🔵 **PSA/IHPF Strategic Brief — September 13, 2026**

Developments since September 10; one newly identified federal resource is explicitly dated earlier.

🟢 **TLDR — What changes PSA's choices**

- **Coverage navigation should begin with existing evidence, not more paperwork.** Federal clarification creates a practical question for New Mexico: which exemptions can the state verify without burdening patients?
- **"Human oversight" needs an interface design.** New research shows that when AI interrupts—and whether it contradicts the professional—changes trust.
- **Neighborhood screening must include downstream capacity.** Promising detection tools have limited value without affordable confirmation, treatment and completed handoffs.

These are PSA implications drawn from the developments below, not findings from an IHPF pilot.

🔵 **1. Medicaid exemption verification offers a concrete coverage-continuity opportunity**

What changed: A CMS framework released **September 8**, highlighted by the AMA on **September 11** and newly identified for this brief, explains how states can use existing claims and other information to establish medical-frailty exclusions from work requirements. Its three-tier approach is optional. CMS framework · AMA explanation and release date

Why it matters: Fewer unnecessary documentation requests could protect coverage and scarce clinician time.

Scale/evidence: Federal implementation guidance—not proof of reduced disenrollment or confirmation that New Mexico has adopted this approach. Insufficient data should trigger individual review, not be treated as evidence that no qualifying condition exists.

PSA implication — now: A Coverage Copilot could organize missing information and track escalation; authorized officials retain eligibility decisions.

Action: Ask HCA which exclusions it will verify automatically and how navigators should route unresolved cases.

🟣 **2. AI oversight depends on how—and when—people encounter its advice**

What changed: A **September 11** experiment tested AI pill-recognition assistance with **50 licensed pharmacists**. Advice timing and disagreement-based interventions changed trust; erroneous challenges to pharmacists' correct judgments produced substantial trust declines. Peer-reviewed study

Why it matters: Adding a human approval button does not, by itself, create effective oversight.

Scale/evidence: Browser-based simulation measuring trust—not evidence of fewer medication errors or better patient outcomes.

PSA implication — now: This complicates the cockpit hypothesis: poorly timed alerts may undermine the very professionals intended to supervise them.

Action: In a nonclinical navigation simulation, compare immediate AI suggestions with suggestions shown after staff review. Measure correct corrections, missed issues, overrides and workload—not satisfaction alone. Retain source-linked evidence and a named reviewer.

🟢 3. Sleep screening is promising, but the complete pathway remains unproven

What changed: A **September 11** systematic review included **60 studies**, with 47 contributing to a meta-analysis of AI sleep-apnea screening. Performance was generally favorable but varied substantially across settings. Review and results

Why it matters: Lower-burden screening could eventually extend neighborhood diagnostics where sleep-laboratory access is difficult.

Scale/evidence: The authors rated evidence certainty low or very low and identified limited external validation. Results combining different tools do not validate a particular device.

PSA implication — investigate now; deployment later: This supports exploring detection beyond today's pilot areas, but not autonomous diagnosis or immediate purchasing.

Action: Ask a clinical partner to map confirmatory testing, Medicaid coverage, equipment access and follow-up first. Evaluate any candidate tool against that pathway, including false positives and missed cases.

🟠 4. New Mexico's latest measles alert tests navigation readiness

What changed: On **September 10**, NMDOH reported a Valencia County case, bringing the state's 2026 total to **19**. The child had no known exposure or recent travel, raising concern about undetected transmission. Official public alert · Provider advisory

Why it matters: Community screening sites need a safe route for people who may require infection-control precautions.

Scale/evidence: A confirmed case and public-health advisory—not evidence of a southern New Mexico outbreak.

PSA implication — now: Navigation must connect people to authoritative guidance without inviting potentially infectious patients into shared waiting areas.

Action: Check that partner scripts direct exposure or symptom questions to clinicians or NMDOH's bilingual helpline, **1-833-796-8773**, and record whether the handoff occurred. AI should not assess individual infection risk.

🔵 **5. Improved suicide figures do not justify reducing support**

What changed: NMDOH's **September 10** release reports a **19% decline in the suicide rate between 2024 and 2025**, using provisional data. Suicide remained the second-leading cause of death among New Mexicans aged 12–17. State findings and resources

Why it matters: School-family partnerships and community navigators remain important points of connection.

Scale/evidence: Statewide observational data; the decline cannot establish that a particular intervention caused improvement.

PSA implication — now: Prioritize trusted human connections and bilingual referral capacity over automated mental-health prediction.

Action: Verify English–Spanish **988** referral procedures and staff training with school and community partners. Evaluate successful connections to support, while protecting privacy—not the number of alerts generated.

💡 **Imaginative Healthcare Ideas — Possibilities to Think With**

🟣 **A community-owned "care completion guarantee"**

Status: Original speculative concept.

What if a community organization accepted responsibility for helping a person complete an agreed next step—not merely issuing a referral? A pooled fund could cover small transport, childcare or connectivity barriers, while a named navigator coordinates the journey. The imaginative shift is from purchasing isolated services to financing completion across organizational boundaries.

PSA might borrow the shared barrier fund and explicit ownership of unfinished work. Payment design would need safeguards against avoiding difficult cases.

What if the unit of accountability were "a person successfully connected to care," rather than a visit or message?

🟠 **Healthcare organized around biological time**

Status: Emerging research direction; not a validated general service.

A **September 3** review—an older inspiration—explores AI-assisted treatment timing using biological rhythms and changing physiology. It challenges the assumption that the clock time convenient for a clinic is necessarily best for a patient. Research review

PSA could imagine future services coordinated around sleep, shift work, caregiving and clinician-approved treatment windows. Individual medication changes would remain clinical decisions.

What if care schedules adapted to people's lives and biology, rather than requiring people to adapt to institutional schedules?