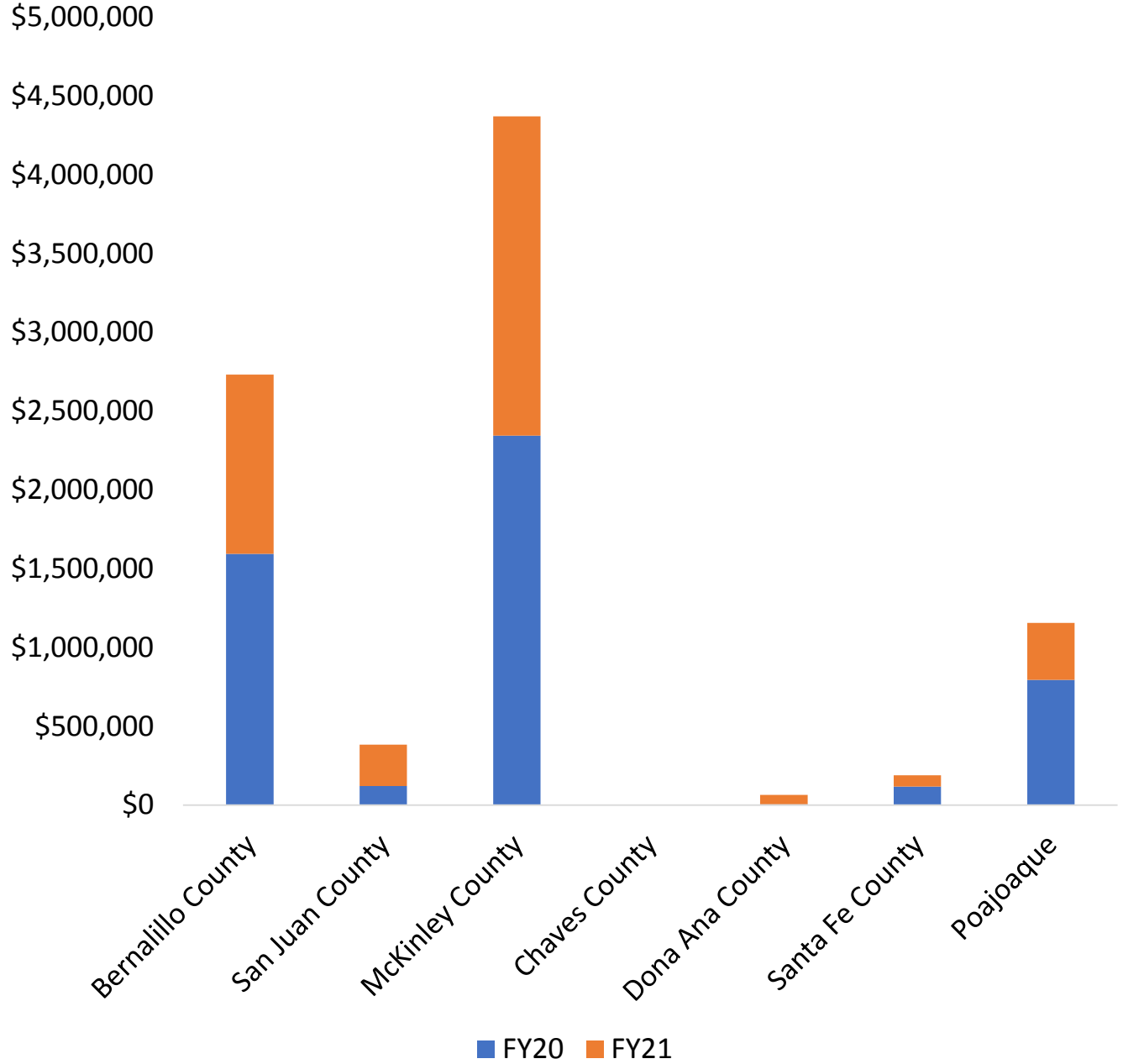
- ESF 6 –coordinates delivery of mass care, emergency assistance, housing, and human services
- Collaboration with Departments of:
  - Indian Affairs
  - Children, Youth & Families
  - Health
  - Human Services



NM COVID-19 Shelter Placements as of 11/30/20
3,486 Individuals totaling 30,328 nights



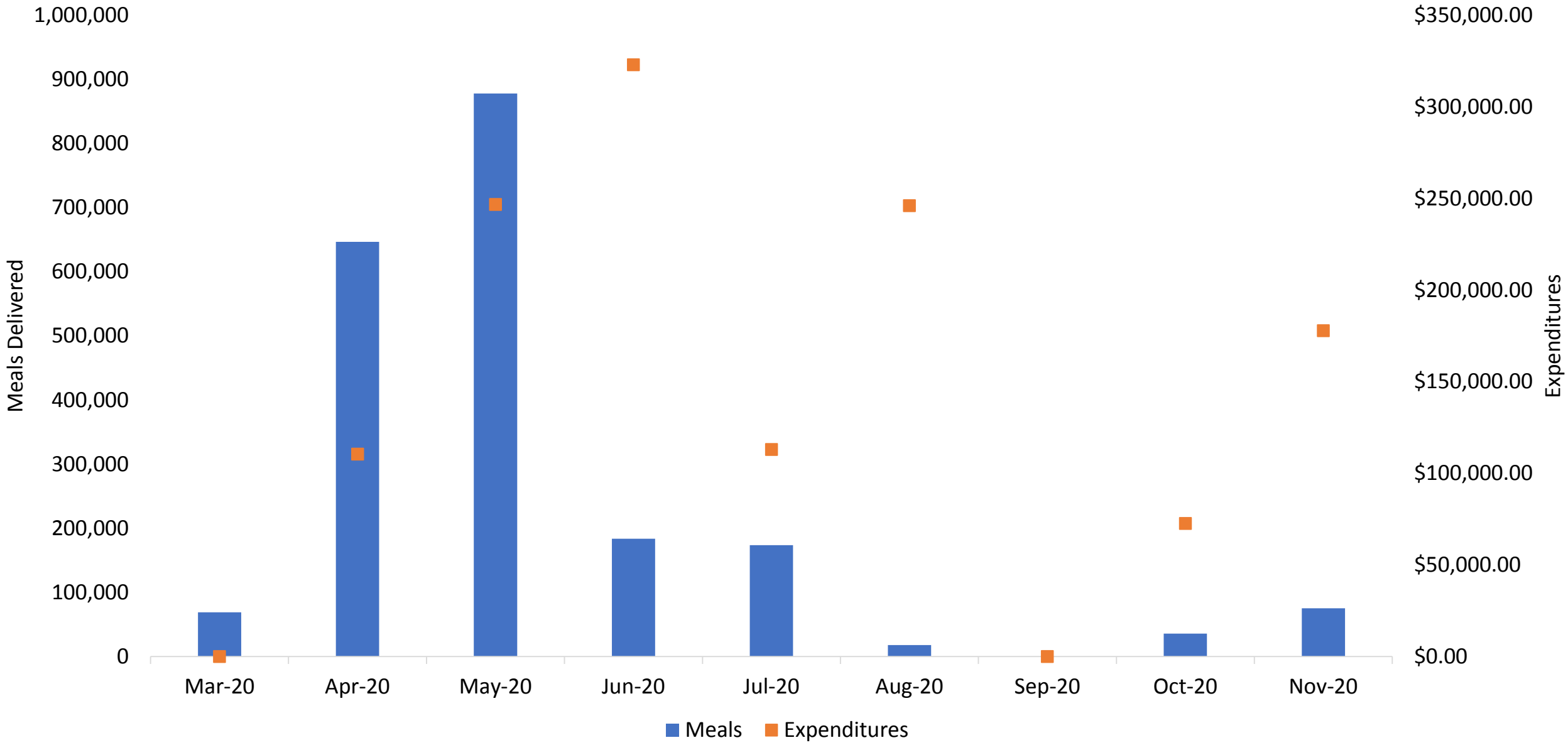
NM State Expenditures for COVID-19 Shelter
Total Expenditure: $8,897,043



NM Emergency Operations Center Food & Water Deliveries & Expenditures

Total Meals Delivered: 2,080,510

Total Expenditures: $1,290,156



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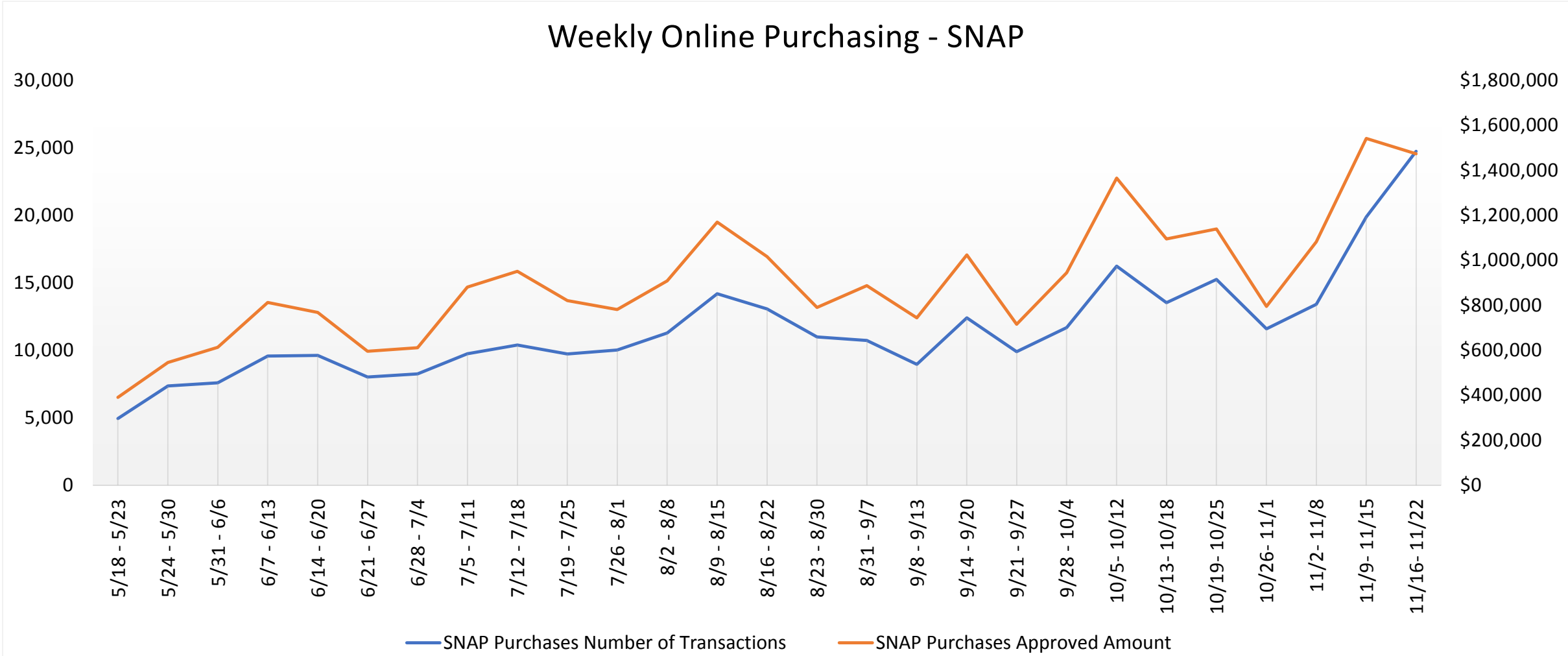
Automated System Program and Eligibility Network

Reporting Date – Nov 22nd,2020



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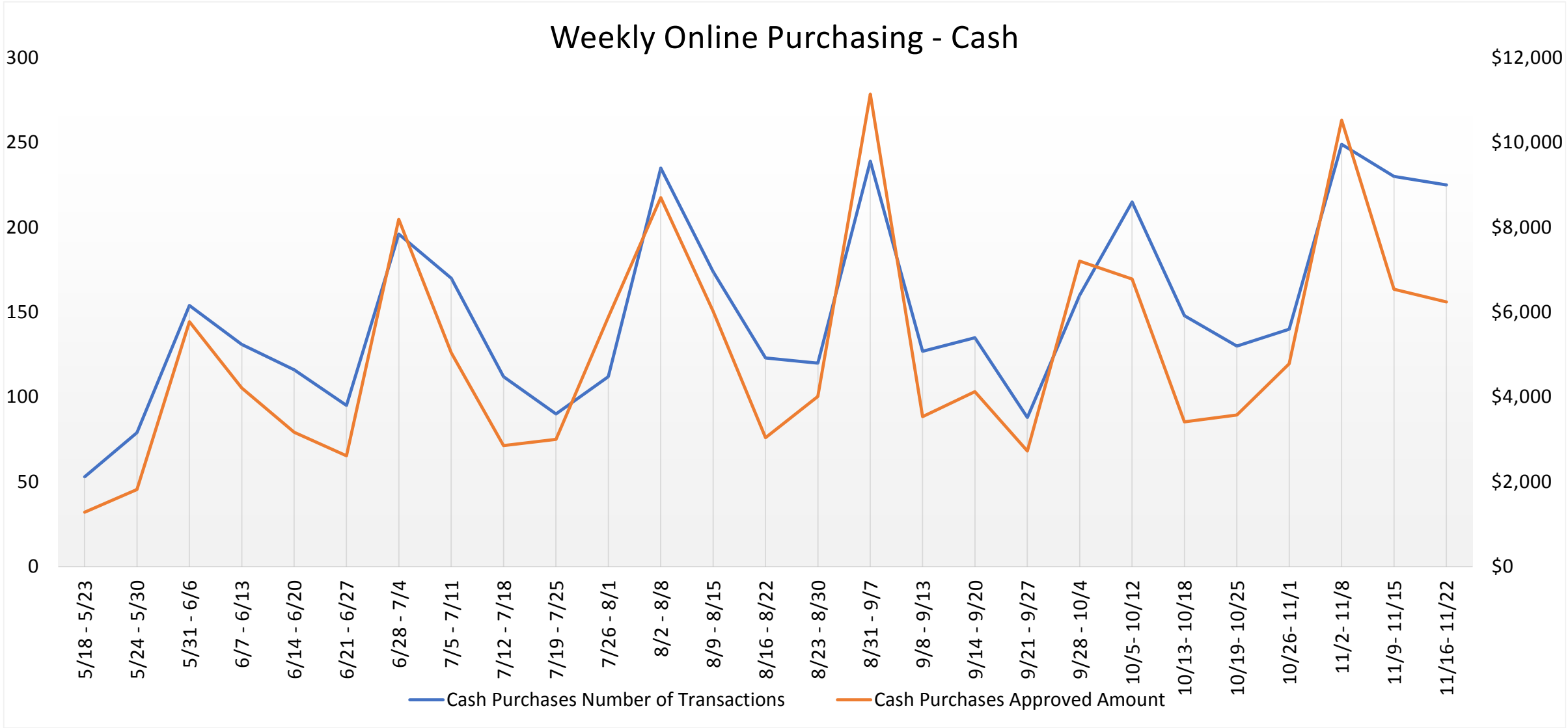
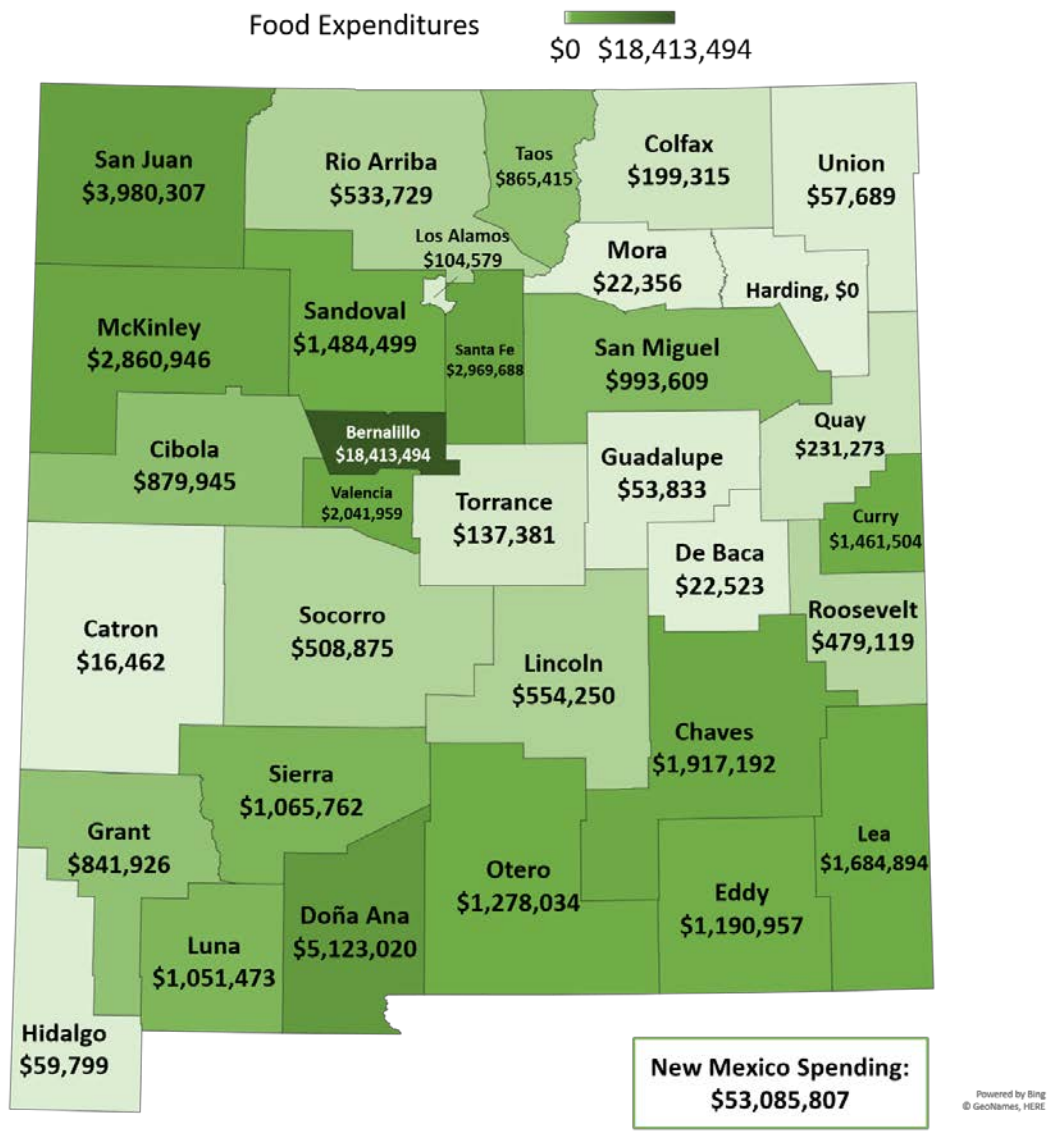
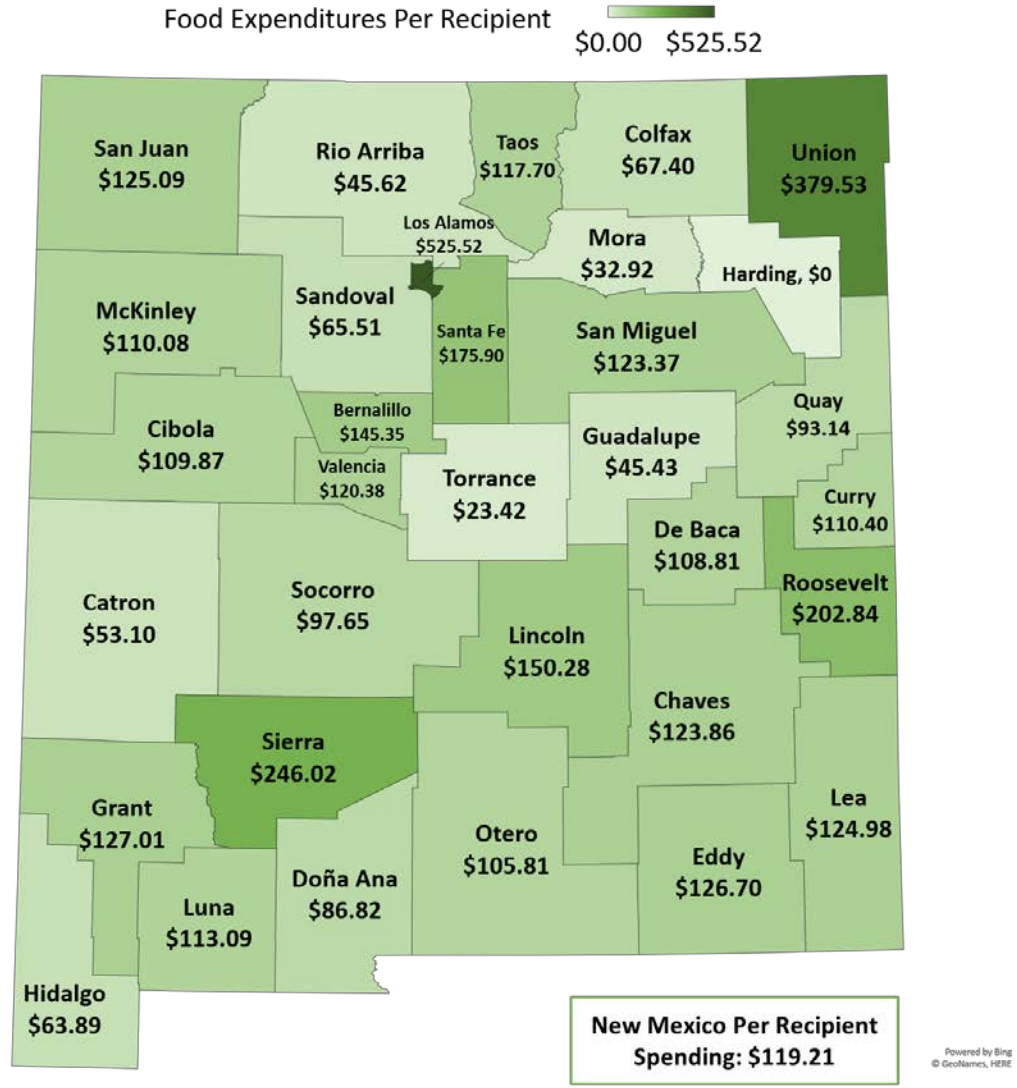


NM Supplemental Nutritional Assistance Program Benefit Spending by County, February 2020



Source: New Mexico Human Services Department EBT transaction records. February 2020. Values are amount of SNAP benefit dollars spent in authorized stores and establishments.

NM Supplemental Nutritional Assistance Program Per Recipient Benefit Spending by County, February 2020



Source: New Mexico Human Services Department EBT transaction records and SNAP enrollment data for February 2020. Values are amount of SNAP benefit dollars spent in authorized stores and establishments per recipient.

COVID-19 pandemic and the $16 trillion virus JAMA

- Aggregated costs for direct economic losses combined with mortality, morbidity, and mental health costs related to COVID-19 to estimate economic burden of pandemic in U.S.
- **Total economic cost of U.S. pandemic through Fall 2021 estimated at $16T or 90% of gross domestic product (GDP).**
  - Cumulative deaths estimated at 625,000 yielding $4.4T in losses for premature death.
  - Losses from long-term COVID-19 complications estimated at $2.6T.
  - Losses for mental health symptoms estimated at $1.6T.
  - Lost economic output estimated at $7.6T over 20 years.
- Lost income from COVID-19-induced recession accounts for 50% of total losses.
- **Economic return on investment of a SARS-CoV-2 testing and contact tracing program was estimated at 30 times the cost.**

Table. Estimated Economic Cost of the COVID-19 Crisis

Category	Cost (billions), US$
Lost GDP	7592
Health loss	
Premature death	4375
Long-term health impairment	2572
Mental health impairment	1581
Total	16 121
Total for a family of 4	196 475
% of annual GDP	90

Abbreviation: GDP, gross domestic product.

2.5 Million Person-Years of Life Have Been Lost Due to COVID-19 in the United States PREPRINT

- Researchers performed calculations of person-years of life lost as a result of 194,000 premature deaths due to SARS-CoV-2 infection as of early October, 2020.
- **Researchers estimate over 2,500,000 person-years of life have been lost so far in the pandemic in the US alone, averaging over 13.25 years per person with differences noted between males and females.**
  - Nearly half of potential years of life lost occur in non-elderly populations.

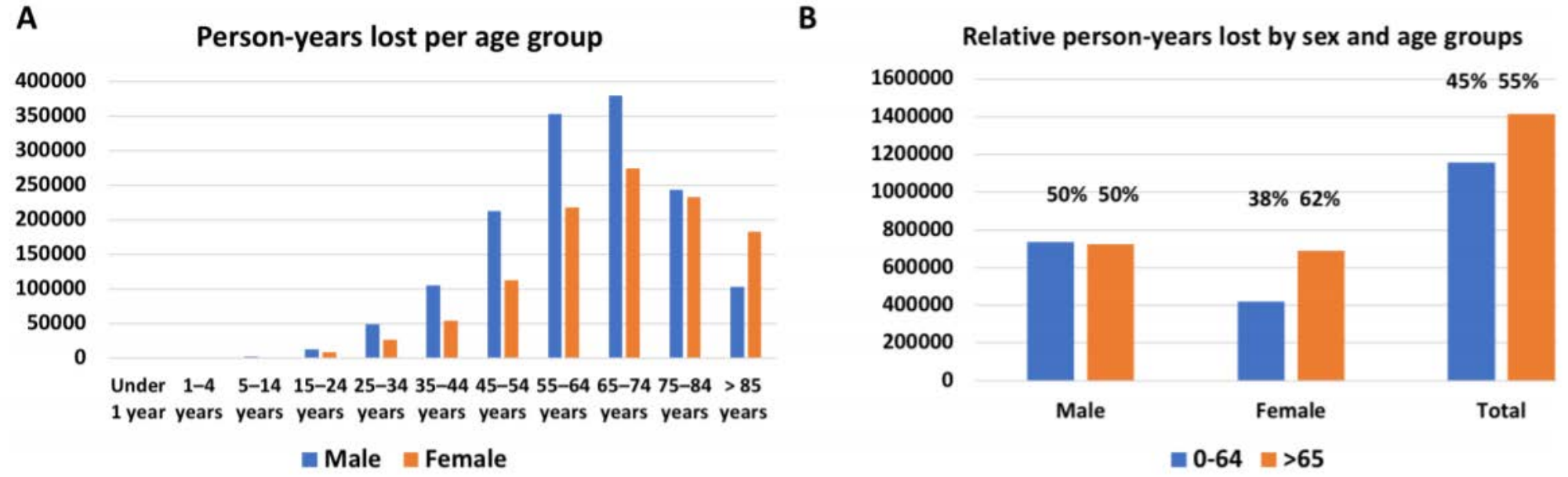


Figure 2. PYLL distribution by sex and age. (**A**) Person-yeast lost by age. (**B**) PYLL by sex.

HUMAN SERVICES DEPARTMENT

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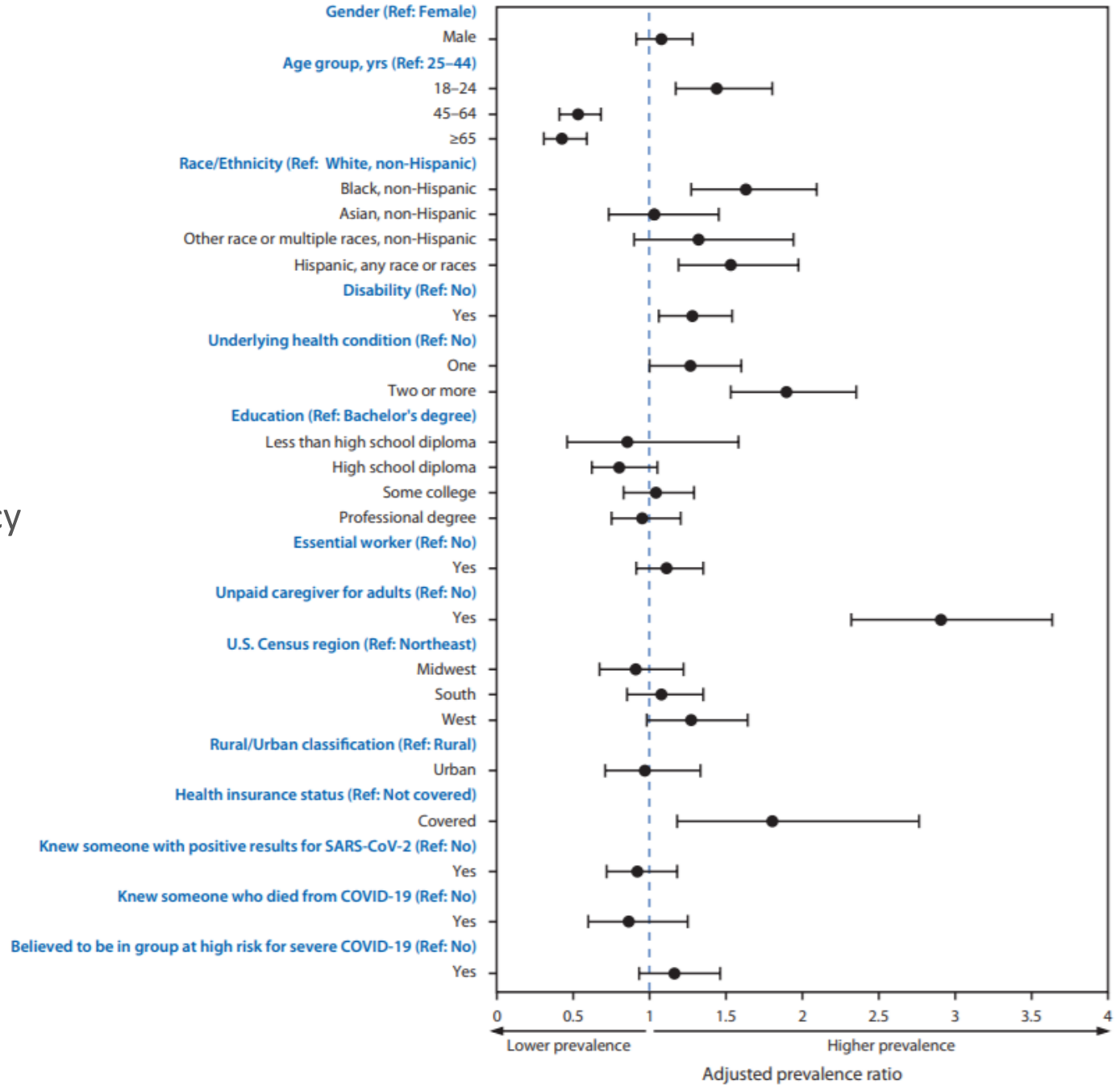
Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns U.S., June 202(

CDC

- **As of June 30, 2020, among 4,975 U.S. adult respondents, 40.9% reported having delayed or avoided any medical care, including:**
  - urgent or emergency care (12.0%)
  - routine care (31.5%)
- Groups of persons among whom urgent or emergency care avoidance exceeded 20% and among whom any care avoidance exceeded 50% included:
  - adults aged 18–24 years (30.9% for urgent or emergency care; 57.2% for any care)
  - unpaid caregivers for adults (29.8%; 64.3%)
  - Hispanic adults (24.6%; 55.5%)
  - persons with disabilities (22.8%; 60.3%)
  - persons with two or more selected underlying medical conditions (22.7%; 54.7%)
  - students (22.7%; 50.3%)

FIGURE. Adjusted prevalence ratios[*,†] for characteristics[§,¶,**,††] associated with delay or avoidance of urgent or emergency medical care because of concerns related to COVID-19 — United States, June 30, 2020



Prevalence of Underlying Medical Conditions Among Selected Essential Critical Infrastructure Workers — Behavioral Risk Factor Surveillance System, 31 States, 2017–2018 CDC

- **Obesity and hypertension were most common conditions in every essential worker group.**
- **Home health aides had highest unadjusted prevalence estimate (aPR) for every chronic condition except severe obesity and had significantly elevated adjusted prevalence ration (aPRs) for 5 conditions.**
- For health care support workers (other than home health), aPRs were significantly elevated for diabetes, obesity, and severe obesity.
- aPRs for nursing home workers significantly elevated for CHD, COPD, diabetes, hypertension, obesity, and severe obesity.
- Non-healthcare industries with statistically significant elevations in aPRs for more than one underlying condition included transit (current asthma and diabetes) and trucking (COPD, obesity, and severe obesity).

TABLE 2. Prevalence* and adjusted prevalence ratio (aPR)† of underlying health conditions among essential workers, by occupation§ — Behavioral Risk Factor Surveillance System, 31 U.S. states,¶ 2017–2018

Underlying condition	All workers**	Health practitioners	Health technicians and technologists	Health care support (except home health)	Home health and personal care aides	Protective services	Teachers, pre-K–grade 12
Asthma, current							
% (95% CI)	7.6 (7.4–7.9)	10.0 (8.7–11.5)	9.3 (7.2–11.7)	10.3 (8.5–12.4)	13.2 (9.6–17.6)	6.9 (5.0–9.2)	11.4 (9.8–13.2)
aPR (95% CI)	—	1.08 (0.94–1.25)	0.99 (0.78–1.27)	0.98 (0.80–1.19)	1.31 (0.96–1.78)	1.04 (0.78–1.39)	1.19 (1.02–1.39)
Asthma, ever							
% (95% CI)	12.8 (12.4–13.1)	14.4 (12.7–16.1)	14.6 (11.6–18.2)	14.3 (12.2– 16.7)	17.1 (12.9–22.0)	13.6 (11.0–16.5)	16.6 (14.6–18.8)
aPR (95% CI)	—	1.04 (0.92–1.18)	1.02 (0.81–1.28)	0.90 (0.76–1.06)	1.16 (0.88–1.78)	1.11 (0.92–1.35)	1.17 (1.03–1.33)
Cancer††							
% (95% CI)	3.7 (3.5–3.8)	4.0 (3.5–4.7)	3.5 (2.7–4.6)	3.0 (1.9–4.4)	5.0 (3.2–7.4)	2.6 (1.6–3.9)	4.3 (3.4–5.3)
aPR (95% CI)	—	0.84 (0.72–0.98)	0.85 (0.65–1.12)	0.83 (0.57–1.22)	1.02 (0.68–1.54)	0.96 (0.64–1.44)	0.96 (0.78–1.19)
Coronary heart disease§§							
% (95% CI)	3.0 (2.8–3.2)	2.0 (1.5–2.6)	1.4 (1.0–2.0)	2.2 (1.5–3.2)	4.4 (2.0–8.3)¶¶	2.7 (1.5–4.5)	1.6 (1.1–2.3)
aPR (95% CI)	—	0.75 (0.57–0.99)	0.64 (0.45–0.90)	1.32 (0.92–1.89)	1.80 (0.93–3.45)	0.95 (0.57–1.57)	0.70 (0.48–1.01)
Chronic kidney disease							
% (95% CI)	1.6 (1.5–1.7)	1.3 (1.0–1.7)	1.6 (0.8–2.9)¶¶	1.0 (0.5–1.6)	4.6 (2.0–9.0)¶¶	1.6 (0.8–3.0)¶¶	1.4 (1.0–1.9)
aPR (95% CI)	—	0.79 (0.59–1.05)	1.07 (0.58–2.00)	0.65 (0.37–1.12)	2.53 (1.24–5.14)	1.22 (0.66–2.26)	0.90 (0.64–1.27)
COPD							
% (95% CI)	3.1 (2.9–3.2)	1.7 (1.4–2.1)	3.0 (2.0–4.3)	4.0 (2.9–5.4)	6.2 (4.0–9.0)	2.5 (1.1–4.7)¶¶	2.7 (1.8–3.8)
aPR (95% CI)	—	0.46 (0.37–0.57)	0.91 (0.63–1.30)	1.25 (0.92–1.70)	1.68 (1.14–2.48)	0.89 (0.46–1.71)	0.76 (0.53–1.08)
Diabetes							
% (95% CI)	6.5 (6.3–6.8)	5.6 (4.7–6.5)	5.9 (4.5–7.5)	6.6 (5.2–8.1)	12.2 (8.2–17.4)	7.1 (5.0–9.7)	5.4 (3.9–7.3)
aPR (95% CI)	—	0.85 (0.72–1.00)	1.02 (0.80–1.31)	1.36 (1.10–1.67)	1.70 (1.21–2.39)	1.13 (0.83–1.53)	0.93 (0.69–1.25)
Hypertension* **							
% (95% CI)	23.7 (23.1–24.4)	20.3 (18.1–22.6)	23.2 (18.8–28.2)	21.2 (17.1–25.7)	29.3 (22.4–37.1)	25.6 (20.4–31.3)	17.8 (15.4–20.4)
aPR (95% CI)	—	0.86 (0.78–0.96)	1.11 (0.94–1.31)	1.10 (0.94–1.30)	1.15 (0.89–1.48)	1.04 (0.86–1.26)	0.81 (0.72–0.92)
Obesity (BMI≥30 kg/m2)†††							
% (95% CI)	29.9 (29.4–30.4)	26.1 (23.7–28.5)	37.4 (32.7–42.3)	40.0 (36.6–43.5)	44.8 (36.9–53.0)	39.6 (35.7–43.6)	27.3 (25.1–29.7)
aPR (95% CI)	—	0.86 (0.78–0.93)	1.27 (1.12–1.45)	1.29 (1.19–1.41)	1.38 (1.12–1.69)	1.24 (1.12–1.37)	0.86 (0.79–0.94)
Severe obesity (BMI≥40 kg/m2)†††							
% (95% CI)	4.3 (4.1–4.5)	3.3 (2.7–4.1)	4.1 (3.0–5.6)	9.1 (7.2–11.2)	9.1 (6.0–13.0)	5.5 (3.6–8.0)	4.9 (3.8–6.3)
aPR (95% CI)	—	0.67 (0.54–0.82)	0.86 (0.64–1.16)	1.62 (1.29–2.03)	1.59 (1.09–2.31)	1.26 (0.86–1.86)	0.95 (0.73–1.23)
Stroke							
% (95% CI)	1.2 (1.1–1.3)	0.8 (0.5–1.1)	1.7 (0.5–4.2)¶¶	0.9 (0.5–1.5)	2.0 (0.8–3.9)¶¶	0.3 (0.1–0.7)¶¶	1.3 (0.6–2.4)¶¶
aPR (95% CI)	—	0.67 (0.47–0.95)	1.68 (0.66–4.29)	0.99 (0.60–1.65)	1.50 (0.74–3.09)	0.32 (0.16–0.66)	1.23 (0.67–2.26)

Abbreviations: BMI = body mass index; CI = confidence interval; COPD = chronic obstructive pulmonary disease.

* Unadjusted, weighted estimates.

† Adjusted for age group (18–29, 30–39, 40–49, 50–59, 60–69, ≥70 years), sex, race/ethnicity (non-Hispanic White, non-Hispanic Black, non-Hispanic Asian, non-Hispanic other race, Hispanic). aPR reference group is all other occupations (essential and non-essential) combined.

§ By U.S. Census codes (https://www.census.gov/programs-surveys/cps/technical-documentation/methodology/industry-and-occupation-classification.html).

¶ California, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Washington, and Wisconsin.

** All currently employed non-active duty military respondents to the Industry and Occupation module of the 2017 or 2018 Behavioral Risk Factor Surveillance System.

†† Except non-melanoma skin cancer.

§§ Includes heart attack/myocardial infarction, coronary heart disease, or angina.

¶¶ Relative standard error >30% but ≤50%.

*** 2017 BRFSS data only, available for 22 states: California, Connecticut, Florida, Georgia, Hawaii, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Tennessee, Washington, and Wisconsin.

††† Body mass index (and thus obesity) was missing for 9% of cohort; all other behaviors and conditions missing for <1% of cohort.

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